DOCUMENT RESUME

ED 294 095 CG 020 761

TITLE	The Federal Response to the AIDS Epidemic: Information and Public Education. Hearing before a Subcommittee of the Committee on Government Operations. House of Representatives, One Hundredth Congress, First Session.
INSTITUTION	Congress of the U. S., Washington, D. C. House Committee on Government Operations.
PUB DATE	16 Mar 87
NOTE	317p.; Portions contain small print.
AVAILABLE FROM	Superintendent of Documents, Congressional Sales Office, U.S. Government Printing Office, Washington, DC 20402.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC13 Plus Postage.
DESCRIPTORS	*Acquired Immune Deficiency Syndrome; Federal Legislation; *Federal Programs; *Health Education; *Health Needs; Hearings; Prevention; Public Health; Public Policy
IDENTIFIERS	Congress 100th

ABSTRACT

The text of the seventh Congressional hearing on the federal response to the Acquired Immune Deficiency Syndrome (AIDS) epidemic, focusing on federal efforts to devise and implement a massive public education campaign, is presented in this document. A statement by Representative Ted Weiss providing a brief overview of the problem opens the document. Testimony by these witnesses is included: (1) Richard Dunne, executive director, Gay Men's Health Crisis; (2) David W. Fraser, member of the Institute of Medicine, and Health Care and Public Health Panel of the National Academy of Sciences Committee on a National Strategy for AIDS; (3) Kristine M. Gebbie, administrator, health division, Oregon Department of Human Resources; (4) Gilberto Gerald, director of minority affairs, National AIDS Network; (5) Stephen C. Joseph, commissioner of health, New York City Health Department; (6) Michael J. Rosenberg, executive director, American Social Health Association; (7) Florence Stroud, deputy director for community public health programs, San Francisco Department of Public Health; (8) George Swales, director, Sunnye Sherman AIDS Education Project; and (9) Robert E. Windom, Assistant Secretary for Health, United States Department of Health and Human Services. Additional materials submitted for the record are included. (ABL)

THE FEDERAL RESPONSE TO THE AIDS EPIDEMIC: INFORMATION AND PUBLIC EDUCATION

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON GOVERNMENT OPERATIONS HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

MARCH 16, 1987

Printed for the use of the Committee on Government Operations

U.S. GOVERNMENT PRINTING OFFICE

74-444 WASHINGTON : 1987

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

COMMITTEE ON GOVERNMENT OPERATIONS

JACK BROOKS, Texas, *Chairman*

JOHN CONYERS, JR., Michigan
CARDISS COLLINS, Illinois
GLENN ENGLISH, Oklahoma
HENRY A. WAXMAN, California
TED WEISS, New York
MIKE SYNAR, Oklahoma
STEPHEN L. NEAL, North Carolina
DOUG BARNARD, JR., Georgia
BARNEY FRANK, Massachusetts
TOM LANTOS, California
ROBERT E. WISE, JR., West Virginia
MAJOR R. OWENS, New York
EDOLPHUS TOWNS, New York
JOHN M. SPRATT, JR., South Carolina
JOE KOLTER, Pennsylvania
BEN ERDREICH, Alabama
GERALD D. KLECZKA, Wisconsin
ALBERT G. BUSTAMANTE, Texas
MATTHEW G. MARTINEZ, California
THOMAS C. SAWYER, Ohio
DAVID E. SKAGGS, Colorado
LOUISE M. SLAUGHTER, New York
BILL GRANT, Florida

FRANK HORTON, New York
ROBERT S. WALKER, Pennsylvania
WILLIAM F. CLINGER, JR., Pennsylvania
AL McCANDLESS, California
LARRY E. CRAIG, Idaho
HOWARD C. NIELSON, Utah
JOSEPH J. DioGUARDI, New York
JIM LIGHTFOOT, Iowa
BEAU BOULTER, Texas
DONALD E. "BUZ" LUKENS, Ohio
AMORY HOUGHTON, JR., New York
J. DENNIS HASTERT, Illinois
JON L. KYL, Arizona
ERNEST L. KONNYU, California
JAMES M. INHOFE, Oklahoma

WILLIAM M. JONES, *General Counsel*
STEPHEN M. DANIELS, *Minority Staff Director and Counsel*

HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE

TED WEISS, NEW YORK, *Chairman*

THOMAS C. SAWYER, Ohio
JOHN CONYERS, JR., Michigan
HENRY A. WAXMAN, California
BARNEY FRANK, Massachusetts

JIM LIGHTFOOT, Iowa
ERNEST L. KONNYU, California
JAMES M. INHOFE, Oklahoma

EX OFFICIO

JACK BROOKS, Texas

FRANK HORTON, New York

JAMES R. GOTTLIEB, *Staff Director*
GWENDOLYN S. MCFADDEN, *Secretary*
MARY KAZMERZAK, *Minority Professional Staff*
LINDA A. VALLEROY, PH.D, *Congressional Science Fellow*

CONTENTS

APPENDIXES

THE FEDERAL RESPONSE TO THE AIDS EPIDEMIC: INFORMATION AND PUBLIC EDUCATION

MONDAY, MARCH 16, 1987

HOUSE OF REPRESENTATIVES,
HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:03 a.m., in room 2154, Rayburn House Office Building, Hon. Ted Weiss (chairman of the subcommittee) presiding.

Present: Representatives Ted Weiss, Barney Frank, and James M. Inhofe.

Also present: James R. Gottlieb, staff director; Gwendolyn S. McFadden, secretary; Mary Kazmerzak, minority professional staff, Committee on Government Operations; and Linda A. Valleroy, Ph.D., congressional science fellow.

OPENING STATEMENT OF CHAIRMAN WEISS

Mr. WEISS. Good morning, The Human Resources and Intergovernmental Relations Subcommittee is now in session. We will be joined by other colleagues as the hearing proceeds.

Since 1981, the Public Health Service has reported almost 32,000 cases of AIDS in the United States. Unknown thousands suffer from pre-AIDS conditions. Medical experts believe that up to 2 million Americans are already infected with the AIDS virus.

Based on the current growth rate of the epidemic, more than 74,000 new cases will be diagnosed in the year 1991 alone.

These numbers only hint at the incredible suffering being endured by those struck down by the disease and by their families and friends and loved ones.

We have no vaccine to prevent the disease. Effective drugs for treatment are not yet in sight, although a few do show some promise. In light of these facts, it would be a grave mistake for the American people to relax and assume that researchers will find a cure for AIDS in the near future.

Public health officials tell us that the greatest hope for stemming the AIDS epidemic is an aggressive public health education campaign, greater than the United States has ever undertaken. Last fall, the National Academy of Sciences concurred, emphasizing that "The most effective measures for significantly reducing the spread

of . . . (AIDS) are education of the public and voluntary changes in behavior."

At about the same time the Surgeon General warned when releasing his excellent report on AIDS last October, "The need (for education) is critical and the price of neglect is high."

Today the subcommittee will hold its seventh public hearing on the Federal response to AIDS. In earlier hearings we have reviewed overall AIDS funding, discrimination, patient care, civil rights, testing and drug development, issues which remain extremely important. Today, we will focus on Federal efforts to devise and implement a massive public education campaign.

There are many dedicated Government Public Health Service people attempting to mount an effective education campaign. But, despite their urging for months, and in some case, for years, of specific education activities that are needed, they have been unable to get administration approval even for an overall AIDS information plan, which has been circulating for months.

In some cases, aggressive Federal activity has been stalled by bureaucratic and interdepartmental fighting, and in other cases, by controversies over the content of education materials being developed by Federal contractors.

Only after this hearing was announced a few weeks ago did a number of important projects finally begin to start moving at the Department. Some of these had been stalled for months, like a proposal to hire an ad agency to begin work on a media campaign. Even with this new initiative, it will probably be another full year before the mass media campaign begins.

One major stumbling block to Federal efforts is the continuing dispute over the content of school education material on AIDS. While I agree that school curriculum should be locally determined, the administration must not use this as an excuse to limit the information local school boards and parents have available to make those decisions. As the Surgeon General stated, "We can no longer afford to sidestep frank, open discussions about sexual practices."

The National Academy of Sciences was forced to conclude last fall that "The present level of AIDS-related education is woefully inadequate. It must be vastly expanded and diversified."

Other countries with many fewer AIDS victims have undertaken some excellent education campaigns. These will hopefully become models for the United States.

Fortunately, many local organizations, and public and private officials have stepped in to fill the void in Federal efforts. Some of these, like the American Red Cross, have been supported by grants from the Public Health Service, but much, much more is needed.

Education, information and the practice of safe behavior are the only weapons we presently have to stop the spread of the epidemic, to lessen unnecessary fear and to cease discrimination against AIDS victims.

Until now, the Federal Government's information and education efforts appear to have been, at best, slow and inadequate. Today, we will attempt to learn why, and try to make sure that everything which can be done, is being done.

As we proceed and other members arrive, we will afford them the opportunity to make their opening statements.

We have a number of panels scheduled. Our first witness, panel one, will be Dr. David W. Fraser, who is president of Swarthmore College, a member of the Institute of Medicine, and a member of the Health Care and Public Health Panel of the National Academy of Sciences Committee on a National Strategy for AIDS.

Dr. Fraser, before we proceed, the tradition and practice of the subcommittees of the Government Operations Committee is to swear in the witnesses. Would you please raise your right hand.

Do you affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth? Let the record indicate that the witness answered in the affirmative.

Dr. Fraser, your entire statement, as prepared, will be entered into the record, without objection.

STATEMENT OF DAVID W. FRASER, M.D., PRESIDENT, SWARTHMORE COLLEGE, AND MEMBER, INSTITUTE OF MEDICINE, AND HEALTH CARE AND PUBLIC HEALTH PANEL OF THE NATIONAL ACADEMY OF SCIENCES COMMITTEE ON A NATIONAL STRATEGY FOR AIDS

Dr. FRASER. Next to the threat of nuclear war, AIDS is fast becoming the most important public health problem of the 20th century. That importance comes from three facts, that it is likely to kill 179,000 people in the United States alone by 1991, that it affects especially young adults and, increasingly, children, and that, although we have no effective drugs to treat it nor vaccine to prevent it, we do know how to prevent the spread of the virus that causes it.

Education is the one tool that we have for controlling the AIDS epidemic but up to now it has not been used with near the effectiveness that is called for. I shall try to lay out the case for a centrally coordinated, comprehensive educational program to halt the spread of HIV, the AIDS virus, via sexual transmission, through intravenous drug use and from mother to infant.

HIV is most commonly spread by sexual intercourse, specifically anal intercourse and vaginal intercourse. People who are intent on not catching HIV have several good strategies they can follow.

The surest is to remain in a monogamous relationship that has been so since 1977 or to abstain from anal or vaginal intercourse but these strategies are not practical for many people and the number for whom this advice is not helpful grows as each generation becomes sexually active.

For those people, using a condom during anal or vaginal intercourse is likely to be very effective. Barring a tear in the condom the HIV is most unlikely to be transmitted through it, and other activity during lovemaking, including kissing and oral-genital intercourse, does not seem to spread the virus.

For couples who become monogamous, the blood test for antibody for HIV may be very helpful in determining when it is safe to stop using a condom. If both partners are seronegative 6 months after entering into a monogamous relationship, they are on pretty solid ground to assume that condoms are no longer needed so long as they have sex only with each other.

I should like to emphasize that I am not offering different advice for heterosexual and homosexual people here. All sexually active people are at risk. The risk of AIDS does not derive from sexual orientation but rather from particular sexual acts, number of partners, and precautions taken or not taken.

To date, educational efforts have clearly been insufficient except in a few special situations like the gay population of San Francisco where intense education has been associated with marked changes in sexual behavior.

One problem is the language used to educate. The Surgeon General has quite appropriately called for blunter, more explicit information about specific sexual acts and specific precautions but advice continues too often to be vague.

Warnings about "intimate sexual activity" or "exchange of bodily fluids" do not adequately differentiate between the potential riskiness of anal and vaginal intercourse and the apparent safety of, say, mutual masturbation.

We have heard welcome, open talk about condoms in recent weeks but the utility of condoms needs to be more widely known and their use encouraged and accepted.

The second most common way for HIV to spread is through the sharing of needles and syringes by intravenous drug users. Again, the mechanics of halting virus spread are simple.

If drug users would not share equipment, the virus in the blood would not be spread this way although spread from infected drug users to their sexual partners would still be a matter of concern.

Because of the complex psychological and social factors associated with intravenous drug use, simple dissemination of information is unlikely to be sufficient to curb spread of HIV in this population.

Public health workers will need also to help addicts get off drugs, to assist them into more stable personal situations, and to help them take more responsibility for their actions.

A great expansion of methadone maintenance programs may be an essential companion to education of drug users about AIDS.

The third biggest educational need has to do with the risk of transmission of HIV from mother to her infant or fetus. Over 300 cases of AIDS have been reported in children, half of them under 1 year of age. Most of the infants are born to mothers who are intravenous drug users themselves, are sexual partners of drug users or bisexual men or are from countries where the prevalence of HIV infection is higher in women than it now is in the United States.

But as heterosexual spread of HIV becomes more common, the number of women of childbearing age who are infected and could in turn pass HIV on to their children will increase.

We must develop educational programs to identify women at high risk of HIV infection and, in conjunction with serologic testing as indicated, counsel them about the risks to them and their children and alternatives open to them such as birth control or abortion.

In focusing on these three groups in need of education, I do not mean to indicate that education is not needed elsewhere. Myths about AIDS need to be dispelled so that people who are infected are not treated innumanely at work or at school by people who think erroneously that they might transmit the virus by such daily

activities as shaking hands, sneezing, coughing or sharing of utensils or even by embracing and kissing.

But the emphasis must be on educating people about ways they can stop HIV transmission through sex, by sharing IV drug paraphernalia and from mother to child.

I understand that the Centers for Disease Control has been given a mandate to oversee a national educational program about AIDS. Concentrating responsibility in that way will be essential for mounting an effective program but five other elements will also be necessary.

First, model programs for education and control must be developed for use in the States and the money must be provided for putting these model programs in place.

Second, counseling of people at high risk in conjunction with confidential serologic testing is critical. This will require great expansion of counseling and voluntary testing in such places as clinics for sexually transmitted diseases, IV drug use, and prenatal care.

Third, private physicians must be mobilized to serve as counselors and educators for all of their patients at risk of AIDS. Professional medical organizations, like the American Medical Association and the American Academy of Pediatrics, and State medical societies should be leaders in encouraging and focusing the work of private physicians to alert their patients to the danger and to help them make responsible choices.

Fourth, special attention must be paid to AIDS education for young people from junior high school on. By taking the initiative in developing models for AIDS education in schools and then providing funds and encouragement for putting them in place, the Federal Government would indicate how important it is that AIDS education be universal, be frank and begin early.

Fifth, advertising must be used more than it has been. Prime time television offers an important opportunity to reach a large portion of the U.S. population with detailed information about AIDS risk and practical preventive measures. The networks should be willing to contribute substantially to this effort as part of their public trust. Direct mailings, local radio spots and billboards can also be used imaginatively.

In summary, AIDS education should be pursued with a sense of urgency and a level of funding that is appropriate for a life-or-death situation. The total budget for AIDS education and public health measures from governmental and private sources combined should approximate $1 billion by 1990.

This represents per capita expenditure equal to that provided by the State of California for San Francisco in 1986. If we are to slow the spread of HIV, we must be ready to educate the entire U.S. population with the intensity that to date has been reserved for selected high-risk groups.

With a disease that has as long an incubation period as AIDS, we cannot afford to initiate intensive and sustained control measures, which means education, only after the disease becomes rampant everywhere.

[The prepared statement of Dr. Fraser follows:]

Testimony of David W. Fraser, M.D.

on AIDS Education

House Subcommittee on Human Resources and Intergovernmental Relations

March 16, 1987

I am David W. Fraser, President of Swarthmore College, a physician and an epidemiologist. Today I am representing the National Academy of Sciences and the Institute of Medicine, on whose Committee on a National Strategy for AIDS I served last year.

Next to the threat of nuclear war, AIDS is fast becoming the most important public health problem of the 20th century. That importance comes from three facts: 1) that it is likely to kill 179,000 people in the U.S. alone by 1991 and the epidemic could continue to expand in the decades afterwards; 2) that it affects especially young adults and, increasingly, children and 3) that, although we have no effective drugs to treat the underlying disease or vaccine to prevent it, we do know how to prevent the spread of the virus that causes it.

The parallels with nuclear war go somewhat further. At one level we know how to prevent nuclear war too -- we could dismantle all nuclear weapons. But to get mankind to the point that that might be done is a very complicated matter, requiring concentrated and comprehensive planning and implementation.

Education is the most promising tool that we now have for controlling the AIDS epidemic but up to now it has not been used with near the effectiveness that is called for. I shall try to lay out the case for a centrally coordinated, comprehensive education program to halt spread of the

virus that causes AIDS, the Human Immunodeficiency Virus or HIV, via sexual intercourse, through intravenous (IV) drug use and from mother to infant.

HIV is most commonly spread by sexual intercourse, specifically anal intercourse and vaginal intercourse. Like all sexually transmitted diseases, the chances of acquiring it go up as ones number of sexual partners goes up. And, the risk is related directly to the proportion of partners who are infected.

People who are intent on not catching HIV have several good strategies that they can follow. The surest is to remain in a monogamous relationship that has been so since 1977, or to abstain from anal or vaginal intercourse But these strategies are not practical for many people and the number for whom this advice is not helpful constantly grows as each new generation becomes sexually active. For those people, using a condom during anal or vaginal intercourse is likely to be very effective. Barring a tear in the condom the HIV is most unlikely to be transmitted through it -- and other activity during love-making, including kissing and oral-genital intercourse, does not seem to spread the virus. For couples who become monogamous, the blood test for antibody to HIV may be very helpful in determining when it is safe to stop using a condom. Most people develop a positive serologic test for HIV within 6-8 weeks of becoming infected; on the outside seroconversion may take 6 months. So if both partners are seronegative 6 months after entering into a monogamous relationship, they are on pretty solid ground to assume that condoms are no longer needed so long as they have sex only with each other.

If a man is found to be seropositive, he should continue to use a condom during intercourse. If a woman is seropositive, her male partners should continue to use condoms.

Those who reject monogamy or condoms may still be able to lower their risk of AIDS considerably by decreasing their number of sexual partners or by ensuring that the people with whom they do have sex are seronegative for HIV.

I should like to emphasize that I am not offering different advice for heterosexual and homosexual people here. The risk of AIDS does not derive, it seems, from sexual orientation but rather from particular sexual acts, numbers of partners, and precautions taken or not taken. All sexually active people are at risk, although that risk will vary (and is varying) according to the frequency of the infection in the population from which one chooses sexual partner(s).

Given that the risk of AIDS is great and growing and that ways to halt the sexual spread of HIV are pretty straight forward, it is essential that we find ways to alert people to their risk and inform them of ways that they can alter their sexual behavior to lower that risk markedly. Efforts to date have clearly been insufficient except in a few special situations like the gay population of San Francisco where intense educational efforts have been associated with marked changes in sexual behavior. One problem is the language that has been used to educate. The Surgeon General has quite appropriately called for blunter, more explicit information about specific

sexual acts and specific precautions but advice continues too often to be vague. Warnings about "intimate sexual activity" or "exchange of bodily fluids" do not adequately differentiate between the potential riskiness of anal and vaginal intercourse and the apparent safety of, say, mutual masturbation. We have heard welcome, open talk about condoms in recent weeks but the utility of condoms needs to be more widely known and their use encouraged and accepted.

The second most common way for HIV to spread is through the sharing of needles and syringes by intravenous drug users. Again, the mechanics of halting virus spread are simple. If drug users would not share equipment the virus in the blood would not be spread this way, although spread from infected drug users to their sexual partners would still be a matter of concern. The importance of educating drug users is especially great because of the wide differences that now exist in the rate of HIV infection among drug users in different cities in the U.S. Many people now at high risk of infection can be spared if effective educational efforts can be mounted quickly, and then sustained.

Because of the complex psychological and social factors associated with intravenous drug use, simple dissemination of information is unlikely to be sufficient to curb spread of HIV in this population. Public health workers will need also to help addicts get off drugs, to assist them into more stable personal situations, and to help them take more responsibility for their actions. A great expansion of methadone maintenance programs may be an essential companion to education of drug users about AIDS.

The third biggest educational need has to do with the risk of transmission of HIV from mother to her fetus or infant. Over 300 cases of AIDS have been reported in children, half of them under one year of age. Most of the infants are born to mothers who are intravenous drug users themselves, are sexual partners of drug users or bisexual men, or are from countries where the prevalence of HIV infection is higher in women than it now is in the United States. But as heterosexual spread of HIV becomes more common the number of women of childbearing age who are infected and could in turn pass HIV on to their children will increase. We must develop educational programs to identify women at high risk of HIV infection and, in conjunction with serologic testing as indicated, counsel them about risks to them and their children and alternatives open to them such as birth control or abortion.

In focusing on these three groups in need of education, I do not mean to indicate that education is not needed elsewhere. Myths about AIDS need to be dispelled so that people who are infected are not treated inhumanely at work or at school by people who think (erroneously) that they might transmit the virus in such daily activities as shaking hands, sneezing, coughing or sharing of utensils--or even by embracing and kissing. But the emphasis must be on educating people about ways they can stop HIV transmission through sex, by sharing IV drug paraphernalia and from mother to child

We understand that the Centers for Disease Control has been given a mandate to oversee a national educational program about AIDS. Concentrating

responsibility in that way will be essential for mounting an effective program, but other elements will also be necessary. Suggestions for model programs for education and control must be developed for use in the states, and the money must be provided for putting those model programs in place. Experienced representatives of state and local health departments, health care providers, educators and potential consumers can help greatly in advising on the content of these model programs.

The use of serologic testing in conjunction with careful counselling is likely to be an important part of education especially of those in high risk groups. This will require great expansion of counselling and voluntary testing in clinics for sexually transmitted diseases, IV drug use, and obstetrics and gynecology. In all of this work, we must be very careful to protect the confidentiality of test results if these programs are to be effective in reaching those that need them.

Private physicians must be mobilized to serve as counsellors and educators for all of their patients at risk of AIDS. Professional medical organizations like the American Medical Association and the American Academy of Pediatrics, and state medical societies should be leaders in encouraging and focusing the work of private physicians -- alert their patients to the danger and to help them make responsible choices.

Special attention must be paid to AIDS education for young people in junior high school, high school and college, many of whom are entering periods of experimentation with sex and drugs Frank discussion of the risk

of AIDS and behaviors that do and do not transmit HIV has become an urgent necessity. CDC could, for example, develop several model curricula for use in junior high schools, allowing local school boards to select which might be most appropriate for their particular settings. By taking the initiative, however, CDC and the Federal government generally would indicate how important it is that AIDS education be universal, be frank and begin early.

A broad and effective educational campaign is likely to require far more use of advertising than has occurred to date. Prime time television offers an important opportunity to reach a large portion of the U.S. population with detailed information about AIDS risk and practical preventive measures. The networks should be willing to contribute substantially to this effort as part of their public trust. Local radio spots and billboards can also be used imaginatively

AIDS education should be pursued with a sense of urgency and a level of funding that is appropriate for a life-or-death situation. Greatly expanded educational programs to effect behavioral change are necessary for high-risk groups and the public at large. The total budget for AIDS education and public health measures from governmental and private sources combined should approximate $1 billion annually by 1990 This represents per capita expenditure equal to that provided by the State of California for San Francisco in 1986. If we are to slow the spread of HIV, we must be ready to educate the entire U.S. population with the intensity that to date has been reserved for selected high risk groups. With a disease that has as long an incubation period as AIDS we cannot afford to initiate intensive and sustained control measures -- which means education -- only after the disease becomes rampant everywhere.

Mr. WEISS. Thank you very much, Dr. Fraser. Before we proceed with questions, let me take note of the fact that we have been joined by one of the newest members on the subcommittee and in the Congress, Mr. Inhofe from Oklahoma. We are delighted to have you with us. I understand that you have an opening statement that you would like to give.

Mr. INHOFE. Yes, I do, Mr. Chairman, if I may be allowed to make a brief opening statement. I want to thank you for holding the hearing on AIDS education and prevention efforts. It is urgent that we as Members of Congress work toward stopping this dreadful killer.

In my home State of Oklahoma, the number of AIDS cases has doubled each year since 1983 according to the State health officials I have personally talked to. By the end of the decade, the disease could become the No. 2 communicable disease in the State. To date, there have been 92 reported cases of AIDS and 49 deaths.

Of the reported cases, 25 have occurred in Tulsa, OK, the district which I represent. Oklahoma health officials estimate that the number of AIDS cases could top 800 by 1990.

Although these numbers are much lower than most other States, the spread of AIDS represents a serious threat to all communities.

Today's tragic reality is that AIDS is continuing to affect more Americans because many of its victims continue to transmit the disease because they are unaware that they are carriers of the virus.

AIDS is no longer confined to homosexuals and drug users but has been spread to the general population. Recent studies by the Federal Public Health Service indicate that approximately 9 percent of all new cases of AIDS involve those who contracted the disease as a result of heterosexual activities.

It is my hope that today's hearing will make significant progress in preventative measures to stop the spread of AIDS.

I want to thank you for giving this emphasis on it, Mr. Chairman. One of the myths that kind of spreads around is that only people on the east coast and the west coast should be concerned with this problem. In visiting with Bill Dannemeyer prior to going into session in January, I found that people out in California are very much concerned.

There seems to be a fear, Mr. Chairman, for people in my part of the country to address this as being a serious problem. So as an experiment and I will share this with you, I went back in the third week in January, and held a news conference just on AIDS and the threat that it was in a very frontier spirited conservative area like Tulsa, OK, and let me assure you that it captivated their attention.

I feel very strongly in my limited exposure to the knowledge on AIDS that it is the greatest life threat in the history of the world. I am very, very much concerned about it. So that comes from out in Oklahoma, and I do have a question for Dr. Fraser when the appropriate time comes.

Mr. WEISS. Thank you very much, Mr. Inhofe.

Dr. Fraser, you are familiar with the Surgeon General's report on AIDS, I'm sure.

Dr. FRASER. Yes.

Mr. WEISS. We will, incidentally, from time to time be placing the various reports and documents that we refer to in the hearing record, without objection. If any of the members or any of the witnesses have material which they would like to place in the record, please so indicate and we will try to make that effort.

Are you in general agreement with the findings and recommendations contained in the report?

Dr. FRASER. Yes. I think in general the U.S. Public Health Service has done a remarkable job in investigating this problem and in identifying ways to control it. I think that more has to be done than has been done. Much of the limitation of that has to do with funding, but clearly the directions are outlined by the Surgeon General.

Mr. WEISS. Are there any areas of serious disagreement between the National Academy of Sciences' report and the Surgeon General's report?

Dr. FRASER. I think the biggest area of contrast is in the concern of the National Academy and Institute of Medicine Committee that the education effort be greatly expanded, centrally coordinated and put forward more assertively than has been the case in the past. We recognize that many in the U.S. Public Health Service want to do that same thing but our Committee wanted to emphasize this even more strongly than the Surgeon General has because there is so much more to do.

Mr. WEISS. The National Academy of Sciences' report states that "education to prevent HIV infection can be strongly expected to bear results," especially in view of the serious and fatal nature of the disease.

What leads you to believe that education will help to prevent HIV infection?

Dr. FRASER. I think the best evidence of that comes from the gay populations, as in San Francisco, where intense efforts have been put in place by the city, by private voluntary organizations, and by the State of California, along with help from the U.S. Public Health Service. There, there has been evidence of changes in sexual behavior, as evidenced by drops in rectal gonorrhea rates, indicating changes in sexual behavior in that population.

Mr. WEISS. Until recently, relatively little money has even been requested by the Public Health Service for information/education. I wonder if this can be connected in any way to the overly optimistic predictions by the administration several years ago that soon we would have a vaccine and effective treatment measures.

Is there still a belief in the administration, do you think, that one need not worry too much about AIDS because we will soon have a cure?

Dr. FRASER. There may be members of the administration who believe that. The scientists with whom I talked believe that, for the next 5 or 10 years, our emphasis has to be on education because it is the only method we have to halt spread of the virus. Even the optimists think that a vaccine will be unavailable for the next 5 years.

Mr. WEISS. The NAS report describing AIDS education to date states "The present level of AIDS related education is woefully inadequate." Why did the Committee come to that conclusion?

Dr. FRASER. Well, for example, if we look at one of the major needs, counseling in conjunction with confidential serologic testing of high-risk groups, perhaps $40 million has been spent last year on that activity. I would estimate that the cost of a really adequate program of counseling and confidential testing of high-risk people would cost somewhere between $200 and $600 million a year.

It is a major expense to train counselors. There is a high burnout rate among counselors. There is the need for very careful work between counselors and high risk people, to make sure that they understand the way this disease is spread, that they understand the mechanisms that are open to them to halt the spread of the disease and they understand what their own situation is, if they happen to be infected.

Mr. WEISS. The report also states that "If behavior modification is the goal of education about AIDS, the content of the material presented must address the behavior in question in as direct a manner as possible."

The Surgeon General agreed with that very conclusion. Based on your experience and the discussions of the NAS Committee, do you believe that the Federal Government can effectively support frank and open education efforts?

Dr. FRASER. I think it's hard for the Federal Government to do that. I think that the Federal Government has taken some steps to put some distance between the tendency to be reserved in speech and the actual decisionmaking about what materials are used at a local level, but I certainly see a trend toward more frankness. I think we need much more frankness than we have had to date, not just talk about condoms but talk about specific sexual acts, as I did in my testimony.

Mr. WEISS. Why did the Committee believe that only the Federal Government was situated "to develop and coordinate a massive campaign to implement the educational program"?

Dr. FRASER. The Federal Government has been superb in my view and I think in the view of all members of the Committee in pursuing the scientific aspects, the epidemiologic aspects and the virological research that has been necessary. It is in a uniquely strong position to provide publicity about the need for education and adequate funding throughout the United States, not just in States where there is already the perception of a very high risk, like California or New York, but in States where the perception is that the risk is not so immediate.

We need to have education put in place intensively now in high- and low-risk areas. I do not see the central drive for that coming efficiently anywhere from any source other than the Federal Government.

Mr. WEISS. The Public Health Service has been working on what they call an AIDS information/education plan for many months. Have you, or to your knowledge, any of the National Academy of Sciences' Committee members been asked to assist in the drafting or review of the Public Health Service plan?

Dr. FRASER. I have not been asked and I don't know of other people who have been asked.

Mr. WEISS. Have you seen the proposed plan?

Dr. FRASER. No. I have talked to people who have seen it but I've not seen it myself.

Mr. WEISS. The NAS Committee expressed serious concerns about the Centers for Disease Control's directive, requiring local review boards to determine whether materials developed for AIDS education were too explicit, the so-called "dirty words" issues. Why is this a problem and who do you think should make these decisions?

Dr. FRASER. I think there are different sensitivities about the use of explicit information. I think it has traditionally been difficult for the Federal Government to impose educational standards on local areas. The U.S. Public Health Service has worked hard not to intrude on State responsibility and local responsibility in this area.

AIDS is a problem that I think pushes us up to the limit of what is appropriate. I think it would be quite useful for the CDC to develop educational information perhaps in two or three different forms with various degrees of explicitness that would be appropriate perhaps for different age groups as well as for different populations and offer that range of educational material to the State and local authorities who could pick out what seemed to be most appropriate for the groups they were educating.

Mr. WEISS. I gather that the NAS Committee felt a great concern about having all this work prepared, and then having the local review board negate what had been developed.

Dr. FRASER. I think we did worry about that but we also worried on the other side about what would happen if the CDC worked out one set of educational material which was then objectionable to local educational and health authorities. We did not want to lose the opportunity to have the fullest education of all populations at risk and were willing to consider a variety of ways that could be effective.

Mr. WEISS. Directly following the expression of concern that I quoted, the next line is "The result of such a process . . . " that is the local review board process, "could be to cut off frank, explicit information from areas where it is needed the most, in regions outside those urban centers that have large concentrations of homosexual men and IV drug users, where awareness of the specifics of HIV transmission is already high."

Do you agree with that?

Dr. FRASER. I do agree with that and I think that to have local review can have that effect, but I think with central leadership from the Federal Government, going further than the Surgeon General has in talking about the importance of bluntness, we can create an environment in which it is all right to talk about sex, and it is all right to talk about behaviors that will prevent the transmission of HIV.

That's the kind of leadership that I think the Federal Government can give. That doesn't mean that the Federal Government need prescribe every letter of the text that is used in schools or with high-risk populations.

Mr. WEISS. It is generally recognized that the private sector must play a major role in AIDS education. In fact, some, such as the American Council of Life Insurance in conjunction with the Red Cross, have done so in the past.

Does the Academy, or do you, have any suggestions on promoting an expansion of private efforts?

Dr. FRASER. Well, certainly looking at those areas where AIDS education has been good, private organizations have contributed mightily to the work in San Francisco or New York. There are private medical groups that we think could do more. The American Medical Association, I think, could have a major effect in educating physicians and in focusing their work on providing proper education to all of their patients who are at risk of AIDS. This is a whole population of counselors that the private medical community could help mobilize.

Mr. WEISS. Have there been efforts to involve the medical associations in the overall effort?

Dr. FRASER. There have been some. I don't think they have been as comprehensive or as effective as they could be.

Mr. WEISS. Up to now, public service announcements have been the primary vehicle used to do what little education has been done. Is this sufficient to reach the people that are the targets in the education campaign?

Dr. FRASER. I think not. They tend to be brief. They tend to be out of prime time. They do not necessarily reach the broad range of U.S. population including high-risk groups that need to be reached. I think we need a far more comprehensive advertising campaign involving extensive time in prime time, involving direct mailings, involving radio spots and billboards. All of these are likely to complement each other in providing for a much more effective outreach to high-risk groups.

Mr. WEISS. The report notes the extremely high costs involved in the use of mass media, such as newspaper, TV and radio advertising, yet reflects that private sector companies are willing to spend $30 to $50 million to introduce a new camera or a new detergent. Those efforts are judged successful if they produce a modest shift in behavior.

How much advertising do you think will be needed to influence the behaviors that spread AIDS?

Dr. FRASER. It's very hard to say nationally. In San Francisco, the average expenditure in 1986 by the State of California was about $5 per person for all educational and public health activities. That included a fair amount of advertising. A comprehensive campaign without my suggesting who actually pays for it, because I think the networks ought to be willing to provide a large proportion of it free, might cost in the area of $100 million a year.

Mr. WEISS. The report indicated that by the year 1991 there should be about $1 billion a year provided for total public education, mass education programs, from a variety of sources, public and private.

The report also said that the major portion of this total should come from Federal sources because only the national agencies are in the position to launch coordinated efforts commensurate with the problem. Even then it is possible that the amounts envisaged by the NAS Committee will not be sufficient to stem the increase in the disease.

Do you agree with those conclusions?

Dr. FRASER. Yes; I do.

Mr. WEISS. Does the National Academy of Sciences have any type of ongoing review of AIDS?

Dr. FRASER. The National Academy of Sciences' Institute of Medicine Committee has not met since its report was released at the end of last fall. It has, however, seen great value in, and discusses in its report the value of, continuing to have oversight. To my knowledge, the next stage has not been taken in that process.

Mr. WEISS. Do you think that the NAS would be willing to undertake a continuing advisory role, such as a Federal contract, to require annual detailed reports and recommendations, such as the 1986 report that you issued?

Dr. FRASER. Yes. I think the National Academy of Sciences and the Institute of Medicine feel an ongoing responsibility to help in overseeing, although not directing, of course, the ongoing Federal, State, and local efforts.

Mr. WEISS. Thank you.

We have been joined, since opening the hearing, by our distinguished colleague from Massachusetts, Mr. Frank, and we welcome him to this hearing. He has played a very important role in the ongoing hearings that this committee has conducted over the years.

Mr. Frank, do you have an opening statement or any comments or questions?

Mr. FRANK. Thank you.

Dr. Fraser, I'm sorry that I missed part of your statement, but I read it through as I was sitting here.

One question that I have has to do with areas that you had touched on by Mr. Weiss. It seemed to me—and I'll be asking our friends from HHS here—that Dr. Koop, who is, I thought, well intentioned, thoughtful, on the right track, got somewhat slowed down when he had to sign a treaty with Secretary of Education Bennett on the question of education, and it seemed to me that Dr. Koop's thoughtful and well-informed direction was somewhat deterred by Mr. Bennett's deciding to ideologize it.

And I will ask the people from HHS about that, and not expect them to answer me, but I will ask them.

But I did want to ask you, without commenting—well, let me ask you specifically—you saw the statement that was issued as a result of the Koop/Bennett meeting, which I think was initiated by people outside of the administration.

Dr. FRASER. I have heard about it. I have not seen it.

Mr. FRANK. All right. Well, it seemed to me to move the educational efforts away from explicitness, et cetera. Do you think that was helpful?

Dr. FRASER. I think it's extremely important that the educational effort be explicit, and I strongly favor the direction that the Surgeon General has gone in suggesting that language be blunt, that we talk about specific sexual acts, and that we talk about specific ways that people can keep from spreading the HIV.

I would be very disappointed if we retreated into euphemisms.

Mr. FRANK. I think that's not just euphemisms that we're talking about, but we're retreating into, it seems to me, not discussing some things, as I understood what Mr. Bennett was trying to do.

I guess, as I understand, what Mr. Bennett seems to be doing, and some others, is that they believe that the education we do

should have a dual purpose, that it should be to inculcate values—in fact, Mr. Bennett's values and Mr. Meese's—and that education which suggested that behavior that Mr. Bennett doesn't approve of might be carried out would be wrong.

I'm wondering what you think, and specifically what, as I understand it now—let me leave aside Mr. Bennett for now—but there are people who argue that any education ought to be based on telling people that they should be monogamously heterosexual, and then—if they are married, and if they are not married, they should abstain from sex, and that those should be essential elements of AIDS education.

I wonder what you think about an AIDS education that would tell people that they should be engaged only in sex after marriage and no other kind? Do you think that will be an effective education program for the part of AIDS that is sexually transmitted?

Dr. FRASER. I don't think it will have the degree of effectiveness that we just have to have in an AIDS education program. I think we have to reach out to all people in our country who are at risk of spreading or acquiring HIV.

Mr. FRANK. Well, I think we should stress——

Dr. FRASER. To do that, we cannot proscribe certain activities, and we cannot write off certain people. We must bring the education to all people who are at high risk, recognizing that there are differences in sexual behavior and sexual orientation. We must be helpful to the people whom we're serving, not condemning of certain actions.

Mr. FRANK. Well, I must say, of all the things I would like to see members of the President's Cabinet doing, proscribing sexual practices for Americans without regard to health effects, seems to me—it's very low on my list, so I would like them to concentrate on the health effects.

I mean, if they are that interested in other things, then they ought to—maybe Secretary Bennett should go be the MC on "The Dating Game," but he ought not—[laughter]—but he ought not to interfere, it seems to me, with efforts to save people's lives.

You're a college president. How effective, aiming at the college population with which you are particularly familiar at Swarthmore and an alumnus of which is making big political news in Massachusetts these days, as you know, but how effective would this type of education which, as I understand it, basically says that the thing you should tell particularly unmarried college students of any sexual orientation is that the best way for them is to abstain and that information should heavily counsel abstention from any sexual activity and should not in any way suggest that it was okay to engage in any form of sexual activity?

Would you find that to be a particularly effective way of transmitting information to the college students with whom you're familiar?

Dr. FRASER. I would find that quixotic. I think it is fine to tell people that the way to lower their risk the most is to abstain from sex. It's probably true.

Mr. FRANK. No one doubts that. I don't think anyone doubts that.

Dr. FRASER. But that is not practical advice for the large majority of people, including a large proportion of college students. So I want to be more helpful to our students than such advice would be.

Mr. FRANK. Well, I notice in your own statement, you, I think, talk about monogamy and that that's the safest way, if you're going to be having sex, and I don't think—and I'm glad you said that—no one is doubting that abstention is the safest. But the question is whether that is sufficient unto itself as advice. And I guess the question basically has been answered by what you say.

I agree very much with what you say, and I think we ought to be clear that we are talking about people in the executive branch of the administration and the executive branch of the Federal Government, who I think are, for ideological reasons, interfering with the most effective form of education.

It seemed to be very clear that Dr. Koop, on his own, was going in a better direction until he was presumably directed by higher political authority—unfortunately not higher medical authority—higher political authority and lower medical authority to water down his efforts, and I think that is unfortunate.

I thank you.

Mr. WEISS. Thank you very much, Mr. Frank.

Mr. Inhofe.

Mr. INHOFE. Dr. Fraser, I think it probably would be more appropriate to explore this with another witness, who is more directly involved in the other concerns, other than just education. But in terms of—do you have any comments or thoughts about the various State laws that might be inhibiting the research and development because of protecting privacy or any other banner under which they are passing laws to inhibit the transfer of information to make a more effective research and development program, insofar as the AIDS virus is concerned?

Dr. FRASER. I think there is a very thorny issue having to do with protecting confidentiality of information about serologic testing for HIV. I don't have an answer for what would be most appropriate.

The poles of the argument are, I'm sure you well know, that on one hand public health authorities need to know who is infected, if they are going to pull together the information and attack the problem in as effective a way as they could.

On the other hand, if there is any thought that the confidentiality of such information would be breached, then people with the greatest need to know their own infection status and to modify their behaviors would be likely to refrain from being tested out of fear that those results would become public.

A number of States have wrestled with what kind of State law to have about reporting or not reporting, and they disagree.

Mr. INHOFE. Yesterday, I read something rather alarming that came out of, I think, Ascension, out of Paraguay, concerning the mosquito being a vector of this. I know that this is not to be discussed, and this isn't your end of it, but I just wondered if you heard—that was over the weekend—there was a release concerning that. Did you read that by any chance?

Dr. FRASER. No. And it's certainly not my area.

Mr. INHOFE. Yes, OK, fine. Thank you.

Mr. WEISS. Thank you very much, Mr. Inhofe.

You have not heard any evidence that, in fact, this disease is transmitted by mosquitos, have you?

Dr. FRASER. No. And I think the probability of that is very small, given the concentration of virus in the blood and the amount of blood that is carried by mosquitos.

Mr. WEISS. Thank you very much. Thank you, Dr. Fraser, for appearing and sharing your knowledge with us.

Our second panel will consist of Federal agency officials, and I want to welcome all of them.

First, we have Dr. Robert E. Windom, our distinguished Assistant Secretary for Health, Department of Health and Human Services, accompanied by other Public Health Service officials, who he will introduce.

Dr. Windom, Dr. Dowdle, Dr. Noble, and the other distinguished members of the panel, as you know, we ask our witnesses to swear or affirm to the truth of their testimony. So would you all please stand to be sworn?

Do you affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth?

Thank you. Let the record indicate that all of the witnesses have replied in the affirmative.

Dr. Windom, your entire statement will be entered into the record as submitted to us, and you can then proceed as you deem most appropriate. We would appreciate it if you could limit your oral presentation to 10 minutes, if possible.

STATEMENT OF ROBERT E. WINDOM, M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DR. LOWELL HARMISON, DEPUTY ASSISTANT SECRETARY FOR HEALTH; DR. WALTER R. DOWDLE, DEPUTY DIRECTOR [AIDS], CENTER FOR INFECTIOUS DISEASES, CENTERS FOR DISEASE CONTROL; DR. JUAN RAMOS, DEPUTY DIRECTOR FOR PREVENTION AND SPECIAL PROJECTS, NATIONAL INSTITUTE OF MENTAL HEALTH; DR. ROY PICKENS, DIRECTOR OF CLINICAL RESEARCH, NATIONAL INSTITUTE OF DRUG ABUSE; DR. GARY NOBLE, AIDS COORDINATOR, PUBLIC HEALTH SERVICE; DR. SAMUEL MATHENY, DIRECTOR, AIDS OFFICE, BUREAU OF RESOURCES AND DEVELOPMENT, HEALTH RESOURCES AND SERVICES ADMINISTRATION; DR. JAMES HILL, ASSISTANT TO THE DIRECTOR, NIAID; AND HARELL LITTLE, CHIEF, BUDGET BRANCH, OASH

Dr. WINDOM. Thank you, Mr. Chairman, and members of the committee. I am pleased to have this opportunity to discuss the Public Health Service's response to the Acquired Immune Deficiency Syndrome epidemic and the emphasis on education and prevention activities.

With me today are Dr. Lowell Harmison, Deputy Assistant Secretary for Health; Dr. Gary Noble, the Public Health Service AIDS Coordinator; Dr. Walt Dowdle, the Deputy Director of the Centers for Disease Control; Dr. Juan Ramos, NIMH Deputy Director for Prevention and Special Projects, Dr. Roy Pickens; Dr. Samuel Matheny; Dr. James Hill; and Mr. Harell Little.

I will now summarize my testimony, Mr. Chairman.

In a few short years, AIDS has grown from a rare and unusual health problem to an epidemic of major proportions; it is expected to continue to grow. More than 31,000 cases of AIDS have been reported to date. Already 16,000 of these patients have died. It is estimated that by the end of 1991, the cumulative total of AIDS cases in the United States will reach 270,000 and result in nearly 180,000 deaths.

Statistics will show that in 1986, AIDS became one of the top 10 leading causes of potential life loss. Cases of AIDS have been reported in all 50 States, Puerto Rico, the Virgin Islands, and the trust territories.

Although the majority of cases continue to occur among homosexual and bisexual men and intravenous drug abusers, the infection is also spreading among non-IV-drug-abusing heterosexuals and from infected mothers to newborn infants. Nearly 1,200 cases of heterosexual transmission and more than 450 cases of AIDS in children have been reported.

In addition, most infected IV drug abusers are heterosexual and can spread the virus by their sexual contacts.

There is no vaccine against AIDS and only a few drugs with very limited therapeutic potential. Complicating the picture is the fact that infected persons are capable of spreading the virus to others for years before experiencing the signs or symptoms of AIDS. At this time, information and education, which provide opportunity for individuals to eliminate or to reduce high-risk behavior, are the only means we have to prevent the spread of AIDS infection.

From the beginning, providing information has been an important part of our work. Our early efforts concentrated on the dissemination of scientific information to America's health community. Recently there have been significant changes in the direction and momentum of these efforts. Eighteen months ago, among our primary concerns were the safety of our blood supplies and the provision of alternate testing sites for people who believed they may have been exposed to the AIDS virus. Since then, safeguards have been put in place to ensure the safety of our blood supply. The alternate test sites have become a nationwide counseling and testing program, and AIDS health education and risk reduction programs are now in place across the Nation.

The report of the Public Health Service meeting in Coolfont, WV, last June and the Surgeon General's report on AIDS that was issued in October together mark the beginning of a more intense phase in our information and education efforts.

Within the Public Health Service, I have taken steps to enhance the effectiveness of our fight against AIDS. I have strengthened the position of the Public Health Service AIDS Coordinator. I have continued to rely on the Public Health Service Executive AIDS Task Force and its work by a series of subgroups, one of which focuses on information, education, and health education risk reduction. I have assigned lead agency responsibility for this activity to the CDC, and they now chair that subgroup.

CDC's Director, Dr. James Mason, has also taken steps to strengthen the management of AIDS activities. Also we initiated a Federal Coordinating Committee on AIDS Information, Education,

and Risk Reduction, which brings together Federal officials to coordinate the Federal Government's AIDS information and education efforts. I serve as Chairman of that Committee.

At my direction, the CDC is coordinating the development of the information education plan to prevent and control AIDS in the United States. This is a comprehensive Public Health Service plan for informing and educating the American people about AIDS. The plan specifies the audiences to be addressed, the basic elements of AIDS information and education, and the outline of strategies by which this education can be accomplished.

The plan draws upon the knowledge and experience the Public Health Service has gained since AIDS was first recognized, and it incorporates the contributions of many experts in the PHS agencies.

Successful implementation of this plan depends upon action and collaborative efforts among State, county, and municipal governments, professional and service organizations, the private sector, and the Federal Government.

From 1983 through 1986, the PHS spent $40 million to inform and educate the public in groups at high risk of acquiring the infection. In fiscal year 1987, we are planning to spend more than $79.5 million and in fiscal year 1988 more than $103.9 million. However, it is expected that funds appropriated by Congress in any given year for information and education will be multiplied many-fold by the efforts and resources of the public, other public agencies, and the private sector. This combined cooperative effort over the long term will have a much greater impact on changing public behavior than the efforts of the Federal Government alone.

Under the plan, our efforts are targeted to certain populations. The first is the general public.

A second is the special population of school- and college-aged youth. Schools, colleges, and family institutions provide an effective channel for appropriately instructing the young people of our Nation about AIDS before and as they reach the ages when they might practice behaviors that put them at risk of infection.

A third target population is those persons at increased risk or who are infected. Our highest priority is informing and educating those groups at increased risk of acquiring or transmitting the AIDS virus because of certain behaviors or circumstances, such as homosexual and bisexual men, IV drug abusers, hemophiliacs, female sex partners of those at risk, and prostitutes and their clients.

The fourth target population is our Nation's health workers. Members of this group have direct responsibility for patient care and for counseling AIDS patients, persons with laboratory evidence of infection, or other concerned persons. They will provide leadership in informing and educating the public.

I will highlight the activities that are being directed toward each of these populations.

Now that we have taken steps to protect our blood supply, we will be concentrating on preventing the sexual transmission of the AIDS virus and preventing the transmission of AIDS among IV drug abusers. Primary Federal responsibility for this aspect lies within the CDC. Information and education efforts to prevent the

sexual transmission of AIDS will encompass a number of major activities. This fiscal year, we are planning to conduct a national public information campaign.

In September 1986, an AIDS hotline service was expanded to a full 24 hours daily operation. We are continuing to distribute our Public Health Service public service announcements, as well as publications and materials prepared in collaboration with the American Red Cross and other organizations. To date, we have distributed about 325,000 copies of the Surgeon General's Report on AIDS.

This fiscal year, we will be establishing a National AIDS Information Clearinghouse in order to manage and handle the many publications regarding AIDS prevention and control. We plan to bring together major public and private sector organizations that are currently actively involved in the fight against AIDS and solicit their contribution to the Nation's effort to stem the epidemic.

Working at community levels, NIDA, the National Institute of Drug Abuse, is utilizing mass media and special print media to inform their special target audiences. Local communities are being encouraged to undertake public education programs. We are working with the entertainment community to encourage the industry to undertake activities to educate the public.

A national toll-free telephone has been established which directs drug abusers to treatment programs in their communities. This hotline service has been promoted in advertising which promotes treatment for intravenous drug abusers. The drug hotline is linked also to our AIDS hotline.

Schools efficiently can inform 90 to 95 percent of young people about the dangers of AIDS and how to avoid becoming infected. The 5 percent of children who do not attend school may be at even greater risk and will require special efforts through mechanisms other than schools if they are to be reached by our efforts.

In 1987, we are initiating a comprehensive school health education program. To supplement the State and local efforts, we will be working with national organizations to help schools provide effective AIDS education. To round out our program, we will be undertaking a number of other activities designed to assist State and local education agencies, such as establishing an annotated, computerized bibliography of relevant AIDS education materials, summarizing the private sector development of effective school health education materials, assessing the impact of national, State, and local efforts, and establishing a national coalition for AIDS school health education.

Prevention and control of AIDS will depend upon successfully interrupting the transmission of the virus among those persons whose behaviors or their circumstances put them or others at risk of infection. The major element of our efforts to prevent sexually transmitted AIDS is the provision of assistance to the States in conducting AIDS prevention programs, which include health education risk reduction programs and counseling and testing.

Currently, we are funding six demonstration projects designed to implement and evaluate intensive community level programs to prevent the transmission of HIV infection. Two of the projects have

program elements directed toward reaching minority populations at risk.

CDC, working with the Health Resources and Services Administration [HRSA] and the National Hemophiliac Foundation, is supporting the development and delivery of health education and risk reduction counseling programs for hemophiliacs.

We will be continuing our joint venture with the Conference of Mayors that is designed to help stimulate information and education programs at the community level. In 1987, we will be initiating pilot projects to develop and test approaches to prevent perinatal transmission of the AIDS virus.

The two major problems confronting this area of public health are (1) how to reach uninformed groups—adolescents, ethnic minorities, drug abusers, and women—with the message on risk reduction, and (2) how to surmount resistance of persons toward changing their behavior. Thus, the National Institute of Mental Health also has funded research into these areas.

Targeted AIDS community demonstrations will be awarded as demonstration research contracts that focus on specific prevention initiatives. Health workers also will be stimulated and involved to help decrease the risk of transmitting the virus to others; they also represent a major channel for providing adequate AIDS information.

NIDA's educational activities are focused on providers who come in contact with drug abusers, such as drug abuse treatment program staff, primary health providers, and social service personnel. Emphasis is placed on building State and local training capacity, developing educational and training materials, and training trainers to facilitate such capacity building.

The National Institute of Mental Health is striving to overcome a shortfall of funding for academic institutions throughout the Nation to train all types of AIDS health care providers to recognize, refer, or treat the mental health elements of this disease.

The National Institute of Dental Research is developing posters and leaflets for use in dental offices, clinics, and schools to increase awareness of the need for the use of barrier techniques for dental care providers.

In fiscal year 1987, HRSA will award grants to develop three regional AIDS Education and Training Centers to provide education and training for health care providers. HRSA is also supporting AIDS service demonstration projects in New York, San Francisco, Los Angeles, and Miami, which provide extensive information related to the prevention of further spread of the AIDS virus.

CDC has engaged in a wide variety of activities, ranging from the issuance of guidelines in the MMWR to distributing slide series in response to nearly 4,000 requests.

In conclusion, sir, I have been highlighting the work of our Public Health Service agencies, and I am proud to be associated with all these dedicated people in the Public Health Service who have committed so much personal effort to the battle to prevent AIDS.

But it must be emphasized that we are not working in isolation. We must recognize the role that the media has played in helping to create the information base among our population upon which we

will be able to build, and it is important that we recognize the hard work and the invaluable efforts of the many voluntary organizations that have been such a major part of this national effort to deal with this modern-day scourge.

As I stated at the onset, to meet the AIDS challenge will require an all-out effort by the whole of our society.

Thank you, Mr. Chairman. My colleagues and I will be happy to help answer questions that you may have.

[The prepared statement of Dr. Windom follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

STATEMENT OF

ROBERT E. WINDOM, M.D.

ASSISTANT SECRETARY FOR HEALTH

PUBLIC HEALTH SERVICE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT OPERATIONS

U.S. HOUSE OF REPRESENTATIVES

MARCH 16, 1987

Mr. Chairman and Members of the Subcommittee:

I am pleased to have this opportunity to discuss the Public Health Service's (PHS) response to the acquired immunodeficiency syndrome (AIDS) epidemic with emphasis on education and prevention activities.

With me today are Dr. Lowell Harmison, Deputy Assistant Secretary for Health, Dr. Gary Noble, the PHS AIDS Coordinator, Dr. Walter R. Dowdle, Deputy Director (AIDS), Centers for Disease Control (CDC); Dr. Juan Ramos, Deputy Director for Prevention and Special Projects, NIMH; Dr. Roy Pickens, Director of Clinical Research, NIDA; Dr. Samuel Matheny, Director, AIDS Office, Bureau of Resources and Development, HRSA; Dr. James Hill, Assistant to the Director, NIAID; and Mr. Harell Little, Chief, Budget Branch, OASH.

In a few short years, AIDS has grown from a rare and unusual health problem to an epidemic of major proportions. It is expected to continue to grow. More than 31,000 cases of AIDS have been reported to date; 16,000 of these patients have already died. It is estimated that by the end of 1991 the cumulative total of AIDS cases in the United States will reach 270,000 and result in nearly 180,000 deaths. In 1985, AIDS became the eleventh leading cause of potential years of life lost before the age of 65 and, when the data has been compiled on all other diseases, the statistics will show that in 1986 it became one of the top ten leading causes of potential life lost. Cases of AIDS have been reported in all 50 States, Puerto Rico, the Virgin Islands, and the Trust Territories.

Although the majority of cases continue to occur among homosexual and bisexual men and intravenous drug abusers, the infection is also spreading among non-IV drug abusing heterosexuals and from infected mothers to newborn infants. Nearly 1,200 cases of heterosexual transmission and more than 450 cases of AIDS in children have been reported. In addition, most infected IV drug abusers are heterosexual and can spread the virus by their sexual contacts.

There is no vaccine against AIDS and only a few drugs with very limited therapeutic potential. Complicating the picture is the fact that infected persons are capable of spreading the virus to others for years before experiencing the signs or symptoms of AIDS. At this time, information and education, which provide opportunity for individuals to eliminate or reduce high-risk behavior, are the only means we have to prevent the spread of AIDS infections.

From the beginning, providing information has been an important part of our work. Our early efforts concentrated on the dissemination of scientific information to America's health community. For example, CDC has published 22 recommendations and guidelines since 1981, and the National Institutes of Health (NIH) has sponsored through the National Institute of Allergy and Infectious Diseases (NIAID) 10 large AIDS related conferences for health care professionals and support personnel. They have collaborated with a number of professional societies by sponsoring workshops on AIDS during national or regional meetings, and two international conferences on AIDS have been held, and a third is planned for 1987.

74-444 O - 87 - 2

Recently there have been significant changes in direction and momentum to the efforts. Eighteen months ago, among our primary concerns were the safety of our blood supplies and the provision of alternate testing sites for people who believed they may have been exposed to the AIDS virus. Since then safeguards have been put in place to ensure the safety of our blood supply; the alternate test sites have become a nationwide counseling and testing program; and AIDS health education/risk reduction (HE/RR) programs are in place across the Nation. We now have further evidence that AIDS is not just a disease of white homosexual males. It is spread heterosexually; it is being transmitted by mothers to their infants; and it is occurring disproportionately among Blacks and Hispanics.

The report of the PHS meeting in Coolfont, West Virginia last June and the Surgeon General's Report on AIDS that was issued in October together mark the beginning of a more intense phase in our information and education efforts. The American public is ready to learn more about how they can protect themselves and others from AIDS.

Within PHS, I have taken steps to enhance the effectiveness of our fight against AIDS. I have strengthened the position of the PHS AIDS Coordinator which is being ably filled by Dr. Noble. I have continued to rely on the PHS AIDS Executive Task Force which meets weekly and is supported in its work by a series of subgroups, one of which focuses on information/education and health education/risk reduction. I have assigned lead agency responsibility for this activity to CDC, and they now chair that subgroup. Dr. James O. Mason, CDC's

Director, has also taken steps to strengthen the management of AIDS activities. He created the position of Deputy Director (AIDS), with full authority and responsibility for all of CDC's AIDS activities, and appointed to that position Dr. Dowdle who is with me here today.

Also, we initiated the Federal Coordinating Committee on AIDS Information, Education and Risk Reduction which brings together Federal officials to coordinate the Federal Government's AIDS information/education efforts. I serve as Chairman of that Committee.

At my direction, CDC is coordinating the development of the "Information/ Education Plan to Prevent and Control AIDS in the United States." This is a comprehensive PHS Plan for informing and educating the American people about AIDS. The Plan specifies the audiences to be addressed, the basic elements of AIDS information and education, and the outline of strategies by which this education can be accomplished. The Plan draws upon the knowledge and experience PHS has gained since AIDS was first recognized, and it incorporates the contributions of many experts in the PHS agencies: Alcohol, Drug Abuse and Mental Health Administration, Centers for Disease Control, Food and Drug Administration, Health Resources and Services Administration, National Institutes of Health, and the Office of the Surgeon General

Successful implementation of this Plan depends upon action and collaborative efforts among State, county, and municipal governments; professional and service organizations; the private sector; and the Federal government. From 1983 through 1986, PHS spent $40 million to inform and educate the public in groups at high risk of acquiring infection; in fiscal year 1987, we are

planning to spend more than $79.5 million; and in fiscal year 1988 more than $103.9 million. However, it is expected that funds appropriated by Congress in any given year for information/education will be multiplied manyfold by the efforts and resources of other public agencies and the public sector. This combined cooperative effort, in the long term, will have a much greater impact on changing public behavior than the efforts of the Federal Government, alone.

Under the Plan, our efforts are targeted to certain populations The first is the general public. In order to control transmission of AIDS virus, everyone must be aware of behavior that puts them at risk of infection They must learn how the virus is and is not spread.

A second special population is school and college-aged youth Schools, colleges, and family institutions provide an effective channel for appropriately instructing the young people of our Nation about AIDS before, and as, they reach the ages when they might practice behaviors that put them at risk of infection.

A third target population is those persons at increased risk or who are infected. Our highest priority is informing and educating those groups at increased risk of acquiring or transmitting the AIDS virus because of certain behaviors or circumstances, such as homosexual and bisexual men, IV drug abusers, hemophiliacs, female sex partners of those at risk (of special concern because of potential pregnancy), and prostitutes and their clients

The fourth target population is our Nation's health workers. Members of this group have direct responsibility for patient care; for counseling AIDS patients, persons with laboratory evidence of infection, or other concerned persons; and for providing leadership in informing and educating the public. Now I will highlight the activities that are being directed toward each of these populations.

THE PUBLIC

An informed public provides the basis upon which other information/education programs operate. Individuals need further information on the steps that can be taken to protect their health. Special efforts are needed to provide information through a variety of channels—television, radio, press, advertisements, and personal appearances. The program must be closely coordinated and sustained over a long period of time in order to adequately inform the public. Now that we have taken steps to protect our blood supply, we will be concentrating on preventing the sexual transmission of AIDS virus—primary Federal responsibility for this aspect rests with CDC, and with preventing the transmission of AIDS among IV drug abusers--the National Institute for Drug Abuse (NIDA) has this responsibility.

The Food and Drug Administration has worked with blood banks and plasma centers on programs: (1) to inform persons at increased risk for AIDS that they should refrain from donation, and (2) to test all blood and blood product donations for the presence of AIDS antibody to reduce the risk of transmitting AIDS virus through the transfusion of blood or plasma

Preventing Sexually Transmitted AIDS

Information/education efforts to prevent the sexual transmission of AIDS will encompass a number of major activities. This fiscal year we are planning to conduct a major national public information campaign This mass media campaign will reach the public through television, radio, and the various print media at the national and local levels. It wil provide the broad backdrop for intense State and community efforts that will be carried out across the country. We will be contracting with a national communications agency to assist in the planning and design of this multimedia campaign.

We are continuing on other fronts to get information to people who need it In September 1986, we contracted with the American Social Health Association to take over the operation of the national AIDS Hotline. Service has been expanded to a full 24 hours of daily operations. The Hotline offers a taped message and referral to an operator for further information. The number of calls steadily increased with taped messages.

We are continuing to distribute PHS-developed public service announcements as well as publications and other materials prepared in collaboration with the American Red Cross and other organizations To date, we have distributed about 325,000 copies of the Surgeon General's Report on AIDS, and other private organizations have reproduced thousands of copies for distribution CDC, which has taken over most of these activities has sent camera-ready copies of the report to all AIDS program coordinators

This fiscal year we will be establishing a national AIDS information clearinghouse system designed to facilitate access to information needed by the public at large and by State and local AIDS program personnel engaged in developing or conducting AIDS prevention and control programs. The clearinghouse will develop and maintain inventories of available AIDS information and assist State and local AIDS program personnel in obtaining, developing, and using information about AIDS. It will iuentify and assist in filling information gaps through the development or identification of needed information for such groups as minorities which require specialized emphasis and culturally sensitive materials. Lastly, it will provide a mechanism for the distribution of PHS information materials. We expect to award a contract for this project in August 1987.

We plan to bring together ma,,r public and private sector organizations that are currently actively involved in the fight against AIDS or which could make significant contributions to our Nation's effort to stem the epidemic Our goal is to provide a continuing forum for the exchange of information and the coordination and stimulation of voluntary information/education programs

AIDS/IV Drug Abuse

Working at the community level, the National Institute on Drug Abuse (NIDA) is utilizing mass media and special print media to inform the general public and special target audiences Market research has been conducted to determine the best means of reaching th target audience of intravenous drug abusers, t: r sex partners, and othe: :lose associates, such as family members, with mass

media messages about AIDS and drug use Based on this research, radio and television, as well as print, materials are being developed to intervene at the different stages of drug use in order to halt or slow the spread of AIDS. Messages are encouraging the drug abusers to seek treatment or to stop sharing needles if treatment is not possible.

Local communities are being encouraged to undertake public education programs Community contacts in target cities are being helped to develop local coalitions among organizations concerned about AIDS in IV drug abuse.

We are working with the entertainment community—including the film, television, and music industries—to encourage the industry to undertake activities to educate the public about the threat of AIDS in IV drug abuse and to communicate an anti-drug message to preteens, teens, and young adults.

A national toll free telephone service has been established which directs drug abusers to treatment programs in their community. This Hotline service is being heavily promoted in advertising which promotes treatment for intravenous drug abusers. The drug Hotline is linked to the AIDS Hotline to assure appropriate handling of special requests and needs.

These media activities have until now been focused at the community level. Given the urgency of the AIDS epidemic and the growing public concern regarding the relationship of AIDS and drug abuse, the climate is improving for getting public service announcements on television NIDA is considering the need for a broader public service campaign including a full range of television, radio, and print advertisements on the AIDS and drug abuse issue.

SCHOOL AND COLLEGE-AGED YOUTH

Every day more than 47 million students attend 90,000 elementary and secondary schools in 15,500 school districts across the United States. Schools efficiently can inform 90 to 95 percent of the young people about the dangers of AIDS and how to avoid becoming infected. Our youth and young adults must understand that sexual activity and IV drug abuse can lead to AIDS. The 5 percent of children who do not attend school may be at even greater risk and will require special efforts through agencies other than schools if they are to be reached by our efforts. To educate our Nation's youth about AIDS, we must be sure that there is a broad base of national, parental, and community support and that school officials, especially classroom teachers, are well prepared. We must be sure that curricula about AIDS are scientifically accurate, culturally sensitive, and developmentally appropriate for students in each community.

In 1987, we are initiating a comprehensive school health education program. A principal feature of the program will be the provision of fiscal support and technical assistance to about 10 State and 12 local education agencies in areas with the highest incidence of AIDS to rapidly implement effective education about AIDS for students and for school-aged youth who do not attend school. The scope and content of these AIDS school health education programs will be determined at the local level with assistance from the health agency. Training and demonstration projects will be established in three metropolitan areas and in one State School officials and teachers from around the country

will be able to attend training sessions in order to learn firsthand how to develop and implement effective AIDS education in the schools. In this way we can assist school systems that do not receive direct funding.

To supplement the State and local efforts, we will be working with national organizations to help schools provide effective AIDS education. Through these organizations, we hope to stimulate, reinforce, and assist State and local efforts to reach students, school-aged youth not attending school, college populations, Black youth, and Hispanic youth.

To round out our program we will be undertaking a number of other activities designed to assist the State and local education agencies, such as establishing an annotated computerized bibliography of relevant AIDS educational materials, stimulating private sector development of effective school health education materials, assessing the impact of national, state and local efforts, and establishing a national coalition for AIDS school health education.

Our work with the State of Indiana provides an example of beneficial results that can come from the collaborative approach we are taking. Indiana State Board of Health, with funds and technical assistance from CDC, developed an AIDS school curriculum guide called AIDS: What Young Adults Should Know. It is a companion to an excellent curriculum on sexually transmitted disease education. This AIDS school health curriculum was recently completed and offered to the Indiana's local school boards. We were told that even before it was off the presses nearly every State in the Union had requested a copy of the curriculum.

PERSONS AT INCREASED RISK OR INFECTED

Prevantion and control of AIDS will depend upon successfully interrupting the transmission of the virus among those persons whose behaviors or their circumstances put them and others at risk of infection. Here again I will discuss our activities in terms of two broad categories: those people at risk of infection through sexual transmission of the virus and those at risk because of IV drug abuse.

Preventing Sexually Transmitted AIDS

The major element of our efforts to prevent sexually transmitted AIDS is the provision of assistance to States in conducting AIDS prevention programs. CDC will be awarding 55 cooperative agreements totaling more than $22 million to States, territories, and selected cities for this purpose. In response to the States requests for streamlining and simplifying the bureaucratic process, CDC has collapsed the two previously separate health education/risk reduction programs and the counseling and testing program into a single award for each participating State. In mid-1985 funding was provided for 50 counseling and testing projects covering nearly 900 sites through which more than 79,000 people were tested Of these, about 17 percent were seropositive. In 1986 testing sites funded by these projects increased to almost 1100 through which more than 150,000 people were tested Preliminary reports indicate that nearly 19 percent of those tested were seropositive Pretest counseling sessions increased 89 percent, and post-test counseling increased by 118 percent in 1986 over 1985.

The health education/risk reduction projects have been more recently funded, and it is too early to report significant results from these efforts. In all of the 55 participating States and metropolitan areas information and education activities have been initiated and work has been started on defining, in detail, their AIDS problems. To date, 21 projects have targeted informational services to black communities and 15 have activities aimed at their Hispanic populations

Concurrently, we are funding six demonstration projects designed to implement and evaluate intensive community level programs to prevent the transmission of HIV infection. These projects are being carried out under a strict protocol that is designed to permit evaluation of the activities in terms of their impact on the disease. Two of the projects have program elements directed toward reaching minority populations at risk. In a further attempt to find effective risk reduction approaches, we have been supporting eight innovative projects that are evaluating risk reduction approaches directed toward homosexuals, IV drug abusers, and minorities.

CDC, working cooperatively with the Health Resources and Services Administration and the National Hemophiliac Foundation (NHF), is supporting the development and delivery of health education and risk reduction counseling programs for hemophiliacs Their particular health problems are being addressed by the NHF through a network of service centers

We will be continuing our joint venture with the Conference of Mayors that is designed to help stimulate information/education programs at the community level.

In 1987, we will be initiating pilot projects to develop and test approaches to prevent perinatal transmission of the AIDS virus. The focus will be on preventing infection among reproductive age women.

The two major problems confronting this area of public health are how to reach uninformed groups (adolescents, ethnic minorities, drug abusers, and women) with the message of risk reduction, and how to surmount resistance of persons towards changing their behavior. AIDS is so pernicious that the National Institute of Mental Health (NIMH) believes it must go beyond campaigns to inform persons about the need for and the techniques of risk reduction. Thus, it also has funded research into identifying elements which influence non-compliance of behavioral changes, and has funded evaluation studies to determine the effectiveness of various intervention techniques.

Persons with AIDS need the support of families and friends. In turn, families and friends of persons with AIDS need help in dealing with the situation. Recognizing this need, the NIMH has prepared publications directed towards the appropriate groups and has incorporated psycho-social considerations into its training programs.

AIDS/IV Drug Abuse

In order to help communities develop AIDS prevention programs and to assess the effectiveness of prevention initiatives, NIDA is implementing two demonstration programs in fiscal year 1987. comprehensive AIDS community demonstration projects and targeted AIDS demonstration projects.

Comprehensive AIDS community demonstration grants will be awarded to five communities that have a high prevalence of AIDS associated with IV drug abuse. The focus of these grants will be outreach services to recruit drug abusers into treatment, to educate intravenous drug abusers and their partners regarding the risks of infection and transmission, and to make antibody testing available to intravenous drug abusers, their sexual partners, and children This effort is complementing the $252 million substance abuse research, prevention, and treatment program expansion that is a part of the war on drugs.

Targeted AIDS community demonstrations will be awarded as demonstration research contracts that focus on specific prevention initiatives, including the use of indigenous outreach workers, outreach to sexual partners and prostitutes associated with IV drug abusers, outreach in emergency rooms and drug abuse detoxification units, case finding in high drug use areas, and increasing the AIDS prevention capabilities of methadone maintenance programs.

HEALTH WORKERS

Health workers must be prepared to address infected persons health needs and to counsel, or refer for counseling, those infected with AIDS virus to reduce the infected person's risk of transmitting the virus to others. Our Nation's health workers represent a major channel for providing accurate AIDS information to the patient, sex partners of the patient, friends and family members of the patient, allied health care workers, and the public Additionally, some health care workers by virtue of their occupation need to

be informed that there is some very small risk of infection and how to avoid it. A number of the PHS components have been actively involved in this aspect of our information/education strategy, and I will highlight some of their activities

ADAMHA

NIDA's educational activities are focused on providers who come in contact with drug abusers such as drug abuse treatment program staff, primary health care providers, and social service personnel. The activities include the development of training manuals for service providers; training workshops for drug abuse treatment program counselors, administrators, and health care workers; technical assistance to treatment programs and drug abuse authorities; and development of video tapes and other materials in English and Spanish for intravenous drug abusers and their sexual partners. Emphasis is placed on building State and local training capacity, developing educational and training materials, and training of trainers to facilitate such a capacity building

The suddenness of AIDS precluded sufficient numbers of care providers trained in its mental health aspects The NIMH is striving to overcome the shortfall by funding academic institutions throughout the Nation to train all types of AIDS health care providers to recognize, refer, or treat the mental health elements of the disease. The training institutions are linked to one another and to research centers in order to share the best educational techniques and most current research findings.

NIH

Earlier I mentioned some of the NIAID past accomplishments. This year NIAID will sponsor regional conferences in Nashville, Atlanta, Minneapolis/St. Paul, Seattle, Denver, and San Diego. These conferences will provide information to nurses and social workers.

The National Heart, Lung, and Blood Institute (NHLBI) is initiating an educational program about blood donation in collaboration with the American Red Cross, the American Association of Blood Banks, and Community Council of Blood Centers. Fear of AIDS and other transfusion related diseases has led to a decrease in donations at the same time the use of blood has continued to increase. The educational program will be directed to the medical profession to prevent excessive use of blood for therapeutic purposes and to the public to dispel incorrect beliefs about acquiring AIDS through donating blood.

The National Institute of Dental Research is developing posters and leaflets for use in dental offices, clinics, and schools to increase awareness of the need for and use of barrier techniques for dental care providers. In addition, a collaborative effort with NIAID is being developed to design conferences aimed at dental care providers, similar to those sponsored by NIAID in the past, and to provide workshops at professional meetings of dental care workers.

HRSA

In fiscal year 1987, HRSA will award grants to develop three regional AIDS Education and Training Centers (ETC). Program objectives for each ETC will be to provide, in collaboration with health professional schools, local hospitals, and health departments, education and training to primary care providers on the treatment and prevention of AIDS and AIDS infection, to provide updates on new and timely information about HIV infection to approximately 1,000 primary and secondary health care providers; and to serve as the support system for area health professionals through the AIDS Hotline, clearinghouse, and referral activities In 1988, there are plans to add additional ETCs.

HRSA is also supporting AIDS service demonstration projects in New York, San Francisco, Los Angeles, and Miami. While the grants are intended to demonstrate the creation of comprehensive, cost effective ambulatory and community-based health and support systems for persons with AIDS, each grant does provide extensive information related to the prevention of further spread of the AIDS virus. During 1987, approximately seven additional such demonstration grants will be awarded.

CDC

CDC has been engaged in a wide variety of activities ranging from the issuance of guidelines in the MMWR, to distributing slide series in response to nearly 4,000 requests to the provision of camera-ready copies of the Surgeon General's Report on AIDS to all AIDS program coordinators and conducting

courses for laboratory workers in the latest techniques. This fall they picked up on the activities that were started at the Public Health Service level involving the development and distribution of educational materials in cooperation with the American Red Cross and distribution of the Surgeon General's Report on AIDS. In 1987, CDC will provide additional specialized training to program coordinators, AIDS health educators, AIDS antibody test counselors, and other health providers. They will also be developing training modules and educational materials to train both practicing dental professionals and dental students about infection control procedures with an emphasis on AIDS.

Conclusion

I have been highlighting the work of our PHS agencies, and I am proud to be associated with all the dedicated persons in the Public Health Service who have committed so much personal effort to the battle to prevent and control AIDS. But it must be emphasized that we are not working in isolation We must recognize the role that the media has played in helping to create the information base among our populations upon which we will be able to build. And, it is important that we recognize the hard work and invaluable efforts of the many voluntary organizations that have been such a major part of this Nation's effort to deal with this modern day scourge. As I stated at the outset, to meet the AIDS challenge will require an all out effort by the whole of our society. Thank you, Mr. Chairman. I will be happy to answer any questions that you may have.

Mr. WEISS. Thank you very much, Dr. Windom. What we will be doing during the course of our questioning is to attempt to determine to what extent the various proposals or programs which you have outlined have in fact been implemented or are being implemented.

Because we will have, I think, extensive questioning, I will be breaking off my part of the questioning from time to time to allow my colleagues also then to ask their questions.

Dr. Windom, several years ago, HHS Secretary Heckler announced with great fanfare that AIDS treatments and vaccines were close at hand. Those predictions, I believe, were extremely misleading, and may have lulled the general public into a false sense of security about the seriousness of AIDS. These may also have lulled the Federal Government into a false sense of security.

How would you now characterize the likelihood that we will have an effective vaccine and treatment in the near future?

Dr. WINDOM. Mr. Chairman, a number of vaccine programs are underway where testing is being done within the laboratory, in animals. It is anticipated that if progress continues as it is estimated based on today's circumstances, there is hope that a vaccine may be available within 5 to 10 years. No one can say that definitely. It's just not possible because of what has to be done at various stages in order to get a final product. This is just a projected estimate.

Mr. WEISS. I appreciate that. Then Secretary Heckler's projection was that within 2 years, we would have a vaccine. Many scientists suggested that that was just an unrealistic statement, but coming from Secretary Heckler it was believed. I think that your statement is a very realistic one. I applaud it because it demonstrates why we have to be focusing, as you said in your statement, on education/information efforts.

Dr. WINDOM. Yes. Thank you, sir.

Mr. WEISS. Did you review the Surgeon General's report on AIDS before it was released in October 1986? Were you in agreement with its findings and recommendations?

Dr. WINDOM. No. We did not review that document because it was produced as a result of a direction to the Surgeon General for him to provide the report and to present it as a response to the President's request. It was Dr. Koop's own document that was put together and distributed without our having been involved in the review.

Mr. WEISS. He reports to you through channels; isn't that right? That's the way the system works?

Dr. WINDOM. Yes, sir.

Mr. WEISS. He received a directive from the President to prepare this report; is that correct?

Dr. WINDOM. Yes, in January 1986, I believe, President Reagan asked him to prepare this report and to release it to the Nation.

Mr. WEISS. He did that, and was not asked to submit it to you before it was released?

Dr. WINDOM. No, sir.

Mr. WEISS. Was the Surgeon General's report presented to the President before it was released?

Dr. WINDOM. I understand it was presented to the Domestic Policy Cabinet Group and I presume to the President. I do not know that for sure, sir.

Mr. WEISS. Has the President made any public statements on the report or on AIDS, since the report was issued in October?

Dr. WINDOM. No, I have not heard any public report on that from the President.

Mr. WEISS. Indeed, I just saw a recent copy of the Department's green sheet, the compilation of stories relating to AIDS. In a story dated March 5, 1987, I read that Koop has urged Reagan to take a lead in the war on AIDS.

Have there been discussions within your Department or with the President urging him to take a lead in the war on AIDS?

Dr. WINDOM. No, not that I'm aware of, sir, any personal contacts or expressions; not that I'm aware of.

Mr. WEISS. Your testimony reflects that 325,000 copies of the Surgeon General's report have been printed. Can you tell us how many have actually been distributed to date?

Dr. WINDOM. I do not know that total number but I know there is an ongoing distribution process. We are continuing to have the report distributed because it has been a very well received and is an important document. I do not know the exact number that have been distributed, sir.

Mr. WEISS. Dr. Dowdle, would you have that information?

Dr. DOWDLE. Yes. In fact, that's very close to the number. It's over 300,000. I think, more to the point, that copies have also been provided in a camera-ready form to all the States and to many other organizations. They also are distributing copies of the report.

Mr. WEISS. There have been some discussions, I understand, of having that report mailed directly to every home in the country. Do you know how much it would cost to do that?

Dr. WINDOM. That proposal, Mr. Chairman, has been raised, and we will be talking about that. I will be convening a group of members of our staff to look at the questions of whether a direct mailing would be feasible, what type of document would be appropriate for a mass mailing, the size, and the cost. That is a concern of ours and we are in the process of evaluating it.

Mr. WEISS. Dr. Koop is quoted in a Sacramento headline, dated March 6, saying that the Public Health Service is considering mailing a simplified version of his widely publicized AIDS report to every household in the country. When do you expect to have a decision on that?

Dr. WINDOM. We would hope probably that by about the middle of April we will come up with something to resolve that question.

Mr. WEISS. At about the same time as the Surgeon General's report in October, the National Academy of Sciences released its comprehensive AIDS report. Have you read that document? Are you familiar with its detailed recommendations?

Dr. WINDOM. Yes, sir.

Mr. WEISS. Are you and the Department in agreement with its findings?

Dr. WINDOM. We feel it makes a very significant contribution to the subject and we have listened to and met with members of the

Institute of Medicine and discussed their findings even prior to their releasing that report.

Mr. WEISS. Did the Department prepare any type of response to the report?

Dr. WINDOM. No, officially, no one asked for a response to the report, sir.

Mr. WEISS. How about unofficially? Did you have an analysis?

Dr. WINDOM. Within our Public Health Service, we asked our various agencies to look at the report and give their opinions to us. That was just in-house.

Mr. WEISS. Can you make copies of those reports available to us?

Dr. WINDOM. Yes, sir.

[On June 2, 1987, the Department advised the subcommittee that "none of the agencies have started the reports."]

Mr. WEISS. Did you express any disagreements? Were any disagreements expressed with the report?

Dr. WINDOM. I think the question that has been raised most has been about the figures for 1991. We feel they are estimations, but we want to try to approach them. We feel we are making progress along the line, and with the budget increases from year to year, particularly in the education area, are approaching the total that they mentioned, Federal combined with other sources, of $1 billion for education. I would say that very likely this target may be met, indeed may be exceeded.

Mr. WEISS. Last month, the Department scheduled a press conference to finally announce a major new AIDS Information/Education Plan. Later, we were advised by your staff that the plan would be released around the 1st of March. In fact, Dr. Mason testified at an Appropriations Committee hearing 2 weeks ago that the plan was complete.

Why was its release delayed?

Dr. WINDOM. In order to come forth with a plan of this type, and in the process to respond to all people and groups involved, a considerable amount of time was needed for the plan to be reviewed and for input to be received. As you can recognize, this is a most sensitive matter, and it is best to react to the concerns of all the individual participants. It has taken time. We are just about ready to go to press. We anticipate that very, very soon.

Mr. WEISS. Dr. Dowdle, when did CDC begin working on this new major information/education plan? When was the plan first requested, by whom, and why?

Dr. DOWDLE. Well, CDC was given the responsibility for working on the plan in November, about the time we were given the responsibility for an information education program. However, it was started a few weeks or months earlier within the Public Health Service.

Mr. WEISS. Who first requested it and why?

Dr. DOWDLE. Dr. Windom requested it.

Mr. WEISS. What was the basis for the request, Dr. Windom?

Dr. WINDOM. The basis, Mr. Chairman, was that I felt we needed to develop a document that would be available for many people in the Nation to use and that it would be best for this document to come from the Public Health Service. In order to do this, I asked

Dr. Mason and his people at CDC to take the lead in putting it together.

Mr. WEISS. When did you make that request?

Dr. WINDOM. It was in November, as I recall. I'm not sure exactly what date.

Mr. WEISS. Dr. Dowdle has just indicated you began working on it—the date actually is October 28, I believe. You had discussions on it for some months previously. You must have made that request earlier.

Dr. Dowdle, what's your recollection as to when you were requested to start working on that plan?

Dr. DOWDLE. Well, actually it emerged from other bits and pieces of work that was going on. It was weeks after the idea had started at PHS that CDC was asked to put the plan together. Again, I don't know the exact date, but early October probably.

Mr. WEISS. Was that before the Coolfont meeting in June 1986?

Dr. DOWDLE. I think actually there may be a little misunderstanding here. As far as the Public Health Service Information/Education strategy goes, all of this evolved out of the meetings that were held as early as 1985. In fact, the Public Health Service published a strategy in 1985 in Public Health reports. It was updated in 1986 with the Coolfont report. Both documents said that a major information/education effort would be required to combat AIDS.

This current document grew out of Dr. Windom's request that there be a specific document on information/education.

Mr. WEISS. The discussions had been going on for the better part of a year before you actually started this final plan?

Dr. DOWDLE. That specific document. Not only were activities discussed, but information education activities have been implemented beginning as early as 1984 and 1985.

Mr. WEISS. When did you, or Dr. Mason, first review a draft of this new plan?

Dr. DOWDLE. The present plan?

Mr. WEISS. Yes.

Dr. DOWDLE. The plan was reviewed over the Christmas holidays and submitted on January 2.

Mr. WEISS. We have a memorandum, minutes of a Public Health Service task force, dated September 8, 1986, and this among other documents will be entered into the record.

[The memorandum follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

Memorandum

Date SEP 18

From Assistant Secretary for Health

Subject Minutes of the September 8, 1986, Meeting of the PHS Executive Task Force on AIDS

To Members, PHS Executive Task Force on AIDS

Attached are the minutes of the September 8, 1986, meeting of the PHS Executive Task Force on AIDS. The next meeting is scheduled for Monday, September 22, 1986, 9 to 10:30 a.m., Conference Room 729G, Humphrey Building.

Robert E. Windom, M.D.

Attachments

PHS Executive Task Force on AIDS
September 8, 1986

Minutes

Participants

Dr. Dickson, Acting Assistant Secretary for Health
Dr. Dowdle, PHS AIDS Coordinator
Ms. Gelberg, Executive Secretary, PHS Executive Task Force on AIDS

Mr. Artim, OASH
Ms. Bart, OASH
Ms. Barth, OASH
Ms. Brady, OASH
Dr. Bridge, ADAMHA
Ms. Casselberry, OASH
Ms. Donoghue, NIH
Ms. Evert, OASH
Mr. Fanning, OASH
Dr. Fauci, NIH
Mr. Forbush, OASH
Dr. Galasso, NIH
Dr. Goodwin, ADAMHA
Dr. Hardy, CDC
Dr. Harmison, OASH
Ms. Hassell, OASH
Dr. Hopkins, CDC
Ms. Kershner, OASH
Dr. Koop, SG
Ms. Lengel, OASH
Dr. McCarthy, NIH
Dr. Meyer, FDA
Dr. Noonan, HRSA
Dr. Pickens, ADAMHA
Ms. Pollard, OASH
Mr. Riseberg, OGC
Dr. Rodrigues, NIH
Dr. Rose, OASH
Dr. Samuels, OSG
Ms. Segal, OASH
Mr. Smith, HCFA
Dr. Wyngaarden, NIH

Dr. Dickson opened the meeting by noting the variable reporting of figures for seropositive testing among the country's youth. Fifteen in 10,000 is the figure for Army recruits; in some areas of New York City, one in 50 test positive. Discussion centered on some of the reasons for this disparity.

Dr. Dickson also reported that the Institute of Medicine (IOM) is completing the analysis for its report on AIDS and that it will be presented and discussed at its annual meeting in October. Dr. Dowdle indicated that the draft report is still being reviewed by IOM. Data presented by PHS at Coolfont are being used.

Report of the AIDS Coordinator

Dr. Dowdle reported that NIDA and CDC are meeting to discuss their mutual activities on AIDS and IV drug abuse and will report to the Task Force shortly. In a meeting with the Swedish Minister of Health last week, Sweden reported nearly 100 cases of AIDS and 3,000 to 5,000 positive antibody tests. AIDS information has been delivered to every home in Sweden. The country is donating about one million dollars to the World Health Organization to assist with the AIDS efforts in developing countries.

Italy has reported 300 cases of AIDS as of July. Fifty-seven percent is among drug addicts and addicts who are also homosexual and 29 percent among homosexuals. Of 28,000 convicts who have been screened, 1,727 test positive. About 6 percent of Italy's AIDS cases are among children of drug abusing parents.

Reports of the six subgroups

- Epidemiology and Prevention

  Dr. Hopkins reported: 1) the Epidemiology and Prevention Subgroup meeting scheduled for today is postponed and will probably meet next Monday; 2) he is expecting the MMWR article on AIDS and Minorities by Friday and will circulate it to the Task Force for comments before the next meeting; 3) an up-dated status report on the Belle Glade investigation is almost complete. The preliminary review of the data will be presented at ICCAC three weeks from today. He will send out the draft report to the Task Force for review within two weeks; 4) the AIDS Hot Line is receiving 800 calls per day to the tape and 300-400 callers are staying on to speak to individuals; 5) the latest draft of the agenda for the PHS Conference on Promoting Public Health Action: Use of HTLV-III/LAV Antibody Testing for Prevention Programs was distributed. The meeting is scheduled for Wednesday and Thursday, October 22-23. Comments and suggestions on the draft agenda should be made to Dr. Jim Allen at CDC, FTS 236-3476. Ms. Lengel suggested a press briefing at the end of the conference; 6) the ACIP is recommending that children with known AIDS should not be given live virus vaccines. Children who test positive, but are asymptomatic can be given MMR but not live polio virus. The ACIP statement on AIDS is also suggesting that children of parents in AIDS high-risk groups be evaluated before immunization.

  Dr. Dickson brought up the issue of the recent press reports about operational problems at the CDC AIDS laboratory. There was some discussion of these reports and the distractions they are causing at CDC. Dr. Dowdle indicated that a report is being prepared for Dr. Windom.

- Blood and Blood Products

Dr. Meyer will be leaving the Public Health Service in October to take a new position in the private sector. Dr. Meyer reported that FDA has licensed the 8th AIDS ELISA test, using a different cell from both the Gallo cell and the Genetic system cell. He also reported that 20/20 is making requests for information relating to blood safety and AIDS.

- Behavior, Neuroscience, and Addiction Aspects

Dr. Goodwin reported that Drs. McFarland and Gibbs from NINCDS have joined the subgroup. A major focus of the subgroup is the issue of IV drug abusers and coordination between CDC and NIDA to avoid overlap. He circulated a copy of the agenda for the NIMH AIDS Research Methodology Conference to be held at the Linden Hill Hotel in Bethesda on September 18 and 19. Dr. Goodwin also discussed the David Jenness' editorial in the August 22 issue of Science, about the role of the social scientist in identifying special populations, attitudinal changes and how to recognize attitudinal changes.

Dr. Pickens reported that new information on needle sharing and IV drug abusers indicates that needle sharing is more prevalent than has been thought. Needle sharing in shooting galleries has increased substantially among heroin and cocaine abusers. These hard core, chronic drug abusers are the most difficult to treat. There was a discussion about the difficulty in obtaining good hard data about how many people abuse drugs intravenously, and to what extent these people know about the risk of AIDS, and the opportunities for prevention. Dr. Pickens also reported that a list of priorities for NIDA has been developed and will be circulated by the next meeting.

- Vaccine and Therapy

Dr. Galasso reported: 1) all committees are meeting and making progress; 2) three RFPs and RFAs on AIDS have been announced, including RFPs on better methodologies to detect the virus, better methodologies for markers of immunity and an RFA on the pathogenesis of AIDS and associated factors; 3) the animal model committee is looking carefully at protocols regarding the use of chimpanzees; 4) the vaccine subgroup is beginning to develop general clinical protocols for the evaluation of vaccines. Dr. Jim Curran is joining the subgroup for this activity; 5) the international conference plans are taking shape and the planning group is ready to publish the call for abstracts. The length of the conference will be four and one-half days.

9/8/86
PHS TASK Force 4

Dr. Dickson asked about the progress being made at the Primate Center at the University of California at Davis in the development of a vaccine for Simian AIDS. The general consensus was that the report was encouraging, but that any implications for AIDS vaccines in humans were unknown.

Dr. Dowdle reported that the Hastings Institute will host a meeting on October 6 and 7 to discuss drug availability for more individuals than is currently possible under protocol studies. PHS's concern is to maintain the scientific credibility of treatment trials. Drs. Dowdle, Fauci, McCarthy and Meyer s representative, Ms. Donoghue and Dr. Hill will participate in the meeting. Dr. Meyer suggested that PHS begin planning for drug distribution in the event a promising drug nears readiness for approval. He stressed that the government will have a real status in working with industry to make such a drug available.

Dr. Dickson asked Dr. Fauci to comment on his work on the effect of the AIDS virus on the B cells in the bone marrow. Dr. Fauci indicated that, though the B cells were stimulated, the effect was that of immunosuppression.

o Patient Care and Health Service Delivery

Dr. Noonan reported that the subgroup functioned as a review panel for the HRSA applications. Five applications were reviewed and four were approved, all with conditions. Negotiations are underway now regarding the conditions. It is expected that the grants will be funded before October 1. The Robert Wood Johnson Foundation (RWJF) had two representatives on HRSA's review panel; and there were two representatives from PHS and one representative from HCFA on the RWJF's review panel in an effort to avoid overlap.

o Information and Education

Ms. Lengel reported that: 1) a flyer on the availability of the three PHS video tapes has been sent to 30,000 groups and organizations; 2) we are purchasing the master reel of 50 celebrity PSAs produced by KPIX-TV in California, to which we can add our own tag line; 3) OGC has ruled to advise that we can use paid advertising.

Dr. Hopkins reported on the draft AIDS Information and Education Action Plan drafted by CDC and modified by this subgroup. The plan examines the relationship of the CDC information and education efforts to all others in PHS in order to reinforce information and help avoid conflicting messages. Comments on the action plan should be made to Ms. Lengel by Monday, September 15.

Dr. Dickson asked Dr. Koop to discuss the status of the Surgeon General's Report on AIDS. Drs. Koop, McTigue, and Samuels have met with 32 groups for 2-4 hour discussions. They have received absolute cooperation from all of the groups. According to Dr. Koop, we have the foundation for a remarkable coalition of organizations reflecting the views of large segments of the population on AIDS.

Dr. Goodwin suggested that more public information efforts be made to describe the importance of animal research on AIDS. He also suggested that any publicity on progress in research include mention of the use of animals in the research. Mr. Riseberg discussed the ruling of a three-judge court that the animal rights' group has no legal standing to challenge the use of animals in research and further that they should not have such standing.

Dr. Koop suggested development of a formal liaison with the entertainment industry to encourage writers, producers and actors to focus on a number of health education issues which could be addressed in soap operas, sitcoms, and other television entertainment.

Dr. Dickson noting the presence of Proposition 64 on the California ballot in November and its quarantine implications, asked Ms. Lengel about her view of its chance for success. She indicated that though there was considerable concern, the likelihood of its passage remains unclear.

Ms. Hassell reported that Congress returns today from its one month recess. No formal hearings have been scheduled yet for AIDS for the month of September.

Mr. WEISS. It says that Dr. Hopkins reported on the draft AIDS Information/Education Plan drafted by CDC and modified by this subgroup. You had a draft plan as of the early part of September; isn't that correct?

Dr. DOWDLE. That is what I was referring to earlier about earlier work that was going on. The plan that has been submitted now actually was begun in early November.

Mr. WEISS. There is no correlation? There was no continuity of these plans?

Dr. DOWDLE. In fact, the work that was part of the earlier plan was incorporated into the present plan.

Mr. WEISS. It's one continuing process; isn't that correct?

Dr. DOWDLE. Yes, sir.

Dr. WINDOM. Yes, sir.

Mr. WEISS. What were described at task force meetings as "final drafts" of the AIDS plan were circulated several times in the months following that September 8th meeting. Yet, it still has not been released and implemented; is that correct?

What was the cause for the continuing delay in issuing the plan? Dr. Dowdle.

Dr. DOWDLE. Well, again, there was sort of an evolution of thinking of what purpose the plan should serve. Initially, it was thought that this was an internal working document as had been the Coolfont report and the 1985 study. Later, the thinking was that this should be more of a public document. Then we took a little different tack.

Mr. WEISS. When was the Public Health Service's Information/Education document first submitted to the Department of Education for review? I am referring to the plan which is about to be released.

Dr. DOWDLE. It was in earlier November. There was a very early draft of the plan sent in the latter part of November.

Mr. WEISS. By November, you had a draft proposal which you submitted to the Department of Education; is that correct?

Dr. DOWDLE. What we were submitting at that time was only two sections of the plan, the introduction and what was called the basic elements of information. We felt that this was an area that we needed to get wide consultation on, so we submitted that first before submitting the second part of the plan dealing with specific activities.

Mr. WEISS. We have a copy of the plan or proposed plan that you submitted to the Department of Education dated November 14, 1986. It is entitled "U.S. Public Health Service Plan To Prevent and Control AIDS Through Information Education and Risk Education." It is a very comprehensive proposal of some 17 pages. It was not just a limited set of suggestions or proposals for Education's attention; isn't that correct?

Dr. DOWDLE. Yes, sir, but the present document is about three times that length.

Mr. WEISS. Because of textual material or charts that have been attached?

Dr. DOWDLE. Well, again, the idea was to get out concepts in that first draft. Now the activities have been sharpened, and the time-

frame in which these activities are to be accomplished is detailed. All of that was done for the document that we are now discussing.

Mr. WEISS. On December 3, the Department of Education sent you their detailed comments and editing of the draft plan. That memorandum was signed by Mr. Jack Klenk, identified as issues staff.

Dr. Dowdle or Dr. Noble, do you know what this gentleman's background and training are? Is he a public health specialist?

Dr. NOBLE. I'm sorry. The question was?

Mr. WEISS. Do you know what Mr. Jack Klenk's background is? Do you know if he is a public health specialist?

Dr. NOBLE. I'm sorry. No; I don't.

Mr. WEISS. Is he to your knowledge an expert on either public health education or school curriculum?

Dr. NOBLE. I have not inquired.

Mr. WEISS. In any event, he made extensive revisions in the documents and returned them. Were his recommendations followed in the subsequent draft of the plan?

Dr. DOWDLE. Well, we incorporated those which we felt were appropriate; yes, sir.

Mr. WEISS. Dr. Windom, for the record, would you please describe the Public Health Service task force?

Dr. WINDOM. The Public Health Service task force?

Mr. WEISS. Yes; please.

Dr. WINDOM. Yes, sir. It was established in early 1984. It is made up of representatives from the five agencies of the Public Health Service. It is broken down into working groups composed of representatives of those agencies who have various special interests that relate to a certain area, such as therapeutics, vaccines, and education.

Mr. WEISS. This is a Task Force on AIDS; right?

Dr. WINDOM. Yes, sir. It has met every 2 weeks over these last 2½ years to update the group as to what progress has been made, what committee action has been taken, what the status of the whole program is at that time.

Mr. WEISS. On December 15, after your November 14 proposal had been analyzed and commented on and edited by the Department of Education's Mr. Klenk, there was another version of the plan that was distributed to the task force. It had omitted from it the so-called messages section.

Dr. Dowdle, Dr. Noble, would you tell us what the messages section comprised and why it was deleted from the plan?

Dr. DOWDLE. I don't recall the specific document. I think you may be referring to the change in the name of that section. In fact, from the very first, it was changed to basic elements of information, which had been referred to sort of loosely as messages.

Mr. WEISS. The minutes of that December 15, 1986, meeting say that:

> Dr. Dowdle reported that the subgroup met during the past week and distributed the current draft version of the plan. Comments are due at the end of this week, the messages are not included in the plan. It was not intended that these elements be the final messages.

Does that refresh your recollection at all?

Dr. DOWDLE. I think what that referred to, when we said "messages were not intended to be final messages," was what we were trying to convey in the plan. The basic elements of information were concepts that we need to get across. Specific messages, and how they would be packaged and what information would be provided, would be worked out for certain situations, certain geographic areas, and certain populations according to the recommendations of our consultants.

Mr. WEISS. But those were then removed after the Department of Education's comments; is that right?

Dr. DOWDLE. Well, the same, quote, "messages," are still in the document. They have not been lost. They have been modified as other people have reviewed them, but they are still there.

Mr. WEISS. By January 12, the "final" plan was circulated to the task force and Dr. Mason stressed it was then important to "implement the plan as soon as possible" and that he would like to resolve issues surrounding the plan by the end of that week so that the important messages contained in it could get out to the public.

What were the important public health messages urgently needed which the plan would help disseminate?

Dr. DOWDLE. Well, the plan essentially, as Dr. Windom has outlined, is aimed toward the public, school-and college-aged youth, those at highest risk, and health care workers. These were elements of information which we felt should be gotten out to those four major groups.

Mr. WEISS. Dr. Dowdle, isn't it true that in fact there were a number of exchanges, written and oral, between you, Dr. Noble, and the Department of Education, during which you were basically attempting to complete this Public Health planning document while the Department of Education was attempting to mold the document into something altogether different?

Didn't you have that kind of disagreement with the Department?

Dr. DOWDLE. We did have a memorandum from them and we did respond to the memorandum from them and we did put in changes. I might add though, we also had suggestions from others as well, both verbal and written.

Mr. WEISS. How would you characterize what the Department of Education was attempting to do to the document?

Dr. DOWDLE. Well, I really can't say what the Department of Education was attempting to do. I think some of the points that they made were good points. In fact, we took some of the points. We did expand some of the elements of information to include their suggestions.

As to some of the other points, we felt that they were not necessarily appropriate for the document that we were trying to produce.

Mr. WEISS. What were those?

Dr. DOWDLE. These were points which we felt were more detailed than we had initially considered. For example, we were trying to create a more generic document, and we felt that some of their comments fit best for certain populations and not for others.

Mr. WEISS. Dr. Noble, didn't it get to the point that you were forced to write to the Department of Education a very stern warning about their continuing delay of the plan?

Dr. NOBLE. We responded to the first set of comments with a memorandum in which we urged the need for speed, since we felt that it was important to proceed with the document as soon as possible.

Mr. WEISS. This is now the second plan. I have a memorandum dated January 29, 1987, which is addressed to Mr. Klenk at the Department of Education. Your closing two sentences are:

> It is absolutely critical that an information education effort move forward in a timely manner. The consequences of delayed action will be AIDS cases that might have been prevented and no one wishes to shoulder that responsibility.

I assume that by that point, you were getting fed up by the constant delays from the Department of Education; is that correct?

Dr. NOBLE. Democracy is a slow process. We wanted to have the best document, and frustrations are inevitable whenever you try to mold together comments and viewpoints from a wide variety of sources. Nonetheless, I think the final document is the better for it.

Mr. WEISS. Well, democracy is indeed a slow process but at the same time, as you indicated, the chief consequence was to delay actions, and that might have been prevented. And what you are saying is that people may be dead because of the delays?

Dr. NOBLE. One point I would like to make here is that despite the absence of a formal published education plan, the workers in the field have gone on unhindered, and the CDC, ADAMHA, HRSA and others have been going full steam ahead. I think those comments might be amplified by others.

Mr. WEISS. Dr. Windom, you also recognized the need to implement this important plan in January, and apparently directed each agency under your direction to immediately prepare new implementation plans which were due April 1. Is that correct?

Dr. WINDOM. Yes, sir.

Mr. WEISS. Now, is that same implementation date still in the current draft of the plan? Is that still operative? Is April 1 the date for implementation?

Dr. WINDOM. Yes, sir.

Mr. WEISS. So that it has not, the plan has not yet been issued? Is that correct?

Dr. WINDOM. That is correct.

Mr. WEISS. Dr. Dowdle, you then proceeded on February 9 to schedule a press conference for the following week to release the plan, indicating that it was complete. Why wasn't that press conference held?

Dr. DOWDLE. Well, I think it was Dr. Windom's press conference, sir.

Dr. WINDOM. There was question about having a press conference. We discussed having one, but never made a definite commitment.

Mr. WEISS. I see. In other words, you reported, but it was not going to be your press conference, then it would be Dr. Windom's press conference on that date?

Dr. DOWDLE. That's correct

Mr. WEISS. OK.

On February 11, in fact, the White House issued a memorandum limiting the scope of AIDS education. Wasn't that the reason that the press conference and the plan were again delayed?

Dr. DOWDLE. No.

Dr. WINDOM. No, sir. No.

Mr. WEISS. Now what specific role did your Department have in the discussions and drafting of the new White House memorandum on AIDS education?

Dr. WINDOM. Well, this was taken into consideration, Mr. Chairman, just like all the other input that we had, and we discussed it. We looked at how it could be fit into our program and into the document. It was considered like any other response that we asked for.

And I might mention that you've been referring to the Department of Education all along, but we do have a Federal coordinating committee, which I established last November. It's made up of many Federal Government departments, and it meets every 2 weeks. Representatives of various Federal departments meet for an update on what has transpired and is in progress in the area of AIDS. We also asked these representatives to look at the plan at various draft stages, and they in turn gave back their responses.

Mr. WEISS. Did you, Dr. Noble, participate in the White House meetings or deliberations on that White House memorandum?

Dr. NOBLE. I did not attend formal meetings, but we participated in discussions.

Mr. WEISS. Did any of the Department people participate in formal meetings?

Dr. WINDOM. Yes, I attended two of the domestic policy group meetings at the White House, and Dr. Koop also attended with me. We presented the program at that point, and discussed various aspects of it. We also apprised them of our progress as time went on.

Mr. WEISS. You had a reaction, you responded to that memorandum, did you not, Dr. Noble? What was your reaction to it?

Dr. NOBLE. The point that I was attempting to make was that the Public Health Service, traditionally, in its nearly 200 years, has been strongest when it is attempting to do what we call risk assessment. That is, we provide the best scientific information on which judgments can be made and actions can be taken. My own personal feeling is that the Public Health Service role is not to try to manage risk, that is, risk management. That, in this particular case, is something that is the responsibility of the local constituted health and education authorities.

Mr. WEISS. And you have said that, in your response, "the Federal Government should leave the job of molding the moral specific message to the local educators, as recommended, and not try to mold the message at the Federal level." Is that correct? Because you were concerned that we would be creating an impossible oversight responsibility for the Public Health Service?

Dr. NOBLE. That's correct.

Mr. WEISS. Are you involved in any further review of Public Health Service plans on AIDS now being conducted by the White House, OMB, Justice Department, or elsewhere in the Government?

Dr. NOBLE. As a part of the Office of the Assistant Secretary for Health, yes, I would expect to continue to be involved.

Mr. WEISS. Now is the plan undergoing review elsewhere at this point?

Dr. WINDOM. No, at this point, sir, it is in our Department, and we're awaiting the Secretary's final review, and his clearance of the document.

Mr. WEISS. We had some indication that under normal processes, you'd have to have that plan submitted to the OMB or to the Domestic Policy Council, or to the Justice Department. Is that not so?

Dr. WINDOM. They have had an opportunity for input, yes. They have looked at this latest draft.

Mr. WEISS. And when did that take place?

Dr. WINDOM. That was the latter part of last week, during last week.

Mr. WEISS. Thank you very much. Mr. Frank.

Mr. FRANK. Thank you. I should begin by saying that in general, I think, your Department deserves a lot of credit for doing a number of very useful things in fighting AIDS at a time when it hasn't always been easy. I don't think the overall Federal response is what it ought to have been. I think your Department, I think Dr. Bowen has done well, and I think Dr. Koop has been particularly useful.

I'm not sure about elsewhere, I don't know if the President—Dr. Koop I guess called on the President to fight a war. Maybe it's one of his covert wars, and that's why we don't quite know that—what's happening. But what has to be done still, and that's why I think these hearings, for which the chairman was, as usual, very well prepared, are very useful.

And I think he has documented an important issue, which is that the good instincts of the medical people in your Department are being somewhat diverted by political and ideological objections elsewhere, and so I—the first question that I have to ask you is that—is about the missing man at the table, Dr. Koop. Did anybody tell him not to come?

Dr. WINDOM. No, he was aware of this hearing, but he said he couldn't make it.

Mr. WEISS. He's traveling and speaking right now.

Mr. FRANK. My understanding is that he was offered a choice of four dates, and my sense is that somebody didn't want him here.

Dr. WINDOM. Oh.

Mr. FRANK. Will we, could we get a promise that he could testify at a hearing on this issue, because it's been hard to get him, and I—to be honest, I mean he wanted it—you know, we ought to be explicit—he, in this, as well as in AIDS education.

He made a statement that politically angered a lot of people in the administration. I'm struck, I just happened to be reading here, and I get behind—the February 20th Washington Post is talking about a conservative political conference. The Secretary of Education, William J. Bennett, sensing the gloom in the room, said he was making headway in his effort to instill values into teaching, but there have been pockets of resistance.

I mean, I get the sense he thinks of several of you as a pocket of resistance for which I congratulate you, but I think that's been part of the problem with Dr. Koop. I think Dr. Koop is getting clipped a little bit, and my understanding is that we want him to

testify. So you're saying there's no problem that he wanted—that he is free to testify on this subject any time, any place?

Dr. WINDOM. Yes, sir. He would have been here today, except he had a commitment of a speaking engagement today.

Mr. FRANK. Well, again my understanding was that he had been asked, he had been offered other dates, and that it was kind of hard to find one.

Dr. WINDOM. I wasn't aware of that. He was welcome to come.

Mr. FRANK. We got the sense that, as I think, people were trying to get a date with Dr. Koop, he was following Dr. Bennett's advice and just abstaining, and wasn't about to be—he wasn't about to be available.

I yield to the chairman.

Mr. WEISS. We try not to make Dr. Koop's life even more difficult than some other people in the administration have been doing, and we did offer some alternative dates through his congressional liaison people, or the Department's congressional liaison people, and they indicated that he was not available, and then we were never able to make sufficient contact with Dr Koop to really tie him down to any specific date. And so we decided to go ahead, but we welcome your assurance that in fact, you will be helpful in making sure that he is not barred from participation.

Dr. WINDOM. Not a bit, sir.

Mr. FRANK. Well, I appreciate it, and I don't want to make a big—I don't want to make trouble with anybody. No one suggested to me that that was the case. I just came and didn't see him, and thought that was kind of unusual, so I initiated a conversation with members of the staff of the subcommittee chairman, and that's where I got the information.

And later on I think it will be important to have him here, because I do—as I think the chairman, in a very, very clear way, documented the point, which is that your willingness to go ahead with what is medically indicated in this case as being somewhat contraindicated—bad word, I guess—counterindicated by the other people in the administration, and that worries me, and I think that what we want to do is to stress that that ought not to be that.

Let me just say in general, when you talk about the Education Department, and I know democracy is a slow process, and all of those things, but let's get specific. Is it the case? It seems to me the case, but the general direction of the Department of Education, and some others, is to say to you what you will do if you were making medical judgments alone, based on the public health menace here, has to be changed because of our ideological position about what is appropriate human sexual behavior. Now is that an accurate characterization of what you've been hearing from people in Education and elsewhere?

Dr. WINDOM. Mr. Frank, I think that when you see the document, you will agree that it is a risk assessment, scientifically directed to people in many, many sectors of our country who will respond to it, and then take that information and use it in the best way they feel they can to communicate to the people whom they serve. I think the input we've had from everybody who has contributed has been meaningful and necessary for us to achieve the best presentations.

Mr. FRANK. Thank you, doctor. Now would you answer my question? And that was very nice of you to say that. Would you answer my question now?

Dr. WINDOM. That this was held back or indifferent?

Mr. FRANK. Yes. It's always nice to talk to you——

Dr. WINDOM. No, I do not feel like that——

Mr. FRANK. For instance, I ask you if the thrust of the—now for instance, if I ask you if the—about the thrust of the advice you were giving the Department of Education? Your response was that everything you heard was meaningful. Well, I'm sure it was meaningful. I think it's very meaningful when Dr. Koop is forced by Secretary Bennett to dilute the quality of what he wants to say, as I would interpret it.

So, I'm not asking you if it was meaningful. I'm willing to stipulate that it was meaningful. What I was asking is, has there been a thrust from the Department of Education in which ideological or political, or however one wants to categorize it, values have been put forward?

You talk about democracy is a slow process, compromise. Have they basically been indicating, it seems to us this way, that what you would do on medical grounds alone, doesn't reflect the proper set of values; that it would appear to be condoning the sexual practices that ought not to be condoned? I don't know how you condone them by taking those facts I don't understand, but—and that's the question.

It's the nature of the input. I mean, I'm sure the document, I will stipulate, that the document will be a risk assessment. You told me that, and I'm sure it will be, and that education was meaningful. Now let's get beyond that to my question. Have they been giving you kind of ideological or value-oriented suggestion to change the nature of what you would do medically?

Dr. WINDOM. No. I do not feel that—no. It will not change the nature of our program.

Dr. HARMISON. Congressman, I think one of the most important parts in addressing this disease is getting behavioral changes; medical judgment is not the only avenue through which those changes occur.

Mr. FRANK. I think so—I agree with that too. But sooner or later you come to these hearings you're going to be told things that everybody knows, and I appreciate that. It has always been true, and surely you have to do that.

But since you volunteered, will you answer my question?

I didn't ask you to talk, but if you want to, that's perfectly OK if you would answer my question as part of what you have to say.

Dr. HARMISON. I think the answer to the question is no. The Department of Education, through Secretary Bennett, has provided input to look at the full spectrum of issues as viewed by the Department of Education. We put the same emphasis on timely response that was in Dr. Noble's——

Mr. FRANK. I didn't ask you about time of response. It shouldn't be that hard. I didn't ask you about time of response.

Dr. HARMISON. We got valuable information from the Department of Education. We did not compromise our medical judgment in the plan.

Mr. FRANK. Was the agreement between Dr. Koop and Dr. Bennett—it looked like some changes in what Dr. Koop had originally said. Is that accurate, or am I misreading that?

Dr. WINDOM. Well, I talked to Dr. Koop and to Mr. Bennett. I met with them because there was a great deal of publicity out there that they were having a fight and disagreeing. They spoke out and, I think, have very similar thoughts about how to approach this subject. That's why they came forth with that statement.

Mr. FRANK. These series of events, Dr. Koop's statement, the statement between Bennett and Koop doesn't reflect any disagreement between them?

Dr. WINDOM. No, it was a combined statement.

Mr. FRANK. I understand that, Doctor. Do you believe it?

Dr. WINDOM. Yes, sir.

Mr. FRANK. You may be the only person in this room who does.

Dr. WINDOM. Is that right?

Mr. FRANK. And I don't think you do, but I understand the constraints you're under. That's why I didn't——

Dr. HARMISON. Well, there's a benefit of having first-hand knowledge of those discussions. I think the discussions were very amicable, and the dimensions of what each was saying were very carefully understood.

Mr. FRANK. Well, again, you know, people can disagree without yelling at each other, as I hope we are manifesting today. But the question—you're telling me that there was no disagreement between Dr. Koop and Mr. Bennett? That Mr. Bennett didn't feel that Dr. Koop, in talking about sex education at an early age, or any of these things, was doing anything wrong, or was not properly value, maybe?

Dr. HARMISON. Well, I think there were perceptual views of what possibly each had said.

Mr. FRANK. Perceptual views? What's that?

Dr. HARMISON. Well, I think that there were a lot of things reported about what each had said, or had not said.

Mr. FRANK. Well, you mean Koop and Bennett were reading about each other in the paper, and incorrectly inferred that there were disagreements when they were really in agreement all the time?

Dr. HARMISON. All I can address is the direct discussions.

Mr. FRANK. All right, you're not under oath, Doctor. You can say whatever you want.

Dr. HARMISON. All right, I think that the point here was demonstrated by the chairman. I don't expect you to talk openly about these disagreements. I don't think we ought to pretend that they're not there, and I think we have a real problem here, that we have political and ideological agendas which are slowing things down and, as the chairman says, when you slow things down, you are causing deaths, not intentionally.

People are well intended, but the fact is that the later this information comes—if you believe education has any value, then in this area you believe in saving lives—the more people who don't read it and do something that they could have been deterred from doing, and they die. And maybe they spread the disease to other people.

And secondly, I think we are getting a dilution, and I think that is unfortunate.

Mr. FRANK. I've been arguing—I would tell you, I would like to think that the Federal Government is capable of doing the job of educating, but—and I am not suggesting that it's the Federal role to tell people that certain kinds of sexual practices are good or bad. I'm a little surprised frankly, to have conservatives announce that it's their job—I thought these were people who believe in a limited role of the Federal Government. When they want to set the Federal Government up as the arbiter of truly consenting private sex fantasies among adults, I guess I don't understand limited Government very well.

But they have the constitutional right to do anything with that they want. But when it retards medical people giving the best advice, and that seems to be clearly happening, then I think we have a problem, and I think the chairman did a good job of demonstrating that, and I think the hearing is important for this reason, and I don't really expect you to say very much, except that we hope that we will be demonstrating by these hearings, that there are people in Congress, and I think in the majority in Congress, if you look at the way we have voted on these things, who understand that the best possible medical information is what people ought to have and want to have, and those who think that particular individuals don't behave in the proper way are free to say so, but they shouldn't be retarding medical information when they do it.

Thanks. I have no further questions.

Mr. WEISS. Thank you very much, Mr. Frank.

We will move on to another area, but related.

Dr. Windom, I understand that the Government's public information program was originally coordinated out of the Office of the Assistant Secretary for Health and was transferred to the CDC in Atlanta.

When was that done and why?

Dr. WINDOM. The education plan?

Mr. WEISS. The Government's public information program was originally coordinated out of your office.

Dr. Dowdle, Dr. Noble, do you know when that was transferred to Atlanta, to CDC?

Dr. WINDOM. In late November last year, when I directed them to go ahead and develop the plan. And that included the production of it, implementation, and followup.

Mr. WEISS. We have memorandums indicating that that was done sometime in 1984 or 1985. Why it was moved from Washington to Atlanta?

Dr. WINDOM. If it was done in 1984, it was done, I'm sure, with the idea in mind that CDC had within it the people who would best be able to put the plan together and carry it out, because they deal with disease control and prevention activities already.

Mr. WEISS. OK. In August 1985, the Director of the Department's Office of Public Affairs, a person named Shelly Lengel, the Chief Public Health Service Information Officer, expressed serious concerns about the status of the Government's AIDS information efforts.

Dr. Dowdle, were you and Dr. Mas. aware of her concerns or any other problems in the program a that time? And to refresh your recollection, let me indicate tha' in a memorandum that she wrote to Dr. Mason on August 26, she said:

As you know, you and I discussed, and it was my idea to move the public information program to Atlanta. However, it has not worked well.

For instance, it took 9 months to update "Facts About AIDS." Our three videotapes are outdated and have been shelved, and there has been no new project undertaken. With a subject like AIDS, I don't think you can be reactive. You must be aggressive in getting information to the public.

I assume that Dr. Mason got that letter. Were you aware of it, or that memorandum?

Dr. DOWDLE. Yes.

Mr. WEISS. And what was your response to that?

Dr. DOWDLE. Well, I think we need to recognize that the first efforts of the Public Health Service in the information and education area were directed toward those at increased risk, and most of that effort was directed through the States in assisting them in developing their own information and education programs, including later demonstration projects and innovative risk-reduction projects.

What she was referring to was the specific activities in the public area.

Mr. WEISS. Yes.

Dr. DOWDLE. CDC's activities to that point represented primarily providing information through the Morbidity and Mortality Weekly Report and developing guidelines. What she was talking about was the need to get more information out into the public area. We quite agreed with her comments.

Mr. WEISS. Well, again, this is not an outside critic. This is the Chief Public Information Officer for the Department of Health and Human Services.

Dr. DOWDLE. That's correct.

Mr. WEISS. Who is saying that "it was my idea to get it down to you guys in Atlanta, because I thought that it was centralized there, you could do a better job, and it took you nine months to update the Facts About AIDS pamphlet." She then goes through another series of things that you did not do or had gotten outdated.

It seems to me that that's somebody above you expressing concern of implementation of programs that were already in place. Never mind whether they were sufficient, but they were in the place, and, in fact, nothing sufficient was being done to keep them operative.

Dr. DOWDLE. Well, I think that Ms. Lengel's point was a good one. She also did an excellent job in developing materials—as well as in collaboration with the other agencies—and getting these out in collaboration with the Red Cross. Many that you see here, in fact, Ms. Lengel was instrumental in doing. Other agencies were also assisting.

Mr. WEISS. Now that same memorandum, that August 26 memorandum, urged that an ad hoc advisory group on AIDS information be created and that members all be communications specialists, not program people.

When did that ad hoc group first meet?

Dr. DOWDLE. Well, there were actually several groups. I don't remember the exact time.

Mr. WEISS. We have a date indicating that it was November 19, 1985. Do you have any reason to disagree with that?

Dr. DOWDLE. No, that's correct.

Mr. WEISS. OK.

Dr. DOWDLE. That's right.

Mr. WEISS. Who participated in that ad hoc group?

Dr. DOWDLE. There were a number of outside organizations. I was not present, but largely these were people who were experts in public information types of activities.

Mr. WEISS. Right. According to the November 4th minutes of 1985, the ad hoc group was comprised of four advertising agencies, the Red Cross, the American Public Health Association, the AMA, gay rights organizations, and others.

The ad hoc group was presented with a new AIDS information plan at its November 1985 meeting. As you'd indicated, that plan had gone back to November, and in addition made some specific recommendations for immediate action.

Do you know what those specific recommendations were?

Dr. DOWDLE. Those recommendations again related to the need for public information, and if I recall them correctly, they were for specific activities. I don't remember the exact details.

Mr. WEISS. One of the recommendations was for the creation of a coordinating council.

Do you know if that coordinating council was ever created, and if so, is that Coordinating Council for AIDS Information the same as what you now call the National Clearinghouse?

Dr. DOWDLE. No, sir, that's not the same.

Mr. WEISS. Tell us when the Coordinating Council was created.

Dr. DOWDLE. Well, the Coordinating Council was to be an outgrowth of that ad hoc group that got together. There were several meetings of that group which expanded to an even larger meeting in the spring of 1986 at NIH. That meeting consisted of representatives of a still larger number of groups that were working on AIDS information and education programs.

Mr. WEISS. Is it still in existence?

Dr. DOWDLE. No, sir.

Mr. WEISS. When was it disbanded?

Dr. DOWDLE. It was not actually a formal group. It was never a formal group.

Mr. WEISS. Has the National Clearinghouse on AIDS Information been put into operation?

Dr. DOWDLE. The National Clearinghouse on AIDS is now in the form of a request for a contract. It's under review at the present time and should be—the clearinghouse should be in force sometime this fall.

May I point out, though, that clearinghouse activities are taking place right now. In fact, the hotline does also provide information on a when-requested basis.

Mr. WEISS. Right. The request for proposals was issued when? March 4, I understand; is that correct?

Dr. DOWDLE. I'm sorry, sir?

Mr. WEISS. The request for proposals for the National Clearinghouse on AIDS Information was issued on March 4.

Dr. DOWDLE. Well, it hasn't been actually issued yet. It's in review right now.

Mr. WEISS. It's in review?

Dr. DOWDLE. Yes, sir.

Mr. WEISS. I understand, according to the contract proposal, that it will not start operating until 6 months after the currently proposed contract date, which is June 30; is that correct?

Dr. DOWDLE. That's correct. We still hope we can hold to that date, right.

Mr. WEISS. That means, then, that the earliest operation date is December 30 1987, if all goes well; isn't that correct?

Dr. DOWDLE. That's correct.

Mr. WEISS. That's an awfully long gap, don't you think?

Dr. DOWDLE. But I would like to point out that clearinghouse operations are in place by a number of different organizations, as well as States. In fact, CDC supports clearinghouse operations within States.

Mr. WEISS. I know. But you were calling for a national clearinghouse; isn't that correct?

Dr. DOWDLE. That's correct.

Mr. WEISS. Right.

Dr. DOWDLE. That's correct.

Mr. WEISS. You still think that it's important to have the national clearinghouse?

Dr. DOWDLE. Oh, absolutely.

Mr. WEISS. Is the delay due, at least in part, to the fact that the OMB initially rejected the proposal for the AIDS Clearinghouse?

Dr. DOWDLE. Well, not this particular clearinghouse that we're discussing here; no, sir.

Mr. WEISS. We have a memorandum indicating that, in fact, you won an appeal from the OMB when they had rejected the clearinghouse request.

Dr. DOWDLE. Oh, is that the 1988 budget request you're referring to?

Mr. WEISS. Yes.

Dr. DOWDLE. Well, that's not the present one and, in fact, that has not affected the present one at all. That referred to 1987 money.

Mr. WEISS. Also that OMB approved the 1987 clearinghouse?

Dr. DOWDLE. Yes.

Mr. WEISS. But they rejected continuation of it for the fiscal 1988 budget; is that correct?

Dr. DOWDLE. Yes. Dr. Windom, would you want to say something?

Dr. WINDOM. I asked Mr. Harell Little, our budget analyst, to comment.

Mr. WEISS. What is your name again, sir.

Mr. LITTLE. Little, L-i-t-t-l-e.

Mr. WEISS. Right, Mr. Little.

Mr. LITTLE. The situation with our requests, 1987 and 1988, to OMB, is this. They did not include funds for a clearinghouse, based on our recommendations that came out of Coolfont.

Subsequently, the Congress passed an appropriation in 1987 for a clearinghouse activity at CDC. The OMB passback, of course, did not include funds for the clearinghouse, although funds were included in 1987. It did not include funds in the 1988 budget, because we hadn't asked for them.

We then went back and appealed to the OMB for the continuation cost of that clearinghouse. Therefore, it is included in both the 1987 and the 1988 budget.

Mr. WEISS. Right. But it is true, is it not, Dr. Dowdle, that the clearinghouse concept—while it may not have been formally requested by the agency because of internal discussions in the various levels of the Government—originally emanated from within the Public Health Service; isn't that correct?

Dr. DOWDLE. Yes, sir.

Mr. WEISS. And when the administration rejection came through, Congress, based on this knowledge of what had been requested internally, decided to give you the money; is that correct?

[Pause.]

Mr. WEISS. Yes, that is correct.

Now the 1985 plan called for formation of an ad hoc communications group to advise the Public Health Service on need and methods for reaching various segments of the public.

Has that been done? Have you created an ad hoc communications group?

Dr. DOWDLE. That was the group that Ms. Lengel was referring to, the ad hoc group, which did meet on several occasions.

Mr. WEISS. Is there an ongoing group in existence currently?

Dr. DOWDLE. Actually, the present plan involves looking at this in a different way. It's become a much larger type of operation, and particularly now with CDC having responsibility for being the lead agency.

Mr. WEISS. The 1985 plan also called for the creation and implementation of a "Master Distribution Plan" for all AIDS materials in fiscal year 1986. Has this been done?

Dr. DOWDLE. The efforts on the distribution of the materials that you see here were actually carried out in collaboration with the Red Cross and with the States, as well as with other community service providers.

Mr. WEISS. What does that mean?

Dr. DOWDLE. All these information/education materials were provided to the States. They were provided to anyone who had an AIDS information/education program, and also were made available through the hotline to anyone who wanted them.

Mr. WEISS. Is it your answer that the "Master Distribution Plan," which was called for in the 1985 plan, was achieved?

Dr. DOWDLE. I think what was achieved was through utilization of as many channels as possible. We did that, short of the clearinghouse we're talking about now.

Mr. WEISS. The 1985 plan reflects that the Public Health Service had undertaken a small media campaign with the American Red Cross.

How much Federal support was involved for that grant; do you know?

Dr. DOWDLE. We can get the sums for you, sir. I don't have the exact figures.

Mr. WEISS. Our information is $100,000. Do you have any reason to disagree with that?

Dr. DOWDLE. That's probably about right.

Mr. WEISS. The November 1985 plan also included a half million dollars to produce and distribute videotapes through the National Institutes of Health outreach programs.

Was that done at any time in 1986, Dr. Hill?

Dr. HILL. We have not done that yet, sir, but we are planning a larger program to distribute tapes of this type, perhaps through medical schools and universities.

Mr. WEISS. You are planning to do that?

Dr. HILL. Yes. We have not done that.

Mr. WEISS. You have not done that, although that was a 1985 proposal.

CDC had its own title, "Separate Plan for Community Level Health Education," at that point.

Dr. Dowdle, do you have a copy of that plan with you, the "Separate Plan for Community Level Health Education"?

Dr. DOWDLE. No, sir, I don't. But what that consisted of was the information/education grants which were provided to the States.

Mr. WEISS. In January 1986, a revised "Facts on AIDS" was apparently available for distribution.

How was that distribution accomplished?

Dr. DOWDLE. Well, there is an organization which distributes these facts under contract with the Public Health Service, and I have the address of the organization here. It's InterAmerica Research. The address goes out in the Surgeon General's report and in other information provided by the Public Health Service. An individual may write to this organization and get copies of AIDS materials. We've also sent these materials to all the AIDS organizations and all individuals with information/education activities.

Mr. WEISS. When was that contract entered into?

Dr. DOWDLE. Perhaps a year and a half to 2 years ago.

Mr. WEISS. And how much is that contract for, do you know?

Dr. DOWDLE. I really don't know. It's a contract to distribute to the public publications provided by the Public Health Service.

Mr. WEISS. Can you tell us how many copies of the publications were distributed by them?

Dr. DOWDLE. We can tell you what items are being distributed; yes, sir. I can't tell you the exact number of how many have been distributed right now, but we can provide that to you.

Mr. WEISS. So you don't know whether a million copies or 15 copies were distributed?

Dr. DOWDLE. Over time hundreds of thousands of copies have been distributed.

Mr. WEISS. Over the years. Over how many years?

Dr. DOWDLE. Over a year to a year and a half.

Mr. WEISS. We have an indication with regard to the "Facts on AIDS" pamphlet, that photostats were given to each Public Health Service agency and the 10 regional offices, so that they could print copies for distribution. This comes from the minutes of January 13, 1986.

Was that a method of distribution for the "Facts on AIDS" pamphlet?

Dr. DOWDLE. Yes.

Mr. WEISS. How many copies of the brochure were sent out in this manner by the regional offices and the Public Health Service agencies?

Dr. DOWDLE. Well, I think it's very difficult to get an actual number of these, because we often provide camera-ready copy to other organizations and ask them to reprint them themselves. So to get a precise number on how many have been distributed would be virtually impossible.

Mr. WEISS. You'd know how many copies your 10 regional offices distributed, would you not?

Dr. DOWDLE. They would, yes, but the States do their own reprinting and distribution, so we would not know the exact number unless we asked each individual State for this information.

Mr. WEISS. Is there an ongoing mechanism by which the regional offices report in regarding the distribution of materials during any particular timeframe?

Dr. DOWDLE. We have not put such a reporting mechanism in place. I'm sure we could go back and try to get some estimate of how many have been distributed.

Mr. WEISS. In January 1986, HHS Secretary Dr. Bowen indicated that he wanted to personally initiate a weekly radio show on AIDS information.

Was that done?

Dr. DOWDLE. I'm sorry, sir. I missed that point.

Mr. WEISS. In January 1986, Dr. Bowen indicated that he wanted to personally initiate a weekly radio show on AIDS information.

When was that done, if it was done?

Dr. DOWDLE. We were involved in developing the script for that show, but I think it's actually planned later on this spring or summer. I'm not certain of the time.

Mr. WEISS. Dr. Windom.

Dr. WINDOM. There were a number of those programs in early 1986 and throughout the year. But I'm not certain of the regularity of them, sir, and exactly how many dealt with AIDS. He covers many different health issues.

Mr. WEISS. No. The January 13, 1986, minutes indicate that "Secretary Bowen has indicated his interest in weekly radio news messages wherein reporters could p' one him and obtain information on AIDS."

Could you, for the record, submit to us what was done to implement that interest on the part of the Secretary?

Dr. WINDOM. Yes, sir.

[The information follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington D C 20201

MEMORANDUM

TO: Bob Irwin
Public Health Service

FROM: James A. Miller
Office of Public Affairs

SUBJECT: "Housecalls" series

Dr. Bowen has been doing a weekly radio series of messages "Housecalls" for 15 months. The very first "Housecalls" program aired, in February 1986, talked about the nationwide shortage of blood caused by the fear of AIDS. Subsequently the Surgeon General began development of his report on AIDS which was issued last October. It is felt that it would be premature for the Secretary to make pronouncements on thisimportant subject while that report was still in preparation. In the months immediately following the issuance of the Surgeon General's report Dr. Koop was the point person for the Department on this subject. In January of this year, Dr. Bowen spoke about AIDS at the National Press Club, a speech carried on national public radio to hundreds of stations and one which received wide public notice.

As we discussed, Secretary Bowen plans to record a special "Housecalls" series on May 26, 1987. At the same time, we will videotape two television spots and record two or more radio spots for the National Association of Broadcasters. NAB will satellite feed them to 800 TV stations and 4,700 radio stations early in June.

I hope this helps you. If there is any more information you need please let me know.

Mr. WEISS. In February 1986, another AIDS public information program was prepared. Among its many recommendations were the following: "at this point, a primary need for fiscal year 1987 is sophisticated market research."

Dr. Windom, in the course of your prepared testimony you talked about market research. Specifically, what market research was undertaken at that time and what were the results?

Dr. WINDOM. I'm not aware of early 1986 research efforts.

Mr. WEISS. You said for fiscal year 1987. We are now halfway through fiscal year 1987.

Dr. WINDOM. Well, in the program that is being planned, further media involvement in disseminating our information is underway. Dr. Dowdle may comment on that.

Mr. WEISS. Dr. Dowdle.

Dr. DOWDLE. Well, that is of course part of the ad agency contract. There would be an evaluation before any campaign would be conducted and after the campaign.

Mr. WEISS. But so far, nothing; right?

Dr. DOWDLE. I might also point out that with the information-education grants that have been given to the States, most States have been requested and have complied with evaluation before and after their programs. We have information coming in now from the various States which is quite helpful in determining what the level of knowledge is within those particular areas.

Mr. WEISS. I'm not a market research expert and I suspect you may not be either, but I think both of us know that evaluation of programs after presentation is not the same as market research.

Dr. DOWDLE. I agree, sir.

Dr. HARMISON. Mr. Chairman, I might point out that the National Institute on Drug Abuse let a contract in 1986 to look at how to get the message out on IV drug abuse and things of that nature, which is a part of this overall effort. We can supply for the record the contract and its objective and what it has accomplished.

Mr. WEISS. Say that again. You had a contract?

Dr. HARMISON. A contract exploring how to move the message out on IV drug abuse was let by one of the institutes within ADAMHA for exploring that question. The contract was let in early 1986. I don't have the details at my fingertips, but we would be pleased to provide that for the record.

Mr. WEISS. It would be worthwhile and helpful to have it.

[The information furnished is in the appendix, see p. 193.]

Mr. WEISS. The February 1986 plan also called for "a mass media campaign with particular emphasis on young people who have not been specifically addressed by our previous efforts."

I'm sure there were earlier calls for mass media campaigns. Why was it that only 2 weeks ago, at least a year after the recognition of the need, that a proposal to do a mass media campaign was finally issued?

Dr. WINDOM. Well, this is part of our continuing development of that program. Of course, many in the school systems have been informed and we have responded to their requests. It is part of the implementation of our plan to do it in a more organized way.

Mr. WEISS. No, we are talking about the mass media campaign. Again, my understanding is that part of it—the request for propos-

als for a mass media campaign—was prepared at least as late as January 12 of this year.

Dr. DOWDLE. That's why we are hiring the ad agency. That's part of the total package.

Mr. WEISS. We have not been able to find a dollar amount in that contract proposal. When our staff inquired about it, we were told that the contract for mass media campaign was planned to be $1 million this year; is that correct?

Dr. DOWDLE. That's for the ad agency, sir. That wouldn't be the entire cost of the campaign.

Mr. WEISS. What do you have in mind for the cost of the campaign itself?

Dr. DOWDLE. Well, in the area of public information, we have set aside something like $6 million now to cover all of that.

Mr. WEISS. That would be for what year?

Dr. DOWDLE. For 1987.

Mr. WEISS. For fiscal 1987.

Dr. DOWDLE. Yes. But I should point out though, as Dr. Windom said earlier, that our efforts will be multiplied manyfold by other organizations, both private and public, and the media in getting out these public messages. We would anticipate that we would be working with others in getting these messages out.

Mr. WEISS. I know, but in this hearing and our series of hearings we are discussing as to the Federal response. I know thank goodness, that there are other people out there doing things. Our concern is what and through what agency the Federal Government is doing things.

Under that new contract proposal, how long will it be until ads actually appear in newspapers or on TV?

Dr. DOWDLE. We should let the contract sometime in June. We are hoping to get the program moving sometime this fall.

Mr. WEISS. Again, the question is when will the ads actually appear? According to the provisions within the proposed RFP, it will be 40 weeks after the contract date of June 21, 1986. Forty weeks is next March or April. At the earliest, it seems to me, under a best case scenario, those ads will not actually appear until around March or April 1988; isn't that correct?

Dr. DOWDLE. No, sir. We expect to have something before then. Even in the process of replying to the RFC, the companies that will be responding will have given considerable thought to the final product. We feel that we certainly should be able to get something from that contract by the fall.

Mr. WEISS. Again, I have before me in the request for proposal, the plans for TV and radio productions, and pretesting and campaign planning workshops. These dates range from 26 to 30 weeks after contract award. One is for 26 to 30 weeks after contract award. The last is for 40 weeks after contract award.

I don't know on what basis you are projecting early fall or any time in the fall. According to those contract provisions, it seems to me you are talking about 1988.

There was also recognition, at about the same time in February 1986, of the need to bring in groups such as the National Education Association, the American Federation of Teachers, the National PTA in the AIDS information activity. Has that been done?

Dr. DOWDLE. We have brought in a number of organizations. I can't tell you the specific names of those organizations, but they are in the education field. They have met with CDC and have worked with CDC in developing draft guidelines and broad outlines of what an education program ought to consist of. That has been done; yes, sir.

Mr. WEISS. The February 1986 plan suggested the need for information specifically geared toward students on college campuses to be done in conjunction with the American College Health Association. What is the status of that program?

Dr. DOWDLE. That has not been done yet.

Mr. WEISS. On March 26, 1986, you conducted a Public Health Service conference on AIDS information and education activities. Who was invited to that conference and what were its recommendations?

We have the recommendations. I don't have a list of who attended it.

Dr. DOWDLE. I'm sorry. I'm not aware of what you are referring to.

Mr. WEISS. I'm going to ask you to look at a copy of it and to respond for the record after looking at it. I'm going to ask you some specific questions about it.

One important recommendation at that meeting was that the Public Health Service should develop a national strategy for educating health care providers. What has been done in that area, and specifically, what did the conference attendees think was needed at that point?

Dr. DOWDLE. For health care providers?

Mr. WEISS. Yes.

Mr. HILL. I don't recognize this, Mr. Chairman, but the National Institute of Allergy and Infectious Diseases as a part of this outreach effort did convene a consultant group at about that time. We asked for advice on our outreach efforts, which have been a series of conferences in the past for health care providers. We have asked for their advice on how we should target our populations and our conferences for the next year to include nurses and social workers. I'm not sure whether this is it.

If I could just back up on the previous question that I didn't answer as far as the videotape, our plan at that time had been to videotape our large conferences for health care providers, and we did in fact videotape them. They turned out to be about 8 hours of fairly boring didactic-type presentations, and they weren't felt suitable for distribution. We have not backed up and made plans for more appropriate tapes.

Mr. WEISS. The memorandum that I asked you to look at, Dr. Dowdle, is from Shelly Lengel, Director of the Office of Public Affairs. It is to attendees of the Public Health Service conference on AIDS information and education activities, on March 26, 1986. It says:

> Thanks to all of you who took time from your busy schedules to meet with us on this important subject of AIDS information and education efforts. The Public Health Service attendees I have spoken with who attended the meeting thought it was worthwhile . . . et cetera.

Do any of you have any recollection as to what——

Dr. DOWDLE. Yes, I'm sorry. I misunderstood the date you were referring to.

Mr. WEISS. March 26, 1986.

Dr. DOWDLE. Yes, that's one of the groups that I had referred to earlier that had been convened by Ms. Lengel. What you have there are the recommendations from that group. These were individuals who were involved in information/education programs.

Mr. WEISS. One suggestion of that March conference was that a followup assessment take place at a similar meeting in the fall of 1986. Do you know if that second conference was ever held?

Dr. DOWDLE. No, sir I don't think it was.

Mr. WEISS. Dr. Dowdle, I am now turning to CDC's School Health Education Initiative. Give us some idea of how that project got started and when you and Dr. Mason first reviewed any plans for it.

Dr. DOWDLE. Recalling anything in AIDS is a major problem. Everything runs together as far as time.

Mr. WEISS. We have a May 15, 1986, memorandum which indicates that by at least that date, Dr. Mason had made specific changes in a draft initiative. You may be able to give us an earlier time.

[The memorandum follows:]

[redacted]

Note to: John Bennett, CID
Don Berreth, OPA
James Curran, CID
Donald Hopkins OD
Martha Katz, OPPE
Steve Margolis, CPS
Gene Matthews, OGC
Bill Muldoon, OPS
Claude Pickelsimer, PHO
Kathy Rufo, OD
Sue Toal, CPS

Attached is our current draft of an initiative for School Health Education to Prevent AIDS. We [redacted] responsive to the request by Dr. Mason in the Monday, May 12, AIDS budget meeting. It is comprehensive in that it covers the risks of sexual behavior as well as IV drug use and it builds on CDC's existing capability in the field of school health as well as well recognized national professional networks and curricula.

We would appreciate your comments directly to Lloyd Kolbe, ext. 3923, either in writing (margin notes or otherwise) or by phone by noon Friday, May 16th, if possible. If major rethinking of the proposal is not required, we would then incorporate necessary changes and be ready to finalize the initiative early next week.

If there are others who should see this draft, please let me know.

Thank you,

Ginny Bales
CHPE
Ext. 2636

-media
-college/grants mgt
-[illegible]

5/29/86

SCHOOL HEALTH EDUCATION TO PREVENT AIDS (FY 87)

Every school day, more than 47 million students attend 90,000 elementary and secondary schools in 15,500 school districts across the Nation. A large proportion of these students will be at increased risk for contracting and spreading HTLVIII/LAV, the virus that causes AIDS. Most males and females will experience intercourse before they graduate from high school, and most will engage in sequential monogamy or nonmonogamous relationships for several years before marrying. Several studies suggest that a sizable proportion of young people will experiment in at least one homosexual activity before reaching adulthood. Many students will discover their bisexual or homosexual orientation. Many other students will experiment with intravenous drugs during late adolescence and early adulthood. By reaching 90-95% of our young people, the Nation's schools could provide an appropriate and efficient vehicle to educate a critical segment of the public about AIDS, and about means to reduce spread of the virus that causes it. Indeed, several studies indicate that people have changed or are willing to change their behavior in response to fear of acquiring or transmitting STDs in general (1-3), and AIDS in particular (4).

Administrators in each of our nearly 16,000 school districts largely are left without public health leadership and resources, and must rely on sketchy information about AIDS provided by the media, as they each autonomously struggle to develop school policies and educational programs about AIDS for their respective faculty, students, and parents. These school officials are far less effective, and become confused and discouraged, when they are required to seek and integrate information about intravenous drug use and AIDS from one Federal agency, information about means to reduce sexual transmission of HTLVIII/LAV from a second Federal agency, and assistance in formulating policies about students or faculty who may be infected from a third. They become further discouraged when they must seek and coordinate opinions and assistance from State and local health departments as well as from State and local education departments; and when they are required to seek and integrate opinions and resources of relevant professional and voluntary health and education organizations in the private sector.

The Office of School Health Programs (OSHP) in the Division of Health Education (DHE), Center for Health Promotion and Education (CHPE), at the Centers for Disease Control (CDC) proposes to enable the Nation's schools to substantially contribute to the primary prevention of AIDS by educating a critical segment of the public about AIDS, and about specific means to reduce its spread. The OSHP will utilize the school health networks, relationships, and experience it has established in nationally developing and disseminating its elementary and secondary school health education curricula, and other school health curricula and interventions, during the past 20 years. More specifically, the OSHP proposes to simultaneously conduct the six complementary activities outlined below.

Page 2 - AIDS Education

1. Develop a Coalition and National Leadership for School Health Education To Prevent AIDS

A national coalition of relevant agencies and leaders periodically will be convened: to provide general direction and technical assistance for the initiative; to coordinate and integrate relevant places, activities, and resources of important public and private sector agencies; and, to ensure that the initiative is acceptable to various constituencies. Illustrative of Federal agencies that could contribute to such a coalition are the U.S. Department of Education, the Center for Prevention Services and Center for Infectious Diseases, CDC, ADAMHA the National Institute on Drug Abuse, and the Division of Maternal and Child Health (HRSA).

Professional and voluntary organizations that have expressed interest in providing school education about AIDS include the American School Health Association, the American Association of School Administrators, the American Red Cross, the National Center for Health Education, the National Association of School Boards, the Association of State and Territorial Health Officers, the National Congress of Parent and Teacher Associations, the American Academy of Pediatrics, and the National School Health Education Coalition. Most of these national private sector education and health organizations have State and local affiliates that consequently can help schools in communities throughout the U.S. to provide effective education about HTLVIII/LAV infection and AIDS. The OSHP has well-established working relationships with each of the public and private sector organizations listed above.

7 principal associations @ $50,000 each, plus 10 secondary associations @ $25,000 each = $600,000 + 20% indirect = $720,000

2. Develop and Disseminate Educational Materials and Curricula to Prevent AIDS

There is an urgent need (1) to develop and rapidly disseminate relatively brief and high focused information about AIDS to schools that want to provide such information quickly; and, (2) to develop more curricula for schools that want to assure that their students are more thoroughly informed about AIDS and means to reduce the spread of these virus that causes it.

Within the first year of the proposed initiative, relatively brief and highly focused educational materials about AIDS will be prepared or adapted and disseminated to: (a) elementary, secondary, and college students, (b) teachers, (c) school administrators and boards, (d) parents and other concerned community members and (e) young people who may not be attending schools or colleges.

Within the second year, more sophisticated and extensive curricula about AIDS will developed: by revising the OSHP's elementary school Growing Healthy curriculum to address AIDS; by adding a new module about AIDS to the OSHP's secondary school Teenage Health Teaching Modules; and, by expanding the Center for Prevention Services' curriculum on STD: A Guide

for Todays's Young Adults. These materials and curricula will be designed: (a) to focus on those specific populations and behaviors that most influence the transmission of AIDS (as suggested by the first paragraph of this proposal); (b) to incorporate our understandings about education techniques that have proven most successful in modifying such behaviors (e.g., increasing decision-making skills and resistance to persuasion); and, (c) to ensure that the materials and curricula are acceptable and feasible for schools to adopt and maintain. Equally if not more important, model teacher training procedures that school districts can use to help school faculty understand and teach about AIDS will be developed (incorporating the brief educational materials as well as the more extensive curricula described above). Furthermore, means to disseminate the teacher training procedures and educational materials will be systematically developed. In addition, techniques will be developed to enable school faculty and other youth workers (e.g., Job Corps and recreation staff) to target and provide education about AIDS to school-age youth who are not attending school. Relatedly, the OSHP will work with various national television and radio broadcasters' associations to design and air messages that will encourage young people to seek and comply with informed recommendations to avoid HTLV-III/LAV infection.

Finally, instruments that already are being used to provide data about important student health knowledge, attitudes, and risks will be expanded to address AIDS. New instruments also will be devised to enable schools and colleges to specifically assess the AIDS knowledge and risks of their respective student populations. These instruments can be used by schools to focus their educational programs on priority AIDS knowledge and risks; they can be used to evaluate the outcomes of such programs; and they can be used to assess State and national improvements in student AIDS knowledge and risks over time.

To rapidly develop and disseminate brief education materials, to revise Growing Healthy, to develop a new Teenage Health Teaching Module on AIDS, to expand STD: A Guide for Today's Young Adults, and to revise and develop instruments to measure student knowledge and risks related to AIDS = $1.45 million + 20% indirect = $1.74 million.

3. Increase the Capacity of States to Provide Education About AIDS

A cooperative agreement will be awarded to each State department of education to work with its respective State department of health to increase their collaborative capacity to encourage and enable all schools in the State to provide effective education about AIDS. The OSHP will use its close working relationships with (1) the Society of State Directors of Health, Physical Education, and Recreation (in State departments of education), and (2) the Association of State and Territorial Directors of Health Promotion (in State departments of health) to plan, coordinate, and implement these activities. As part of its cooperative agreement, each State will be asked to systematically delineate the extent to which students in that State were provided education about AIDS from year to year.

54 States and territories @ $60,000 each = $3.24 million + 20% indirect = $3.888 million

4. Increase the Capacity of Colleges and Trade Schools to Provide Education about AIDS for School Teachers, School Administrators, Community Youth Personnel, and College and Trade School Students

A cooperative agreement will be awarded to organizations that represent and influence colleges and trade schools (e.g., American Association of Colleges for Teacher Education, American College Health Association, Association for Supervision and Curriculum Development, Phi Delta Kappa) to help colleges and trade schools immediately provide inservice (i.e., continuing education) training about AIDS for current school faculty and community youth workers; and to provide preservice training about AIDS for future school faculty and community youth workers. These organizations also collaboratively will design and encourage colleges and trade schools to provide education about AIDS for their students.

5 organizations @ $100,000 each = $500,000 + 20% indirect = $600,000

5. Accelerated Response for the Primary Prevention of AIDS in Ten High Risk Cities

Incorporating each of the four activities outlined above, immediate and intensive programs to prevent the spread of HTLVIII/LAV among school-age and college-age populations will be planned and implemented in each of ten high risk cities (as determined by the size of the infected reservoir, the size of the school-age population, the prevalence of intravenous drug use, etc.). OSHP staff will work with relevant public and private health and education agencies in each of these cities to plan and implement these intensive primary prevention programs. These programs will enable the educational institutions in high risk cities to collaboratively focus on those who are not identified as seropositive; and will complement the intensive community-based prevention programs currently being planned and implemented by CDC.

10 cities @ $400,000 = 4 million + 20% indirect = $4.8 million

$5 4.8

6. Core Support to Implement and Manage the Projects Listed Above

A small number of core staff will be required to implement and manage the five component programs listed above. Staff will be required who are trained and experienced: in designing and implementing broad-scale school and community health education programs; in developing and evaluating school and community programs to influence health behaviors of children and adolescents; in disseminating and managing health education interventions in State and local health and education agencies; to Although scientific and technical assistance about AIDS will be sought from CDC staff (rather than being duplicated at CHPE), employment of core staff with the skills suggested above will be critical to enable CDC to help coordinate this initiative among participating national public and private sector agencies;

to direct extramural development and dissemination of educational materials and curricula; to provide assistance and stewardship for developing interventions in the fifty States and in the ten high risk cities; and to monitor and ensure the quality and effectiveness of all activities associated with this initiative.

10 FTE @ $75,000 each = $750,000 + 20% indirect = $900,000

Summary of Resources Required

1. Develop a National Coalition and Leadership	$ 720,000
2. Develop an Disseminate Educational Materials	$ 1,740,000
3. Increase the Capacity of the States to Provide Education	$ 3,888,000
4. Increase the Capacity of Colleges and Universities to Train Teachers	$ 600,000
5. Accelerated Response in Ten High Risk Cities	$ 4,800,000
6. Core Support for the Initiative	$ 900,000
Total	$12,648,000 (including 10 FTE's)

CENTERS FOR DISEASE CONTROL
School Health Education to Prevent AIDS

Projects	1986 Planned	1987 Planned	1987 Amendmt	1988 Request
	(dollars in thousands			
1. Develop a National Coalition and Leadership	-	-	-	-
a. 7 principal association cooperative aggreements	-	-	420	420
b. 10 secondary association cooperative aggreements	-	-	300	300
2. Develop and Disseminate Educational Materials				
a. rapidly develop and disseminate brief educational mater.ala	-	-	960	960
b. revise Growing Healthy to address AIDS	-	-	120	120
c. develop a new Teenage Health on AIDS	-	-	300	300
d. expand STD: A Guide for Today's Young Adults to address AIDS	-	-	120	120
e. develop instruments to measure student AIDS knowledge and risks	-	-	240	240
3. Increase the Capacities of States to Provide Education - 54 States and territories	-	-	3888	3988
4. Increase the Capacity of Colleges and Trade Schools to Train Teachers - 5 cooperative aggreements	-	-	600	600
5. Accelerated Response in Ten High Risk Cities - provide technical assistance to high risks cities	-	-	4800	4800
6. Core Support to Implement and Manage the initiative	-	-	1050	1050
Total	-	-	12798	12798

CENTERS FOR DISEASE CONTROL
School Health Education to Prevent AIDS

Projects	1986 Planned	1987 Planned	1988 Amendmt	1989 Request
1. Develop a National Coalition & Leadership	-	-	720	720
2. Develop & Disseminate Educational Materials	-	-	1740	1740
3. Increase the Capacity of Colleges and Universities to Train Teachers	-	-	3888	3888
4. Increase the Capacity of the States to Provide Education	-	-	600	600
5. Accelerated Response in Ten High Risks Cities	-	-	4800	4800
6. Core Support for the Initiative	-	-	1050	1050
Total		-	12798	12798

Dr. DOWDLE. It was in th[illegible] at year; that's correct. I'm not certain of the exact date [illegible]hen essentially all the discussions took place.

Mr. WEISS. When was that School Health Education Initiative finally issued and how much has been spent on it to date?

Dr. DOWDLE. About $11 million has been set aside for the school initiative in fiscal year 1987. All of that, in one way or another is now planned. RFC's have been written and are in clearance.

Mr. WEISS. So far, none of that has been spent?

Dr. DOWDLE. The intent is to have all of that out by this fiscal year.

Mr. WEISS. That again takes us from May 1986.

The figure we have is $13 million. As you say, that has not been spent yet.

The May 1986 draft of the School Health Education Initiative included the following quotation.

> There's an urgent need to (1) develop and rapidly disseminate relatively brief and high focused information about AIDS to schools that want to provide such information quickly, and (2) to develop curricula for schools that want to assure that their students are more thoroughly informed about AIDS and means to reduce the spread of the virus that causes it.

Here we have what is perceived by the Government to be an urgent need, almost a year ago, and the Federal Government has been unable to get the initiative started.

Do you find that acceptable?

Dr. DOWDLE. Well, I think we have to recognize that groups have been called together to begin discussions as to what constituted a program I mentioned that earlier. Also we have to consider that funds were appropriated in November 1986 and we are now talking about getting the contracts out in the next month or so. That's not as long as it might appear.

Mr. WEISS. The sense that I get is that we are almost at the stage, in regard to information/education, that we were in 1983, in regard to research, even though information/education had been pressed just as urgently since 1983. It really is troublesome, because all of you at the CDC and the Public Health Service have had a recognition of the urgency of the problem, the critical nature of the problem and the need to move forward. Yet there seems to be no driving mechanism to put any of these programs for broad educational outreach and appeal into effect.

My question is, who should be providing that drive? Is there anybody in the Federal Government who is providing that drive?

I assume you all may be frustrated. I'm frustrated More significant than that, we have people who are already infected with the disease. We have people who could be prevented from being infected. We are now talking about hundreds of thousands of cases coming at us. Perhaps almost 2 million people already infected and carrying the virus.

I don't see the organizational effort and the drive within your agencies to intervene, to do anything. It's all plans and it is all suggestions and the plan is followed upon by a plan and nothing ever seems to really happen. Other people are doing some things, yes, indeed, they are. Thank goodness they are.

What do you say about that?

Dr. DOWDLE. Mr. Chairman, I'm very pleased that you raised that point.

Mr. WEISS. Dr. Windom, would you like to respond, sir?

Dr. WINDOM. Thank you, Mr. Chairman. I do think much has been going on. You say it is not evident, but when it comes to the reality of the situation, for months and even the last 2 or 3 years, many have been speaking about the problem of AIDS and trying to educate the public in many forums. We are continuing aggressively to do that. I think the focus on this document possibly has made it look like that is the only way in which we are going to solve the problem. There has been an ongoing public affairs activity within our department and all the agencies have played a part. For several years now, the word has come forth through the scientific community about the disease. Information has been spread through medical centers, medical schools, local forums, and so forth.

I think there has been a very active program. It's just a matter that it is not in the form of one document.

Mr. WEISS. The program may be there. The planning may be there. It sure as heck is not working——

Dr. Dowdle.

Dr. DOWDLE. I'd like to respond, if I may, just to say that I really can't let this go by without responding, considering the number of hours put in by the people who are responsible for getting out the RFP's and developing the education/information program for the schools. It's an exceptional bunch of people, very hardworking, who have spent many, many hours of consultation.

Mr. WEISS. I don't question that at all. And that, I think, is part of the frustration. They meet, they plan, they propose, and ultimately nothing or very insignificant——

Dr. DOWDLE. But it's in the pipeline now. It's in progress. And I think they've done a remarkable job getting it out as soon as they have. There is nothing we can do to speed up that process. The RFP's will be out on the street and it will be bid on.

Mr. WEISS. Well, it seems that one of the things that can be done to speed it up is to recognize the kind of moneys that need to be spent on it. You can't get any of this with just a wish and a prayer. It's going to cost a lot of money, and we have, thankfully, because of the commitment of both Houses of Congress, forced and thrust money upon the administration, which you people have spent well. Each year, except this year, you are forced to come back asking us for less than what we gave you the previous year. Then we find out that the administration is trying to rescind some of that and cut back some of that.

I can see that by 1991 you could be meeting the billion dollar goal that the National Academy of Sciences has set forth as far as research and health programs are concerned. But I don't see how, given the present rate of spending that the Federal Government is going to come anywhere close to the billion dollars for education and information recommended by the National Academy of Sciences.

Unless that kind of commitment is made, then you can have all the good people in the world meeting all the long hours that they're willing to contribute, and ultimately you're not going to have mass education programs. Somebody someplace in the admin-

istration ought to be driving this effort, otherwise all you have is words. The words sound pretty. If you don't remember what was said a year ago, they sound great. But we'll come back a year from now and they will be the same words, and lives will have been lost.

I know that you all are concerned about that. What I'm asking is, how can you get the people who control the purse strings to understand that these programs you're talking about cannot take effect unless money is spent and committed?

Dr WINDOM. Well, we are urging more money. As you know, the President's budget contains a request for 28 percent more than this year for 1988. I think that escalation is evidence of the fact that we do recognize the needs that must be met. I am going to be out more and more speaking about this issue. I want to give you the good news, Mr. Chairman, if I may, that I just got the message that the Secretary has signed the document, and therefore it will be at the printer very soon. I am hopeful that we'll have that printed copy out within 5 to 10 days.

Mr. WEISS. Dr. Harmison, you had wanted to say something. Do you want to add anything?

Dr. HARMISON. Yes. Thank you, sir.

I think as one looks back at it, the capacity for the research on AIDS was laid during more than 10 years of molecular biological work. The same basis has been laid for the AIDS education activity.

Beginning in June 1982, documents issued on how to recognize the disease, long before we knew what the cause was—I'd be pleased to provide for the record material beginning in March 1983 on prevention of acquired immune deficiency—laid the framework for formulating the education message that has gone out through scientific journals and through the efforts of our Public Affairs Office that was headed by Shelly Lengel.

In mid to late 1984, we informed the education effort in a more concise way within the Office of the Assistant Secretary of Health, following the identification of the AIDS etiological agent.

There has been an enormous framework. I certainly can agree with you that more has to be done, and that it should be more timely, but we are very concerned that a solid, sound information base be laid. I think there has been no effort left unaddressed in creating that solid foundation of information, and we hope to reach out through this plan as another step in trying to solidify our education efforts.

Mr. WEISS. Tell me precisely what your title is.

Dr. HARMISON. I'm the Deputy Assistant Secretary for Health.

Mr. WEISS. And what falls within your area of responsibility?

Dr. HARMISON. Well, I assist Dr. Windom in carrying out his responsibilities. My role in this effort has been to take the blood test, when it was initially identified in Dr. Robert Gallo's laboratory, and carry it through various stages of getting it tested and developed.

Mr. WEISS. Well, I would suggest that on public and mass education, you might want to do a little bit more research into what actually has been done. Never mind what the framework was that was accomplished 4 or 5 years ago.

Dr. Dowdle, I assume that you attempt to keep apprised of what other countries, especially England and Western Europe, are doing in the AIDS information/education area.

Would you give us some idea of the programs undertaken in England and France and what you understand to be the cost of those campaigns?

Dr. DOWDLE. Well, perhaps the most aggressive campaigns in Europe are in Great Britain, and they have set aside $20 million for that purpose. Their program has consisted of mailings to all households, as well as radio spots, television advertising, and even special television programs for the youth.

Denmark has had a similar type of program, with increased emphasis on television.

Switzerland and the Netherlands have done much the same thing.

Mr. WEISS. Why do you think it is that those foreign countries, all of which have far fewer cases of AIDS than we do, have spent so much more per case or per capita and are so much ahead of the United States in information efforts?

Dr. DOWDLE. I really can't answer that, except I think that when we've asked them this, before, "how can you get out the information messages so quickly?" We have received several answers. For example, Denmark feels that they are much more of a homogeneous group in terms of thinking. Therefore, it's easier to get out these types of campaigns. In this country, we're a much more diverse group, and there are many, many different ideas and many different backgrounds that have to be taken into consideration.

Mr. WEISS. In fact, you've been urging within the Department that we undertake exactly that kind of campaign that has been undertaken in Europe or England; isn't that correct?

Dr. DOWDLE. Yes, sir. It's something we should be considering. And, as Dr. [illegible]m pointed out, we will be.

Mr. WEISS. [illegible]ast June, the Public Health Service held a major planning conference at Coolfont, after which a new Public Health Service plan for prevention and control of AIDS and the AIDS virus was issued. Two of the recommendations issued on information and education were: (1) the need for a major national information/education campaign, and (2) to explore the use of paid media advertising.

Was the Coolfont conference recommendations the basis for drafting the AIDS information/education plan that you just said Dr. Bowen has signed off on?

Dr. WINDOM. Yes, sir.

Mr. WEISS. What other implementation activities were begun as a result of that Coolfont meeting and report? Dr. Dowdle?

Dr. DOWDLE. Well, I think that basically the Coolfont report put in perspective what the predicted caseload would be in 1990 and 1991. It also pointed out that those at risk sexually in the heterosexual population should also be targeted for information/education programs.

Mr. WEISS. I have a few questions about some of the specific ongoing items reflected in the post-Coolfont plans.

One, information and education program grants for high-AIDS-incidence areas. How much was budgeted, and how much was actually spent in fiscal year 1986; do you know?

Dr. DOWDLE. In 1986?

Mr. WEISS. In 1986, yes.

Dr. DOWDLE. We would have to submit that for the—are you talking about total?

Mr. WEISS. Well, your budget person, I think, is here. Maybe he can respond.

Mr. LITTLE. I'm not sure I have the exact amount for CDC in 1986.

Mr. WEISS. Pardon?

Mr. LITTLE. In total, we will spend $26.9 million in 1986. I'm not sure exactly how much of that went to CDC's high-incidence areas. In total, the Public Health Service will spend over $32 million in information and education activities.

I can supply that—or CDC can supply that for the record.

Mr. WEISS. Will you please supply that for the record?

Mr. LITTLE. Yes, sir.

[The information follows:]

In FY 1986, approximately $17.9 million was awarded to high incidence areas.

Mr. WEISS. How about in 1987 so far? Do you know how much has been budgeted and how much spent in fiscal 1987 up to this date?

Mr. LITTLE. For 1987, $80 million has been budgeted.

Mr. WEISS. For high-AIDS-incidence areas is the question.

Mr. LITTLE. I'm sorry. This is for the total information, health education, risk reduction budget. I do not have the answer for high-incidence areas.

Mr. WEISS. Thank you.

Dr. DOWDLE. We can give that to you, sir, the breakdown by State and by location.

Mr. WEISS. I would welcome that.

Dr. DOWDLE. We can provide that.

[The information follows:]

AIDS Prevention projects were awarded on April 30, 1987, for a total of approximately $24.4 million, of which $14.3 million went to high incidence areas. The breakdown for high incidence areas by project area is as follows:

Area of High AIDS Incidence	FY 1987 Funds Awarded
California (Includes separate award to Los Angeles and San Francisco)	$ 2,607,184
Colorado	744,375
Connecticut	480,262
Florida	1,425,213
Georgia	489,915
Louisiana	569,484
Massachusetts	648,206
Michigan	575,321
New Jersey	969,931
New York State (Includes separate award to N.Y. City)	2,654,664
Ohio	607,284
Pennsylvania	716,342
Texas	978,291
Washington	492,978
Washington, D.C.	371,221
TOTAL FY 1987 Funds High Incidence Areas	14,330,671

Dr. DOWDLE. I might also say that the new funding for all locations in the States will actually not come out until May. The States are still operating on the previous allocations.

Mr. WEISS. The U.S. Conference of Mayors, to aid community-based groups, was funded at $250,000 in 1986. How much has been budgeted and spent on this in fiscal year 1987?

Dr. WINDOM. I can't give that to you at the moment, sir. I will have to try to supply that for the record.

[The information follows:]

Approximately $250,000 is budgeted for FY 1987, and is expected to be awarded on June 1, 1987.

Mr. WEISS. Our information is that, in fact, there has been zero spent in fiscal 1987 for the U.S. Conference of Mayors' eight community-based groups program.

Dr. WINDOM. That we would have to check, sir.

Mr. WEISS. All right.

Dr. DOWDLE. It is budgeted, sir, for 1987 and 1988.

Mr. WEISS. How much was budgeted for 1987?

Dr. DOWDLE. $300,000.

Mr. WEISS. Can you tell us how much of that has been spent in fiscal 1987?

Dr. DOWDLE. No; I really can't speak to that; no.

Mr. WEISS. You will supply that for the record.

[The information follows:]

Approximately $250,000 is budgeted for FY 1987, and is expected to be awarded on June 1, 1987.

Mr. WEISS. And now I would like to ask about the community-based capacity project in 37 low incidence States. How much of the budgeted $5 million was actually spent in fiscal year 1986? Does Budget have that? Do you have that breakdown?

Dr. WINDOM. We don't have that breakdown, sir.

Mr. WEISS. Will you give that information as well as how much has been spent so far in the first 5 months of the current fiscal year?

Dr. WINDOM. Yes, sir.

[The information follows:]

In FY 1986, $4,580,744 was spent on Community-based capacity building projects. In FY 1987, the funds for these projects were consolidated with the funds for the Augmentation projects and the Counseling and Testing projects, and were awarded on April 30, for a total of approximately $24.4 million.

Mr. WEISS. The AIDS prevention augmentation projects were funded at $5 million for fiscal year 1986. Can you tell us how much was actually spent in fiscal year 1986 and so far in 1987? Again, if you don't have that, please submit it for the record.

Dr. WINDOM. We will submit that, sir.

[The information follows:]

In FY 1986, $6,611,095 was spent on the AIDS Augmentation projects. In FY 1987, the funds for these projects were consolidated with the funds for the Capacity building projects and the Counseling and Testing projects, and were awarded on April 30, for a total of approximately $24.4 million.

Mr. WEISS. Finally, the community-based demonstration projects were funded at $4 million in fiscal year 1986. How much was actually spent in 1986 and how much was spent in 1987?

Dr. WINDOM. That again will have to be submitted for the record, sir.

Mr. WEISS. I am distressed that we don't have that information available since these are your major information education programs that are currently ongoing. I would think that somebody would have that information.

Dr. WINDOM. We do have it. We want to give it to you exactly, sir, and we just don't have it right at our fingertips.

[The information follows:]

In FY 1986, $3,732,152 was spent on the AIDS Community based Demonstration projects. In FY 1987, no funds have been obligated to date. The projects are expected to be renewed no later than September 29, 1987, for an estimated $4,006,098.

Mr. WEISS. All right. I am going to ask you a summary question. Excluding funds for testing for other risk reduction projects, how much was appropriated and how much was actually spent by the Federal Government in all of fiscal year 1986 for AIDS information dissemination and education?

Dr. DOWDLE. For 1986?

Mr. LITTLE. Excluding testing, but including the health education, risk reduction activities?

Mr. WEISS. Right. Would you come closer to the microphone so that we can hear you?

Mr. LITTLE. $26.9 million, excluding——

Mr. WEISS. Say that again.

Mr. LITTLE. Excluding the alternate test site activity that occurred in 1986, the total in 1986 was $26.9 million, including the health education and risk reduction activities in the State health departments.

Mr. WEISS. For this year, Dr. Windom, you stated in your testimony that the Public Health Service will spend more than $79.5 million solely for education. Is that correct?

Dr. WINDOM. Yes, sir.

Mr. WEISS. Again, that is solely for education, not for the risk reduction programs or the testing programs; is that right?

Dr. WINDOM. That includes risk reduction which is part of the education packet, the program is education and risk reduction and dissemination of information. That would be $79.5 million.

Mr. WEISS. How much is it just for education and information?

Mr. LITTLE. Approximately $15 million, sir.

Mr. WEISS. Approximately?

Mr. LITTLE. $15 million.

Mr. WEISS. Do you have any idea how much has actually been spent so far within the first 6 months of fiscal year 1987?

Mr. LITTLE. Sir, since the appropriation was only enacted in November and many of these programs are new, the $80 million total for 1987 compares to approximately $30 million in 1986. The RFP's we discussed earlier have not all been finalized, and much of the money has not been awarded. I would estimate that the awards to date would be very small, but that is due in large part to the fact that we had such a large increase in 1987 compared to 1986.

I can give you the exact numbers for the record.

Mr. WEISS. I would appreciate that.

[The information follows:]

Acquired Immune Deficiency Syndrome Information Dissemination/Public Affairs

[Total 1987 obligations as of Mar 31, 1987]

CDC	$475,000
NIH	360,000
ADAMHA	236,000
Total PHS	1,071,000

Mr. WEISS. For fiscal year 1988, which as you all know, begins October 1 of this year, and again, exclusive of moneys for testing and other prevention activities, how much has been requested by the Department just on information education?

Dr. WINDOM. $15,900,000.

Mr. WEISS. That will include the total major media campaign that you just issued the request for proposal on; is that correct?

Dr. WINDOM. Yes, sir.

Mr. WEISS. Dr. Dowdle, last summer you said, and I quote, and I hope accurately, "It's very clear we haven't done everything in the education field that we would like to do and should be doing" and "The money is not here for a large educational program right now."

As the Federal leader on AIDS, can you tell us what is needed by way of dollars? What should we be looking for, for an education program that in fact would do the job?

Dr. DOWDLE. I don't know that I could give an exact figure, sir. Quite frankly, there are a number of different opinions and a number of different ideas. I'm sure a number of different experts have different ideas on how the information education program ought to be run at a national level.

One of the reasons for getting the ad agency involved is to get experts together with other consultants to determine the most effective way that we can run this campaign, what is the most effective way not only to get information out—which, by the way, is considerable at the moment—but to have it out in such a way that we can effectively change behavior.

Mr. WEISS. Late last year, you contracted to have a management consultant firm, Coopers & Lybrand, review CDC's organization and management of AIDS activities. Why was that undertaken at that time?

Dr. DOWDLE. Why, sir?

Mr. WEISS. Yes.

Dr. DOWDLE. Because the feeling was that CDC's earlier role had been in epidemiology and in laboratory research, leading to prevention, but that now, we were going to be involved in a much different and much more extensive way in information and education programs. In short, this was a different mode than what CDC had been involved in up to now. That was the reason for the review.

Mr. WEISS. I have the memorandum concerning their findings and recommendations. I will ask you to tell us what the findings were rather than my quoting them.

Dr. DOWDLE. Well, basically, they recommended that there be a central office for AIDS within CDC, under a Deputy Director of CDC, and that that office should have line responsibility. I was appointed to that particular job. Second, they pointed out that there should be consolidation of CDC contracts with the States. That con-

solidation is well underway. They were talking about consolidating three grants, and consolidation of at least two of the three grants is in process.

They also referred to different ways in which the organization within CDC should lead to enhanced communication. That too is now in effect through the organizational arrangement that we now have.

One of the other points was to emphasize the need for CDC to go out into further types of information education responsibilities.

Mr. WEISS. The findings that we have indicate the following: First, that AIDS has placed a severe strain on CDC, and second, that major changes should be given serious consideration.

Dr. DOWDLE. Yes.

Mr. WEISS. Major State and local discontent with CDC regarding grant programs and management exists.

Dr. DOWDLE. That's correct.

Mr. WEISS. Third, that the traditional CDC response to crisis has apparently not worked well and places great strains on the agency personnel. They say that the single greatest scarcity is personnel. The number of people allocated to CDC to perform the new duties expected of it clearly does not allow the agency to fulfill its new responsibilities.

Dr. DOWDLE. That's correct.

Mr. WEISS. Finally, AIDS has consumed considerably more time, not only of people assigned to AIDS, but of others; right? Then they made a number of recommendations based on that. One was to request needed personnel; two, to contract out some activities; three, to simplify grant and cooperative agreement processes and miscellaneous others.

Dr. Dowdle, last December 1, you expressed again the need to mobilize the non-Federal sector into the AIDS information effort. Before I get into that, what has been done to follow up on the findings and recommendations besides, I guess, your work and your coordinating role which is an important step? Beyond that what has been done to get additional personnel and so on?

Dr. DOWDLE. Well, as I've indicated, all of the recommendations with one exception—that we look at other ways of contracting out in-house activities have been implemented. The one reason why we have not gone further in contracting out is because we think we have explored this quite thoroughly. All of the recommendations of the Coopers & Lybrand group essentially are in place.

Mr. WEISS. Have you requested additional personnel?

Dr. DOWDLE. Additional personnel?

Mr. WEISS. Yes.

Dr. DOWDLE. Yes. We are getting additional personnel for the Office of the Deputy Director; yes.

Mr. WEISS. Is that the only area where the consultants thought you needed personnel?

Dr. DOWDLE. No. There are other areas, too, in which additional FTE's were thought to be needed.

Mr. WEISS. Have you made the request for those?

Dr. DOWDLE. Yes, sir, we have.

Mr. WEISS. To whom?

Dr. DOWDLE. The requests have been made in the usual funding cycle.

Mr. WEISS. Have those requests been made to the Appropriations Committee?

Dr. DOWDLE. They are part of the 1988 request.

Mr. WEISS. On the non-Federal sector mobilization in the AIDS information effort, you proposed a meeting in January or February of private sector organizations which are already involved in AIDS activities. What was the purpose of the meeting?

Dr. DOWDLE. This was a private sector——

Mr. WEISS. Again, according to December 1, 1986, minutes of the task force, Dr. Dowdle proposed convening a meeting in January or February of private sector organizations who are already involved in AIDS activities.

Dr. DOWDLE. Yes.

Mr. WEISS. What was the purpose?

Dr. DOWDLE. The purpose of this was to try to encourage the formation of a coalition of private and public organizations, which we are very much interested in supporting.

Mr. WEISS. Was that meeting held?

Dr. DOWDLE. There have been several meetings, and we believe we will have such a coalition this summer.

Mr. WEISS. It is not going to be January or February, it is going to be sometime around June, July, or August?

Dr. DOWDLE. I can assure you that it is in progress and we are certain that it will be done.

Mr. WEISS. Dr. Windom, in your testimony you state that Federal funds appropriated for AIDS will be multiplied manyfold by other public and private agencies. The National Academy of Sciences' report stated that the leadership and major portion of the funding for AIDS education must come from the Federal Government.

Are those views compatible? Can we depend on the States to have the expertise and the funds to do the job that is needed?

Dr. WINDOM. We feel they will be able to complement and help supplement the Federal funds and, as we progress from year to year, we anticipate they also will participate more

Mr. WEISS. What proportion of the education and information funds—say that $1 billion that you think might very well be reachable by the target date—will have to come from Federal sources and what proportion from other sources?

Dr. WINDOM. There is a great deal of speculation about that ratio, sir. I think if we look now to see what is going on out there in the public as far as dissemination of information, there has been a substantial but indefinite increase. I think the recent survey in the Washington Post showed significant evidence in 6 months of public awareness, lifestyle changes and so forth. The information is getting out, but I don't know that we can pinpoint the exact percent or dollar increases there are.

Mr. WEISS. You do agree with the NAS that the major portion of that funding for AIDS education will have to come from the Federal Government?

Dr. WINDOM. Yes, I think it will and we are working toward that, sir.

Mr. WEISS. The budget information supplied to us last week includes an indication that OMB has approved and has or will request $100 million additional supplemental for AIDS to be transferred from other HHS accounts.

What accounts will it be transferred from and for what AIDS purposes?

Dr WINDOM. That has not been decided yet. We will look closely at which agencies could contribute and how much could be obtained from each. No definitive action has yet been taken.

Mr. WEISS. It is under discussion between you and OMB?

Dr. WINDOM. I'll have Mr. Little please comment on that.

Mr. LITTLE. The 1987 portion of the President's 1988 budget proposed that authority be provided to the Secretary to permit him to transfer up to 1 percent of any funds appropriated to the Department for discretionary programs from such programs to the AIDS efforts.

At this point there has been no discussion of such a transfer to AIDS being necessary. And we, of course, would have to have the approval of the Congressional Appropriations Committees before we could implement such a proposal.

Mr. WEISS. Well, did you request that authority from OMB to begin with? How did it come about? How did that $100 million supplemental discussion start?

Mr. LITTLE. It came back as a part of the OMB allowance. It was not requested, to my knowledge, by the Department. I believe it reflects the President's and the Secretary's position that AIDS is the No. 1 public health priority, and as such it warrants special attention. We want to give the Secretary as much flexibility as possible to respond to any emergency or unique opportunity by a shifting of funds to AIDS.

Mr. WEISS. I have no further questions at this time. If any of you want to make additional comments before we close out this panel, please feel free to make them at this time.

Let me just state that, we know that you have a very, very difficult, but also, a very, very heavy and important responsibility.

What you do, Dr. Windom, and what your associates, Dr. Dowdle, Dr. Noble and the others in the Public Health Service do, can and will determine whether literally hundreds of thousands, perhaps millions of Americans will or will not fall to this dread epidemic.

So, I hope that in the course of the inhouse bureaucratic discussions that will be ongoing, that you will take with you the assurance that Congress has been and will continue to be supportive of your efforts. But you have to provide the thrust and the lead. It's your ball game, really. And that is the purpose of these hearings that we're holding: to try to get a continuing update as to where we are in various aspects of the struggle against AIDS, and to what we need to do, we on our side, you on your side. If nothing else, I hope you walk away from these hearings with a sense that we're really concerned about the sense of urgency which has to be injected into this fight.

Dr. WINDOM. I want to thank you, Mr. Chairman, again, for the opportunity to be here and to express our views and to hear yours and those of others in Congress. We realize the magnitude of this problem. And I'd like to point out that we're very thankful that

this happened now rather than 10 or 20 years ago, because we have been able to move more rapidly than ever before. We have a great challenge ahead of us. It's going to take the cooperation and involvement of every sector, and we're going to work hard to lead that movement and continue to be actively involved.

Mr. WEISS. Anybody else?

[No response.]

Mr. WEISS. Thank you all very, very much for your participation.

Dr. WINDOM. Thank you.

Mr. WEISS. I assume we'll be getting a copy of the plan just signed off by Dr. Bowen——

Dr. WINDOM. Yes, sir.

Mr. WEISS [continuing]. In time for inclusion in this record. Thank you.

[The AIDS information/education plan is in the appendix, p. 255.]

Mr. WEISS. This brings us to our third panel consisting of witnesses from agencies which are directly involved in providing essential services to persons with AIDS, and the information/education needs at the State and local level.

And, so, if Ms. Gebbie, Dr. Joseph, and Ms. Stroud will come forward, I think we can proceed with this panel. Would you please remain standing and raise your right hand?

Do you affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

Let the record indicate that all three of the witnesses responded in the affirmative.

Dr. Joseph, I understand that you have a difficult transportation schedule, and so we will hear from you first. If you have time to stay for your part of the questions before we hear from Ms. Stroud and Ms. Gebbie, that will be all right. If you have to rush off we will understand, and we'll submit questions to you and have you respond in writing.

Dr. JOSEPH. Thank you very much.

Mr. WEISS. We have your prepared statements which will be entered into the record in their entirety, and we would appreciate your limiting your oral presentations to about 7 minutes, if possible.

Dr. Joseph, We'll start with you.

STATEMENT OF STEPHEN C. JOSEPH, M.D., M.P.H., COMMISSIONER OF HEALTH, NEW YORK CITY HEALTH DEPARTMENT

Dr. JOSEPH. Thank you very much, Mr. Chairman, thank you for your courtesy. I appreciate the opportunity to be here today to talk about the AIDS epidemic as it appears on the line in New York City. Although I must say, some of the things I've heard in the last several hours make me wonder at times whether we're talking about the same epidemic.

But a view from New York City with particular reference to our education and health promotion activities really must start from the fact that we have seen, as of the end of February 1987, approximately 9,200 diagnosed cases of AIDS in the city, 58 percent of those people are dead, and AIDS is currently the leading cause of

death in New York City for men age 25 to 44, and for women age 25 to 29.

Half a million New Yorkers are estimated to be infected with the HIV virus. Gay and bisexual men make up the largest percentage of cases, although their proportion of AIDS cases has fallen from 73 percent in 1981 to 55 percent in 1986, while the proportion of cases among intravenous drug abusers or IVDA's has risen from 22 percent to 36 percent in 1986.

We have some 200,000 people in New York City who shoot IV drugs, and from 50 to 60 percent of them are thought to be HIV virus infected. The growing numbers of IV drug abusers who are infected present unique problems in controlling the spread of the disease. And had I time, I would refer you to one of the charts that I gave you in my prepared testimony that I think indicate the magnitude of the problem and the multiple complexities of the problem.

IVDA's have been and will likely continue to be the major source of the spread of infection to women and children. We've had 932 women with AIDS in New York City diagnosed since 1981; 80 percent of these women have been intravenous drug users or the partners of IVDA's. We have 178 of those, some 400 cases of AIDS in children that were described in the last panel, and the vast majority of those children have been infected from their mothers; 92 percent of the mothers who infected those children were either IV drug abusers or the sex partners of IV drug abusers.

Of great concern is the increase of AIDS and HIV infection among New York City's minority communities. More than half of all AIDS victims in New York City are black or Hispanic; 86 percent of male IV drug users with AIDS are black or Hispanic; and 91 percent of mothers of children with AIDS are black or Hispanic.

You perhaps have seen our projections, that by the end of 1991 we will accumulate something like 40,000 cases of AIDS with perhaps 30,000 deaths. I think one of the things that needs repeating, when we talk about health promotion and risk reduction, is that no one knows what the cumulative burden will be more than 5 or 6 years out in the epidemic; we do not know what the 10- or 20-year clinical horizon is.

Well, against this background, and as the epidemic spreads in New York City, let me mention a number of public policy and public health policy issues that are emerging and seem to us to be critical.

First, intensive and explicit public education efforts need to be implemented without creating irrational anxiety and hysteria. Presently, the only feasible way to alter the AIDS epidemic is by education of the public, training health and social service professionals, and counseling for personal risk reduction and antibody testing.

In my written testimony I've listed the various groups ranging from the sanitation workers to policemen and parole officers that we have been working with, and the general education programs and specialized training programs throughout the city. I have also submitted for the committee's interest a packet of the various brochures, flyers, and wallet cards that we've produced in recent months and years, and our subway cards. The poster that you have

which is entitled, "Women Can Get AIDS, Too," has just gone up within the last month. It will be viewed by an estimated 5 million subway riders, something like 120 million times.

We've been working with two advertising agencies for a multimedia public health advertising campaign that will run this spring. This will focus on the two issues of IV drug use and heterosexual transmission risks. And I would just like to accentuate what you and Dr. Fraser said about the importance, the critical importance of getting moving with mass media activities.

Another one of our major health education and promotion activities is a campaign to promote condom use, educate about condom use, and distribute condoms. We have a midyear funding initiative which will allow us to distribute 1 million condoms in New York City this year as part of a broader based educational campaign.

We're increasing our outreach and education to higher risk populations. I go back to my comments about the intravenous drug abusers. This is a group of people where we do not have the cohesive base that I think was found in the gay community, particularly in San Francisco and New York, that has led to such success as we have had so far in behavior modification. I think there's a long way to go before we're able, with confidence, to have in place risk reduction strategies that we know will work with the IV drug abuser.

I've listed in my prepared testimony some of the activities that we have, working on the street, working with community-based organizations that are actually in the shooting galleries. And you may note that we are proposing in New York City a small, carefully controlled experiment to distribute clean needles and syringes as part of the risk reduction effort.

We believe that much more work needs to be done with physicians, through our hotline activities and directly. I've distributed for you our new counseling and testing policy in which we state that there needs to be much more access to information and activity by private physicians.

The second critical public health policy issue is that vigorous public health actions need to be increased while resisting ineffective measures of social control. There has been much discussion recently, as I'm sure you are well aware, of the issue of keeping testing in a voluntary, confidential, and counseling-based mode. We've been moving aggressively in New York City to make testing in this context more widely available.

In addition to the physician-based testing of the past, we have now opened two anonymous test sites run by the city. The State has also opened five anonymous test sites in New York City. We are offering counseling and testing in half of our sexually transmitted disease clinics. We'll increase that to 100 percent in the next fiscal year. We also are permitting teaching hospitals to be sites for performing the laboratory tests.

We are now recommending that physicians should actively consider if their patients may be at risk of HIV infection, discuss risk avoiding behavior as a part of routine medical care of all patients, and offer counseling, and if appropriate, HIV testing to patients considered to be at risk.

We have begun a program that we call, "Contact notification," rather than the old term of, "Contact tracing." We believe that it's critical for infected persons to notify their sex and drug partners of the risk. And where an index person requests us either to help in this process or to undertake the process for him or her, we will directly and actively do so.

The third critical public health policy issue is that increases and available resources for research and education must support the broad range of clinical public health and social service needs.

I commend you, Mr. Chairman, for your bill to waive the 24-month waiting period for Medicare eligibility. All across the service front, whether in the development of community-based organizations or in making more help available for the homeless, we need vastly increased resources.

In fiscal 1987, New York City will spend approximately $258 million on programs in AIDS treatment, human services, public health initiatives, and human rights discrimination; $73 million of those dollars are city tax levy. Next year we will spend $335 million, and I would anticipate a good deal more than that, of which some $90 million or more will be city tax levy. These kinds of numbers underscore what I find very discouraging: The reluctance and slowness with which the Federal administration has recognized the true dimensions of the AIDS crisis, and their slowness in moving to support us adequately with resources and leadership in that area.

We have had the forthright statements of Dr. Koop and echoed elsewhere in the administration. We have the CDC shouting alarm. But no one really has been willing to send us a fire bucket.

I would associate myself entirely with the comments made by Dr. Fraser, and we'll skip the part of my testimony related to the National Academy of Sciences' report.

Let me just end by mentioning some things that I think increased Federal support could translate into, in terms of specific measures for controlling the spread of AIDS in New York City. It would provide us with funding to enable us to rapidly increase confidential, voluntary counseling and testing. I would anticipate that we will see the demands for counseling and testing multiply many-fold within the next 12 months.

We desperately need increased funding to provide access to substance abuse treatment programs for IV addicts; waiting time for methadone maintenance in New York City is estimated to be as long as 3 months, and 6 months to get into drug free programs. We've got to have more help both from the Federal and State level to increase our access to the addict community.

We continue to need funding for increased efforts to expand the knowledge base, both directly in New York City and nationally. In my testimony you will see a description of the research activities that we are currently carrying on.

There needs to be, as I think everyone has said this morning, a massive increase in public health education and risk reduction efforts; much of that leadership must emanate from the Federal Government. One thing that made my life easier over the last 12 months, and there haven't been many things, was the NAS Committee report. If we could have that kind of clear thinking, direct and explicit leadership, as I think Dr. Koop has attempted to give

us, if we could continue to see that from a Federal level, it would enable us at a local level to do much more, to gain more credibility, to garner both the resources and the support that we need.

And finally, we need Federal support to really underscore that we must eliminate the false dichotomy between civil liberties and public health. Stands on issues such as contact tracing and mandatory antibody testing have at times been portrayed as sacrificing public health in the name of civil liberties. But I believe that all the localities that are of high prevalence really are combining in their insistence on voluntary, confidential testing, and the other voluntary measures, which are based on sound public health principles, as well as a concern for civil rights and civil liberties.

I think we need leadership from the Federal level to get the message across that this is not an either/or affair. The kinds of damage done by the ill-considered Justice Department opinion on discrimination last summer created enormous problems for us in New York, and I think throughout the Nation.

Finally, the AIDS epidemic and our understanding of it is growing and changing constantly. Responsible policy must be continually reexamined against these changes in conditions; and it must be modified, if necessary, to reflect current knowledge of disease transmission, and at the same time remain flexible enough to accommodate important discoveries.

There are few, if any, certainties in this crisis, and we must be willing to change course as the data warrant it.

Biomedical research cannot eliminate the problem of AIDS in the short run; education, health promotion, and risk reduction will remain our critical weapons in the fight against AIDS for at least the next several years.

I do apologize, thinking I had an earlier morning testimony. I have a meeting with the board of health and the mayor on AIDS, as a matter of fact, at 3:30. But I'd be pleased to answer any direct questions you have, and certainly happy to respond to any written questions that the staff or anyone else on the committee wishes to send us.

Thank you.

[The prepared statement of Dr. Joseph follows:]

TESTIMONY OF

STEPHEN C. JOSEPH, M.D., M.P.H.

COMMISSIONER OF HEALTH

NEW YORK CITY

presented to the

U.S. HOUSE OF REPRESENTATIVES
GOVERNMENT OPERATIONS SUBCOMMITTEE ON HUMAN RESOURCES
AND INTERGOVERNMENTAL RELATIONS

HEARING ON AIDS EDUCATION

MARCH 16, 1987

WASHINGTON, D.C.

Nowhere in North America is the relentless tragedy of AIDS more starkly felt than in New York City. As of the end of February 1987, 9,188 people have been diagnosed with AIDS in New York City since 1981; 58 percent have died. AIDS is the leading cause of death in New York City for men 25 to 44 years of age, and women 25 to 29.

Half a million people are estimated to be HIV-infected in New York City today. Gay and bisexual men make up the largest percentage of cases, though their proportion of AIDS cases has fallen from 73 percent in 1981 to 55 percent in 1986, while the proportion of cases among intravenous drug abusers (IVDAs) has risen from 22 percent in 1981 to 36 percent in 1986. Fifty to 60 percent of the City's estimated 200,000 heroin users are thought to be HIV-infected. The growing numbers of infected IV drug abusers present unique problems in controlling the spread of the disease (Chart I).

IVDAs have been, and will likely continue to be, the major source of the spread of HIV infection to women and children in New York City. Of the 932 women with AIDS diagnosed in New York City since 1981, 80 percent have been IVDAs or the sex partners of IVDAs. We have seen 178 cases of AIDS in children, the vast majority infected from their mothers; 92 percent of mothers who infected their children were IVDAs or the sex partners of IVDAs (Chart II).

AIDS is also increasing among New York City's minority communities. Thirty-one percent of AIDS cases in New York City are among Blacks, and 23 percent are among Hispanics;

together, Blacks and Hispanics represent more than half of all people with AIDS in New York City. Eighty-six percent of male IV drug users with AIDS are Black or Hispanic; 91 percent of mothers of children who have AIDS are Black or Hispanic.

By the end of 1991, over 40,000 people will have developed AIDS in New York City alone; 30,000 will have died (Chart III). Our projections are based on a five-year horizon; no one knows the 10- or 20-year clinical outlook for those now infected. Nor do we know what long-term burdens will be posed by HIV-associated illness, for example, tuberculosis. The impact of HIV-immunodeficiency on the trends of other important diseases is under study and as yet is incompletely understood.

Against this background, and as the epidemic spreads in New York City, a number of public health policy issues are emerging as critical.

First, intensive and explicit public education efforts need to be implemented without creating irrational anxiety and hysteria. Presently, the only feasible way to alter the AIDS epidemic is by educating the public, training health and social service professionals, and counseling for personal risk reduction and antibody testing. The New York City Department of Health program for AIDS education and counseling is a multifaceted prevention and risk reduction effort that on the one hand directs education at the general public, health providers, social service personnel, and community organizations, and on the other hand targets information and outreach for people engaged in high-risk behavior.

Our campaign to educate the general population about AIDS includes information in a variety of formats, such as brochures, flyers, videotapes, wallet cards, and posters in English and Spanish. The first in a series of bilingual posters for City subway cars appeared in early 1986. The second poster, entitled "Women Can Get AIDS Too," has just gone up. The posters will appear in subway cars for approximately three months, during which time they will be viewed an estimated 120 million times by some five million subway riders. We have also been working with two advertising agencies for a multimedia public health advertising campaign that will run in the spring, hitting the issues of IV drug use and AIDS, and heterosexual transmission risks.

The Health Department has launched an educational campaign, on which we will spend $1 million this year, to promote latex condom use. This includes distributing a million condoms next year, with educational material, through clinics and education and counseling programs, pregnancy testing sites, and other places where we find people who need to change their behavior.

For community and professional groups, the Department provides specialized training programs to help people incorporate AIDS information into their community and work lives. Professional groups that Health Department educators have trained include Board of Education personnel; Sanitation workers; health care and social service workers; drug treatment professionals; and police, probation, and corrections officers. Our public health educators reach over

3,000 people per month; they receive more than 20 requests for educational sessions per week, per educator.

To provide the medical community in New York City accurate, current information about clinical research and disease surveillance, the Health Department holds monthly AIDS Clinical Investigators Meetings. An AIDS Forum is held every month for city officials, representatives of voluntary organizations, and others concerned about AIDS.

We are increasing our outreach and education to high-risk populations. Special efforts address IV drug users and their sexual partners. Public health educators are assigned to local areas with the highest incidence of IV drug use to raise community awareness of AIDS prevention. To educate IV drug addicts on the need to use clean drug injection equipment, or "works," Health Department brochures, including one entitled, AIDS and Drugs, caution that "the best protection is no injection," and describe methods of cleaning "works." Videotapes and posters as well as training for drug counselors and social service workers target people at risk because of drug use. The Department cooperates with many city-wide and local organizations, including supporting the community group ADAPT (Association for Drug Abuse Prevention and Treatment), to reach those at risk through IV drug abuse. The Department is working with ADAPT on AIDS outreach projects such as doing AIDS prevention and education programs in high risk areas, even within shooting galleries themselves.

The January 1987 Financial Plan for New York City includes additional City funds for contracts with

community-based agencies for further AIDS educational programs directed at minorities, homosexuals, and IV drug abusers.

For members of high-risk groups as well as the general and professional public, the Health Department AIDS Information Hotline gives anonymous and confidential counseling and information about AIDS and risk behavior, as well as referrals for persons wishing antibody testing. Last month the number of lines increased from four to seven, with four lines to handle physicians' questions. Increases in the public health education campaign on subways and in the mass media, in the numbers of physicians involved in testing and counseling, in the counseling and testing sites, and in the number of people who are becoming aware of their risk, all point to a continuing increase in the demand for the Hotline. We need to expand Hotline days and hours to improve access to this most important source of anonymous, confidential information and counseling for people who are at risk, as well as who are at the point where prevention against infection is still possible.

The second critical public health policy issue is that vigorous public health actions need to be increased while resisting ineffective measures of social control. Virtually all public health officials from areas of highest AIDS prevalence agree that mandatory HIV-antibody testing when no treatment is available, and unless confidentiality can be assured, would be unwise and counterproductive. HIV-infected people -- already facing devastating discrimination in housing, employment, and insurance -- would not cooperate with our counseling, education, and testing if they feared that society

was considering measures that could lead to quarantine, isolation, and additional forms of discrimination.

New York City is moving aggressively to make voluntary, confidential counseling and testing much more widely accessible. We have just published a policy regarding the increased availability of voluntary, confidential HIV antibody testing and counseling. The policy contains guidelines for health professionals on preventing and treating HIV infection, as well as education of those at risk.

In New York City, our policy is that anyone who wishes to know his or her antibody status should have access to this information, provided the test results are confidential, tests are voluntarily undergone, and counseling is available before and after testing. We recommend that physicians should actively consider if their patients may be at risk of HIV infection, discuss risk-avoiding behavior as a part of routine medical care of all patients, and offer counseling and, if appropriate, HIV testing to patients considered to be at risk.

Testing in New York City is available through free, anonymous test sites established in the City by the City and State Health Departments; through any licensed physician in New York City, using a laboratory with a special permit issued by the New York City Health Department if counseling, consent, and confidentiality are guaranteed by the lab; and at five of our Sexually Transmitted Disease clinics in New York City.

To support the confidential, voluntary aspects of counseling and testing, we have adopted a course of action known as contact notification. With this approach, the Health

Department is urging, and directly and actively assisting when asked, people who are seropositive to notify their contacts.

The third critical public health policy issue is that increases in available resources for research and education must support the broad range of clinical, public health, and social service needs. In Fiscal 1987, New York City will spend approximately $258 million on programs in AIDS treatment, human services, public health initiatives, and human rights discrimination. The City share of this figure is $73 million in tax levy dollars. Next year, we will spend $335 million, of which $90 million is City tax levy dollars.

The federal administration has been very reluctant to recognize the true dimensions of and propose an adequately funded federal response to AIDS. It must do much more to support the unprecedented demands for AIDS treatment, human services, public health initiatives, and human rights discrimination resources, without sacrificing the research and education efforts that are so necessary.

A milestone in our efforts to increase federal funding for AIDS research, care, and education was the report of the National Academy of Sciences, calling for a $2 billion AIDS research and education effort. The Academy recommended that $1 billion a year be newly appropriated for extensive basic and applied biomedical investigations of the disease. Another $1 billion would go for a massive, continuing education campaign to increase public awareness of the ways of protecting against infection. The money would also be applied to other necessary public health measures, such as screening the blood supply,

voluntary confidential testing, and increased efforts in treatment and prevention of IV drug use. The Academy's call must herald an increase in the national commitment against the massive problem of AIDS.

Increased federal support would translate into measures for controlling the spread of AIDS in New York City in the following ways. It would:

- Provide funding to enable us to rapidly increase confidential, voluntary counseling and testing. By the beginning of this year, over 17,000 people had used these counseling and testing services. We will continue to make voluntary, confidential counseling and testing sites more widely available -- though expanded testing requires substantial investments in money and trained personnel.

- Provide funding to increase access to substance abuse treatment programs for IV addicts. This is one of our most critical options for halting the spread of AIDS among addicts and to women and children. Currently, New York City has long waiting lists for methadone maintenance; drug-free rehabilitation programs are full to capacity. The federal government must consider drug rehabilitation programs as one of our important priorities, and provide more federal dollars through states and communities so that more addicts may find treatment for their addiction.

The Department of Health, in conjunction with the Division of Substance Abuse Services of New York State, has developed a proposal to explore an additional strategy for reducing the spread of HIV among drug users: a research

project to determine the effect of the exchange of clean needles to a small, carefully selected and monitored group of IV drug addicts awaiting entry into drug treatment. If approved by the State Health Commissioner, the research study will serve as the basis for evaluating the efficacy of this approach in halting the further spread of the AIDS virus, while avoiding promotion of IV substance abuse.

- Provide funding to increase efforts to expand our knowledge base. Research needs to be expanded to investigate the nature of HIV and its transmission. Currently, Health Department researchers are collecting data for two studies, a survey of hospital patients suspected of having AIDS to identify associated risk factors, and a study of risk factors for transmission of AIDS in heterosexual couples in which one partner contracted AIDS from a blood transfusion. In another project, Department researchers and five participating hospitals are studying HIV transmission from infected mother to child. A series of blind and anonymous serosurveys are planned, to shed greater light on current infection patterns, especially among women of childbearing age.

- Provide funding to increase massive public health education risk reduction efforts. We must have more support for the programs we are already operating: the Hotline, training programs, community-based presentations, counseling and testing. Additionally, we need more funding to allow more community-based groups to take on more responsibilities for continuing the educational programs we have established. We

desperately need more media programs on AIDS services and risk reduction.

• Support policies that eliminate the false dichotomy between civil liberties and public health. Stands on issues such as contact tracing and mandatory antibody testing have at times been portrayed as sacrificing public health in the name of civil liberties. Yet the approaches taken by New York City are based on sound public health principles; virtually all public health professionals agree that public health would be hindered by control measures such as mandatory testing -- as well as by ill-conceived judicial opinions such as the Justice Department's opinion last year, although the Supreme Court decision in the Arline case takes a substantial step toward overturning the inappropriate Justice Department decision.

The AIDS epidemic, and our understanding of it, is growing and changing constantly. Responsible policy must be continually reexamined against these changing conditions, and be modified if necessary to reflect current knowledge of disease transmission while at the same time remain flexible enough to accommodate important discoveries.

Biomedical research cannot eliminate the problem of AIDS in the short run. Education, health promotion, and risk reduction will remain our critical weapons in the fight against AIDS for at least the next several years. Those of us in a position to influence policy must do all we can to advance these weapons against this major and mounting health problem in New York City, across the United States, and around the world.

- End -

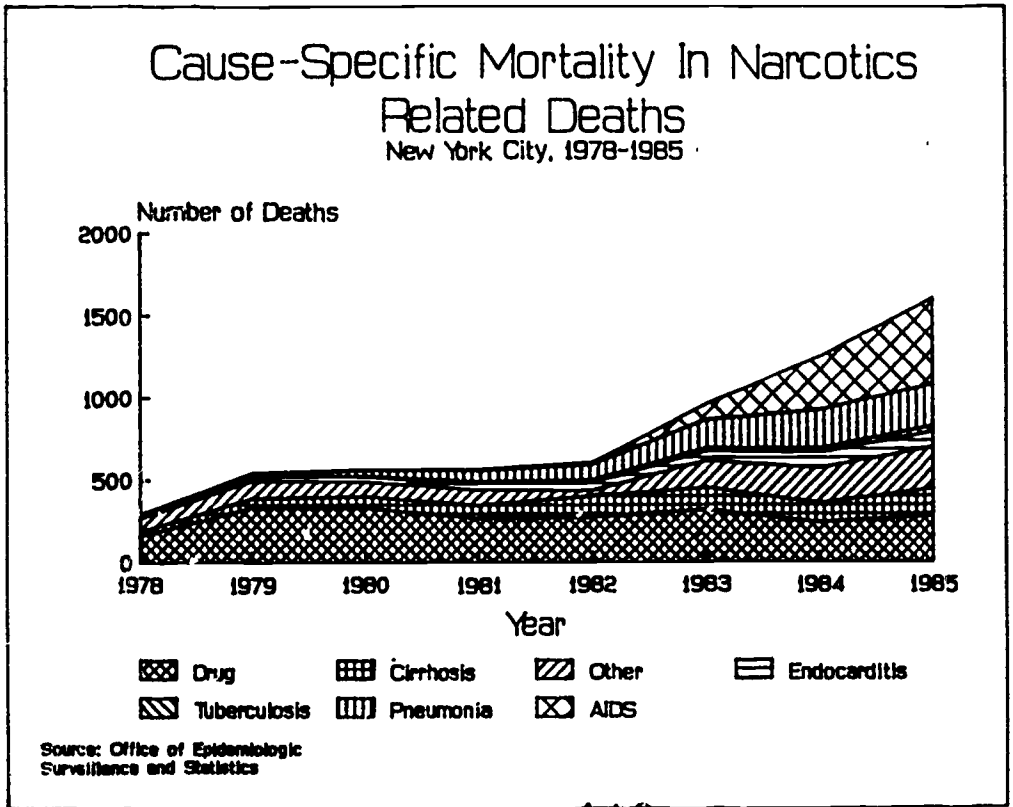
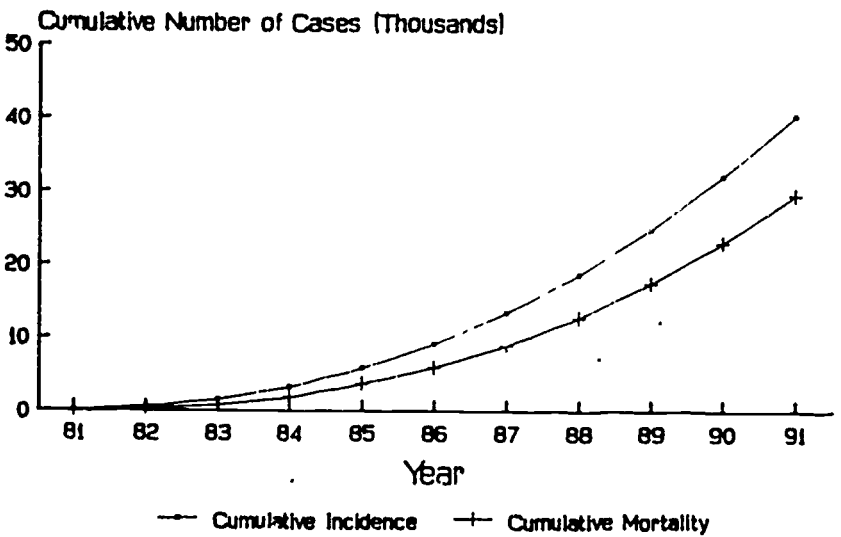

Cause-Specific Mortality In Narcotics Related Deaths
New York City, 1978-1985
Number of Deaths
2000
1500
1000
500
0
1978
1979
1980
1981
1982
1983
1984
1985
Year
Drug
Cirrhosis
Other
Endocarditis
Tuberculosis
Pneumonia
AIDS
Source: Office of Epidemiologic Surveillance and Statistics

Chart I

Chart II

AIDS Projections: Cumulative Incidence and Cumulative Mortality

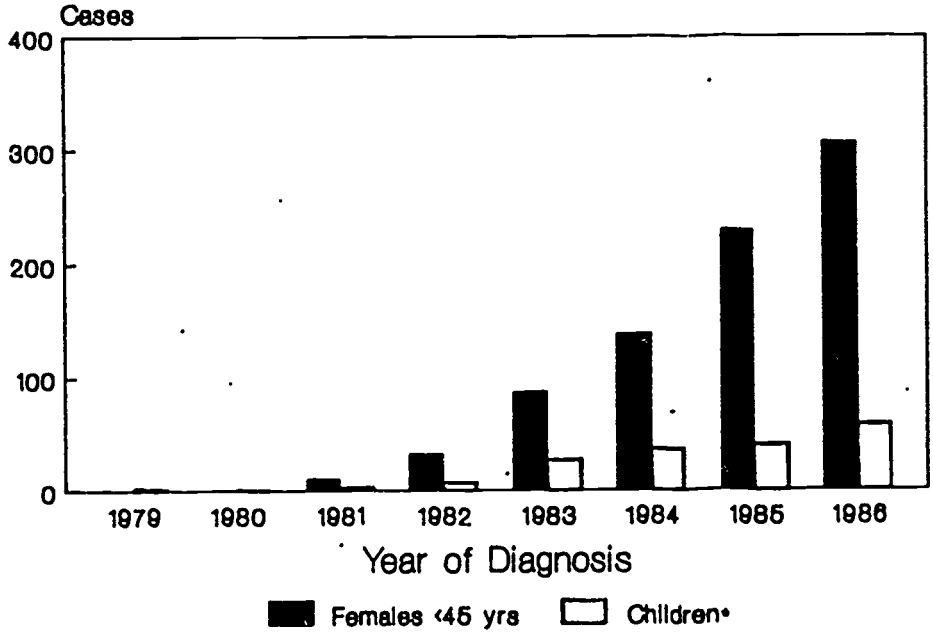
New York City, 1981-1991



Source: Office of Epidemiologic Surveillance and Statistics

AIDS INCIDENCE NYC, DECEMBER 1986

Females <45 yrs and Children



* Transfusion associated cases excluded

Chart III

Mr. WEISS. Thank you very much, Dr. Joseph. To a significant extent, I think you have responded in your testimony to the questions that we have prepared. I welcome the material that you have supplied. While we can't include all of it in the record, because of the volume, we will keep it in our archives and use it that way. I want to make special note of the subway and bus posters that you've referred to. Will you show that, Jim? How long has that been used?

Dr. JOSEPH. That went up last summer, I believe in May or June 1986. The other one, "Women Can Get AIDS, Too"—both of these are in English and Spanish. You're showing the English versions—this went up a month ago. I think, you know, these are important, but there's no single channel answer. We need mass media activity, we need a great expansion of our hotline.

In my written testimony, I talk about our hotline being expanded from seven telephones—from four telephones to seven. Since that testimony was written at the end of the last week, we've expanded from 7 to 14. You'll hear from others about voluntary hotlines in the city. I think we've got to move on the educational front, completely across the board. In the schools, with the hotlines, community outreach, one on one on the street and in the galleries, mass media on TV, subway posters. We really have to go with every weapon that we have.

Mr. WEISS. Are your mass media efforts based on contributed time and talent, or are you paying?

Dr. JOSEPH. The mass media campaigns that I mentioned are pro bono efforts on the part of the advertising agencies, but the production costs, as you know, need to be paid for. We received $300,000 specifically for mass media efforts from the city council in this budget, and those moneys will be used up in the two campaigns that I'm describing for the spring.

Mr. WEISS. You have our gratitude and sincere appreciation for taking the time to come down for this hearing today, and for the ongoing tremendous work that you are doing in the city of New York.

Dr. JOSEPH. Thank you very much, Mr. Chairman. I do apologize again, both to you and my colleagues on the panel for dashing off. Thank you.

Mr. WEISS. Thank you.

Ms. Gebbie, we'll hear from you next.

STATEMENT OF KRISTINE M. GEBBIE, R.N., A.N., ADMINISTRATOR, HEALTH DIVISION, OREGON DEPARTMENT OF HUMAN RESOURCES

Ms. GEBBIE. Mr. Chairman, I appreciate the opportunity to be here, and to represent particularly the AIDS education concerns and interests of the parts of the country other than those with the highest incidences of the disease. I come not only as the head of the health division for the State of Oregon, but as the chair of the AIDS Committee for the Association of State and Territorial Health Officials. One of our major efforts has been to provide some policy guidance for our member States, being particularly interested in States which had a low incidence of the disease early on, and

were able in part to insulate themselves from working on this epidemic early because of a broad public perception that this disease would not cross—in our case, the boundary of California—an invisible barrier.

Because of the difficult nature of this epidemic, the fact that you cannot talk about it long without talking about death and sex; without talking about homosexuality, which is taboo in many areas; it was easier for many parts of the public to say, "not me," rather than to say "what can we do to prevent it from becoming a high incidence disease in our locality?" For that reason I differentiate the educational campaign into two components. One is the factual educational campaign about the disease, what it can do, and what should be done about it. And then the second part, that which goes beyond that, to teach the behavior change necessary to prevent spread of the disease.

The first part, just the basic education is necessary to get people interested in what they need to do, and also to allay the panic which complicated our educational efforts at the beginning. The second part, the behavior change, is necessary for anyone who is putting themselves at risk of the disease, in order to reduce spread.

A major part of the problem with this educational effort is the luxury we have not had, of testing what to do first, seeing what really, really works and then putting it into effect in an organized, very slowly developed way. We've had to leap in and do things, testing them as we go, operating out of the best informed estimates of public health workers, who are familiar with epidemics, out of the efforts of those familiar with people at high risk, and then to put our evaluation campaigns in place as we go along.

Oregon is typical, I think, of most States, in that our educational activities are organized at a statewide level, providing resources, materials—printed materials, videotapes and the like—but carried out at the local level, through community-based groups, and through our local health departments, who can tailor activities to the experiences of each separate community. That experience at the State level I think, is a parallel of what happens nationally. We need to be able to tailor our educational programs to the different demographics, the different social attitudes, the different vocabularies of each area of this country, or of each State.

I'd like to go through some of the separate target audiences that we have focused on within Oregon, again because I think it's typical, and because it illustrates the diversity with which educational materials need to be developed.

The first target audience are public health officials. We needed people in every single one of our 35 local health departments, at least 1 person who could respond to public questions, who could coordinate alternate site testing activities, field questions about that, and who can provide the public speaking that's needed on a regular basis in every part of the State. We did that through a program of training trainers in every local health department, major educational efforts that were undertaken before any Federal funds were available to a State like ours.

A second major target audience for us are all other health providers. Physicians, nurses, dentists, emergency medical services providers, you name them, they're on our target list. We have tried

to work with their own associations. For example, the Oregon Medical Association has sponsored a road show education program to reach family practitioners and other primary care providers outside of the metropolitan area. The Association of Practitioners in Infection Control has provided a ready to move road show that will go into any institution receiving its first AIDS patient to go over attitudinal information, and to go over basic infection control information for the nursing or housekeeping or other staff as they have their first encounter with this disease. We need to continue to repeat that kind of program. As has been referenced several times earlier today, many health care providers have yet to see their first patient with AIDS, have yet to really take on their responsibility for education, and it will take continued reinforcement from public health officials and from professional associations to get all of the health providers participating in this.

A third major target audience for us has been school officials. We started with them by developing policies for school practices, trying to have policies in place prior to a first public confrontation on admission of a child to school. We have yet to have such a public confrontation. I'd like to believe it's because we won't ever have a major public confrontation, that the policies are in place, and a child's first enrollment in school will be very quiet. But in fact, as is true of many States, we do not yet have school age children of any number with this disease. That foot in the door of developing policies with the school board, with the school principals, with the school superintendents, with the PTA, was also our starting point for making schools aware of the need for education, and provided us with a foundation of a relationship that then lets us come back and say, "now what are you going to do about curriculum? You've got the policies, now you need the knowledge." And we have been able to move on to that.

A fourth target audience, current high risk groups, are being reached as much through the counseling and testing programs as they are through any form of mass education program. We see those groups needing much more personalized education. We are using our community-based groups, such as our AIDS networks, and our drug abuse treatment programs to reach out to the identified high risk groups.

Our fifth major target audience are young people not yet experimenting with drugs or sexual activity. References have been made earlier today to curriculum activities in the high school and in the junior high school. I want to emphasize that that education has to go down to the grade school level. I only have to look at the girls who are 11 who get pregnant every year in Oregon to know that waiting until junior high school is too late to teach people about safe sex activities. And we have in fact got schools down to the grade school level in Oregon providing educational materials on AIDS. It is specifically tailored in each case to the abilities of that student group, and it is not uniform across the State. We have a high school curriculum available across the State, that's in place in 50 schools—50 school districts, out of our 300. We hope to have it statewide within another year. We have a middle school curriculum available and taking it statewide. It has helped break the barrier of many discussions of sexually related activity in the schools.

You have heard much mention already this morning of sexually active heterosexuals, and the need for a broad based public education campaign, so that all people who may be at risk of this disease grasp that the threat is outside of the previously talked about high-risk groups, and that anybody is at risk. Women are a special target in this group in our State as elsewhere, and we do see the mass media as a major participant here. We have, like other places, had the donation of public advertising firms to help us with that campaign.

I will add, anybody else who doesn't fit in the above groups as our final target audience. There are people who may not be sexually active today, or who may be in a mutually monogamous relationship since prior to 1977, who still need all of the basic information to support the activities. One of our goals is to have every single service organization in the State of Oregon, the Lions, the Kiwanis, the Rotary, the PTA, to have an AIDS topic on their regular program sometime in the next year, so that we really reach out to a broader audience. That helps break the barrier of talking about things like sexual activity. It gets people thinking about what they need to do in the school, in the workplace and other places.

Let me close with a brief reference to resources. I concur with the thrust of several things that have been said this morning, that a bigger Federal investment is necessary. I think we could easily double the Federal investment in education, and spend the money wisely, particularly on dissemination of information, and on the evaluation of what works and doesn't work. I think that can best be done nationally.

But I want to underscore the need for continued State and local resources because that's what promotes ownership of the program, and allows the tailoring of the program to what works in the community, and gets around that barrier of denying that this is a particular local problem, not just in New York or San Francisco, but in Portland and John Day, and Halfway, Oregon, and all those other places that I'm trying to reach, and my counterparts in every other State are trying to reach.

We need the national leadership, but we need to collaborate, and that will expand the dollars exponentially to what we can do. Thank you very much.

Mr. WEISS. Thank you very much, Ms. Gebbie.

[The prepared statement of Ms. Gebbie follows:]

Department of Human Resources
HEALTH DIVISION
1400 S.W 5th AVENUE, PORTLAND, OREGON 97201 PHONE
(503)229-5032

March 13, 1987

PRESENTATION OF LEGISLATIVE TESTIMONY

TO: Human Resources and Intergovernmental Relations Subcommittee

FROM: Kristine Gebbie, Administrator
Oregon Health Division
Chair, AIDS Committee, ASTHO

AIDS EDUCATION

A major component of each state's public health program in response to the epidemic of Acquired Immunodeficiency Syndrome (AIDS) and infection with Human Immunodeficiency Virus (HIV) is education. This is an essential component because lack of information about the virus, the disease it causes, its method of spread, the ability of individuals to choose behavior which can eliminate or greatly reduce the risk of infection is one of the major weapons available to combat both the spread of the disease and spread of the panic which has complicated our public health effort. Any educational program has two components, education about HIV infection and AIDS and education to prevent the spread of HIV infection and therefore AIDS. The factual information about the disease, its methods of spread, its effect on the body and the complex of social reactions which surround it are necessary for health providers to accurately deal with their patients or their communities and to dispell the myths and rumors that have complicated our effort. Education to prevent spread of the virus must not only include the facts and figures but be capable of motivating people to change their behavior or to maintain a behavior pattern which can protect them from the disease.

In all parts of the education we have been putting programs into practice without the luxury of carefully controlled test programs to identify exactly which form of education, which style of presentation, what level of detail, or other variables will effect the learning which takes place, the retention of that learning, and the actual effect of the learning on behavior. We are using the best informed estimates of experienced public health workers of those familiar with groups at high risk of this infection and implementing evaluation programs as as we go along.

Mailing Address P.O. Box 231 Portland Oregon 97207
EMERGENCY PHONE (503) 229-5599
TTY (503) 229-6974

24-26 REV 11/86

As with a large number of public health programs in this country, AIDS prevention education is being organized at the level of state public health agencies but is further particularized and carried out by local health agencies. In some jurisdictions, very large local health departments are carrying out programs which may be bigger than the state programs with which they relate. Thia is particularly true in those large cities which have very high rates of infection and of the disease and have had substantial public health resources available in general. Oregon is typical of many states in which the program development and general framework are being organized at the statewide level with the day to day activity carried out at the local level allowing materials to be tailored to the experiences, attitudes, and resources of the local community.

TARGET AUDIENCES

For a variety of reasons, the educational programs are targetted at several different audiences, each of which need different levels of detail on the virus, its spread, its effect on individuals, the methods of preventing infection, and methods of dealing with those who have been exposed, who have been infected or who are experiencing illness Briefly, important audiences include:

(1) Public health officials - each public health agency must have staff who are knowledgeable about this disease, can coordinate efforts at the local level and participate in the educational program. In Oregon, we have prepared local health officials in two ways, first with a basic education program that prepares them to participate in our alternate site testing program and in epidemiologic activities, and second , through a train the trainer program which prepares them to provide educational programming within their local jurisdiction.

(2) Other health providers - this target audience is important (1) because they will be caring for or responding to infected individuals or ill individuals and (2) because they are looked to as a resource by the worried members of the community seeking accurate information about the disease. In Oregon, providers have scheduled AIDS related programs onto regular meetings of their associations. The Association of Practitioners

in Infection Control have provided core training for health care institutions regarding infection control practices and appropriate response to hospitalized infected persons. The Oregon Medical Association has cooperated in an educational program geared at the practicing physician who is not specializing in infectious diseases but may be seeing the worried well or the exposed person seeking testing or information. This program has been well received and will be repeated in various geographic areas of the state.

(3) School officials - because of the major public policy problem caused with the admission of children with AIDS in other states, school officials were an early target of education, primarily through the development of policies regarding the admission of children with AIDS to school. Working through associations of school boards, school administrators, educators, the State Department of Education, sufficient information was provided to facilitate the adoption of the policies. Work is now going on with the Department of Education regarding implementation of an AIDS curriculum in all schools. A high school level curriculum is available and is being utilized in many schools. One of our next targets is to adapt this curriculum for use with younger students. As schools become interested in use of the curriculum, teachers, administrators and parents must be educated so that implementation of the program goes smoothly. In each school district, there are unique resources and needs which must be taken into account in planning and presenting the material.

(4) Current high risk groups - this is the area of education that has probably received the most attention and of which many people are aware. Education within the gay community and within the drug using community is being done utilizing the resources of those already familiar with these communities. In Oregon, as elsewhere, the community-based AIDS organizations which have grown out of the gay community have been particularly active and effective and

have brought resources and capacities to the program which could not have been quickly developed, if at all, within the public health community. The programs working with drug abusers have also become actively involved in identifying ways of reaching out to their group.

(5) Young people not yet experimenting with drugs or sexual activity - this is the target audience for the school-based program. The middle school and upper grade school level is key to stopping spread of the disease in the next generation of adults. We have not got comprehensive materials available yet. As school officials, which were mentioned as a target audience earlier, become informed, they will be able to work more actively with the health agencies in designing materials. This program particularly must be geared to the individual attitudes and experiences of each local community because of the history of concern about any information on sexuality in the schools.

(6) Sexually active heterosexuals - this group has until very recently succeeded in denying the risk for AIDS and HIV infection and is one of the groups with the fastest growth of rate of infection. While general media attention has made some members of this group aware of their potential risk, we have not yet got clear programs which we can assure ourselves are changing behavior. Approaches will have to be on a large scale using general public education and advertising techniques.

(7) Anybody else who didn't fit into the above groups - This includes, for example, all employers In order to prepare them for their first experience with a known infected person in the worksite to improve infection control practices in first aide stations, to encourage consideration of issues related to continued employment and insurance coverage for those with AIDS.

RESOURCES FOR EDUCATION

Education is one of the most important components of the attack on HIV infection. In response to recent questions about a much broader use of

the HIV antibody test, I and many other public health officials pointed out that as weapons to fight this infection, each antibody test done is a tradeoff against dollars that could be spent on education and in many cases, the tradeoff to use of the test is not a wise investment of dollars. I believe education programs must be "owned" by the public through their public health agencies at all levels. This allows the particularlization of the program to local needs, the involvement of a broader group of people in preparation and delivery of materials and a much better funded program than we probably would have if any one level of government were totally responsible for it.

Up until the present, the State of Oregon, both at the state and local level, is spending at least one dollar of local resources for every dollar of federal funding available for AIDS education. This is, in fact, probably more likely to be one and a half to two times but it is impossible to fully calculate the dollar value of the volunteer hours which have been utilized. Budgetting for the next two years, it looks more likely that local resourceds will be three times what we are currently anticipating from the federal effort. More federal dollars certainly could be used but as indicated earlier, fully funding education federally a) may not be affordable and b) may not be the best because it could reduce the local ownership and commitment to the program.

There are some things that can be best bought at a nationwide level and could support local activities. From my perspective, a major one is the evaluation of our educational efforts. We have been implementing programs based on intuition and experience with other diseases. We know this disease is different. The social response has made that clear. We are implementing what is our best shot but we must have extensive evaluation of our effectiveness. That evaluation must be long term and must allow comparison of different groups and experiences in different areas. Such evaluations are, I think, best developed and supported at a national level. That would also allow a federal role in communicating quickly across the country the results of work and experiences so that adaptations can be made based on emerging knowledge.

Another major role for the federal agencies and one that is being developed well in the new plan for education is that of preparing the national leadership in key areas regarding AIDS so that they can, through their own networks, prepare local groups to be responsive to local education. An example of this is work with national school-related associations and organizations so that when a local school district is approached by a local health department they not only get the message about AIDS and its prevention at that level but can look to

their national association of educators, of PTA's, of school principals, for reinforcement. I want to emphasize that the national work does not replace the local efforts. Education must be organized and delivered locally but the national work is reinforcing.

It is difficult to put a specific dollar amount on the need, but experience in Oregon would indicate that amounts of money spent on education could be doubled effectively for the next several years to allow for adequate development of the teaching materials needed and outreach to all target audiences. State and local health officials are eager to continue collaborating with their federal colleagues in preventing further spread of HIV infection. Education is one of the most potent weapons.

Mr. WEISS. Ms. Stroud.

STATEMENT OF FLORENCE STROUD, R.N., M.P.H., DEPUTY DIRECTOR FOR COMMUNITY PUBLIC HEALTH PROGRAMS, SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Ms. STROUD. Thank you, Mr. Chairman. My comments today are going to be focused on our efforts with adolescents, but I wanted to take the opportunity to second a couple of comments Dr. Joseph made, with respect to needed funding for expansion of testing programs.

We believe both in our alternative test sites, as well as our provider-based testing, that more Federal money is needed not only for the analysis of the tests, but for some of the kinds of education and counseling that have to go on with individuals who come for the test, and community residents from where they come. So I would certainly echo the need in the high prevalence area of San Francisco, for increased money for alternative testing and provider testing, and increased money for methadone treatment of our IV drug users.

There's been a great deal of discussion today about the National Academy of Sciences report, and I wanted to start my testimony with one of its recommendations as it related to young people. Special attention must be paid to AIDS education for young people in schools and colleges, many of whom are entering periods of experimentation with sex and drugs. Frank discussion of behaviors that do and do not transmit HIV has become an urgent necessity for this target population. I think it's within the spirit of that recommendation that we in San Francisco decided that we must move quickly to provide public education to our adolescents and to our preadolescents living in San Francisco. I would like to describe three specific programs or projects for you today.

The first has to do with a school-based education. In the fall of 1985, a survey was conducted among high schoolers in San Francisco, primarily to find out what they knew about AIDS, whether they wanted accurate information about the disease, and whether they believed that it ought to be a part of their school curriculum.

Many of us working in San Francisco were really kind of surprised that there was so much misinformation among our adolescents who really were exposed to a media that talked about AIDS all the time. However, the reality was that there was a lot of misinformation. Students wanted accurate information, and they almost unanimously agreed that it ought to be a part of the regular school curriculum.

A joint task force was formed, including teachers, parents, health department staff, and school board staff. And that group developed a joint policy not only in management of children with HIV infection, but it also developed a plan on how youngsters in the district ought to be educated.

We came up with what we felt was a short-term and long-term strategy. The short-term strategy was that in May of last year, all students, grades 9 through 12, 25,000 of them, would not leave school that year without having participated in a one class session on AIDS. We now call it AIDS-101 for kids.

The longer term strategy required that we needed to run—train a core of teachers who felt comfortable, who were well informed, and who could teach in the district about AIDS, and to develop a curriculum for the middle schoolers, grade 6 through 8, as well as the high schoolers.

The one class session response was gratifying from students. They learned information, you had a pre- and post-test, so we knew what they learned, or could remember at least at that point, and they were able to transfer the knowledge very well. But more important, we provided for them an opportunity to call our public health centers if they had need for answers to other questions. We were very gratified that a number of the students, very sexually active students, who felt they could not discuss some of their own concerns in the classroom, availed themselves of our health centers, where they could discuss one on one, what the danger of contracting AIDS was, how they could prevent it, and how they might protect themselves. We decided that one session experience was so good, that we're going to do it again this year in May.

In the meantime, during the summer of 1986, we were able to get money from CDC to train a core of teachers, and that began last summer and fall. We now have 130 teachers in the San Francisco unified school district who are trained, and I must say that it's impossible for school districts to release teachers for training without some kind of outside funding. Most of our districts are very strapped in terms of funds for education, and unless there is outside funding to relieve teachers who can be trained, and they can be adequately trained in 5 days, then we're not going to have people who can competently implement the kinds of curriculum that are being designed.

We've just completed the curriculum. It will be out in print, in fact it probably was on Friday, for the middle school and the high school students, and I've included an outline of that curriculum, so that you get a little flavor of what is included in the curriculum.

The elementary—I mean, also, to agree with Ms. Gebbie that it's important that the elementary age youngsters know about human reproduction, disease control, and self-esteem. And the later elementary age youngsters need more explicit information, I think, about human sexuality.

Let me move quickly to a second effort that we've been involved in, and it was one using a medium that is a part of the adolescent culture, particularly the black and Hispanic culture in our community. And we were very alarmed at the high rates of STD's among blacks and Hispanics in San Francisco.

We decided to borrow from the whopping medium that is so popular among our kids, and we initiated a rap contest. The purpose was, not only to have the kids develop messages in their own language that they could give to their peers, but we also did it because we wanted to get a foothold in youth serving agencies in San Francisco, so that we could go back time and time again to reenforce the message about AIDS prevention. The contest, we felt, was a monumental success. We offered the kids money for the first three winning raps. They grasped the information very well. They put it to poetry and a beat. And we used local media folks who agreed to produce PSA's out of the winning raps. And they're in the process

of doing that. The winning rap, by the way, was held on Monday, March 9. So, we've just completed that, and we're really delighted at how adolescents grasped this information, and how they can convey it.

We don't know whether or not it was enough to change or modify people's behavior. And again, we believe one of the roles the Federal Government can play is to assist those of us at the local level who come up with innovative programs, to help us evaluate which strategies seem to be effective in modifying behavior of kids who are already sexually active; which strategies seem to be effective in helping kids delay initiating sexual activity.

And the third thing I'll briefly run through is a series of radio messages. We are not unaware of youngsters in our community who are almost always with their little boxes. And they listen to the radio, and we figure that some 80 to 1,000 of our kids listen to the radio daily. And we decided to develop a series of radio messages at times when they listen, when they're not in school, for those who are in school, but in the early evening and in the early morning. These messages will be aired twice a day over ethnic stations in San Francisco. And after each message, those listening to the messages will be given two or three phone numbers of places they can go, should they like to discuss further the messages that they've heard.

I also would like to reemphasize the fact that, I believe, for the adolescent, any kind of educational program has to be multidimensional in order to reach our youngsters. And I also would like to reinforce that it is important that teachers be trained, that teachers can, with intensive training, deal with some of their own hangups about human sexuality, learn about AIDS, and be as effective in providing education, as many of the health providers that we work with.

Another thing I wanted to say, and I think it's critical as we impact on minority communities, that there has to be an attempt to educate at the infrastructure of each of those communities. We've begun working in churches and community groups because we know the kids who get our information go back to those communities, and go back to those churches. And it is very difficult, when you're talking about a disease like AIDS, and you come smack into some religious beliefs that will not allow people to really hear you.

And I believe in the future we will need more funding to really work with those community groups, and try to change some of the religious attitudes that really, I think, will at some point impede our ability to get the information where it ought to be.

It is critical at the local level that there be coordination and collaboration between local governmental entities, as well as collaboration and coordination among private agencies. We would not have been able to produce the PSA's that are now in process had we not been able to find a production company that gave us, not pro bono, but at a marked discount their time and their skills to shake these PSA's, so that they would really appeal to teenagers. That kind of collaboration and coordination, I think, is essential.

And the last thing I want to say is, I do support the National Academy's recommendation that for public education there is a

need for a total of $1 billion from Government and private sources in public education through the year 1991 or 1990.

[The prepared statement of Ms. Stroud follows:]

EDUCATIONAL PROGRAMS

FOR

YOUTH IN SAN FRANCISCO

SUBMITTED

BY

FLORENCE STROUD
DEPUTY DIRECTOR
FOR
COMMUNITY PUBLIC HEALTH PROGRAMS

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

March 16, 1987

One of the recommendations on public education made by the National Academy of Sciences' Committee on a National Strategy for AIDS reads as follows:

> "Special attention must be paid to AIDS education for young people in schools and colleges, many of whom are entering periods of experimentation with sex and drugs. Frank discussion of behaviors that do and do not transmit HIV has become an urgent necessity for this target population."

It is the spirit and substance of that recommendation that has guided and informed our educational efforts with youth in San Francisco. I would like to describe three separate but related projects in which we are involved that are designed to educate our youth who are in school, as well as those who are not.

I. School-based Education

In the Fall of 1985, a survey was conducted among high school students in our public school system to determine (a) what they knew about AIDS, (b) whether they wanted accurate information about the disease, and (c) whether they believed it ought to be a part of their school curriculum. The results revealed that students had a lot of misinformation about AIDS, that they wanted accurate information and that they believed it ought to be a part of the curriculum.

A joint task force including teachers, parents and Health Department staff was formed to develop a policy and plans for educating students. This policy was adopted by the School Board and Health Commission. The program that grew from this joint policy had a short-term and long-term strategy.

The short-term strategy required that during the Spring of 1986, students would have at least one class session on AIDS. The longer-term strategy required the development of a curriculum on AIDS for middle school and high school students, and special training of teachers.

Students' response to the one-class sessions was very gratifying. Students really wanted information and, after some initial uneasiness, asked excellent

questions about the disease, how it was spread and how they could protect themselves. Parents were given the opportunity to review materials and to attend special evening meetings to discuss the classes.

We have just completed three separate, four-day teacher training courses for middle school, high school and elementary teachers. The middle and high school curriculum has been completed after piloting it at several sites, and is now in use.

Funding for these activities was provided by the Health Department and the School District with the exception of a $60,000 grant from CDC for teacher training and curriculum development. The project could have moved more expeditiously had more federal funding been available, e.g. we would have developed a more credible evaluation methodology for documenting and evaluating our efforts in a stepwise fashion, and we could have invested more time working with private schools in our city.

II. Rap'n Contest

A second program we initiated was a rap'n contest - geared to youth from 13 to 19 years of age. This program enlisted youth who were in school, as well as those who were not. Since rap'n is a contemporary form of communication among adolescents, we felt it would be an effective medium to use for youth educating other youth about ways to protect themselves about AIDS and prevent its spread. The contest was followed by a series of meetings with those who participated so we could learn what they learned, determine whether it modified their behavior, or helped them think more critically about the consequences of certain sexual behavior and use of drugs. The winning "raps" are being developed as television and radio PSAs. Staff from our Department and several community agencies continue their work with the diverse youth in our community to reinforce the learning that has already occurred, and to assist youth to maintain more healthy behaviors (I've attached some of the "raps" that the youth developed). We wish that we had the funds to follow a cohort of these young people over time to determine whether our efforts, and which educational strategies in particular, were effective in helping our youth adopt more healthy behaviors. This would assist us and others in choosing those community programs more likely to influence their behavior.

III. Radio Messages

A third program developed to appeal to youth in school and out of school was a series of radio messages about AIDS - what it is and how it can be prevented. These one-minute information spots are being aired on key stations that appeal to youth and are aired during those day and evening hours when youngsters are known to tune in. Each message ends by directing the listener to contact their local health department for more information and/or a physical examination. We believe this technique has the potential for reaching thousands of young people in a repetitive way. We will monitor inquiries to our facilities that were prompted by the radio messages.

Our efforts to educate and change behavior of our youth were based on several principles:

1. Didactic education, while necessary, was not sufficient to change their behavior;
2. Educational strategies must be multifaceted if they are to appeal to youth;
3. Programs must involve youth as teachers, and employ their own methods for transmitting information;
4. There have to be ways, at a family and/or community level, to reinforce learning in culturally sensitive and linguistically appropriate ways;
5. Programs will succeed only if there is viable collaboration between local governmental entities and community agencies.

Local governments do not have the funding to mount the kinds of programs needed to reach our youth. Local governments also can benefit from direction from the federal government with respect to general kinds of programs that are likely to succeed. This direction can and must be modified to local environments. Again, I would support the Academy's recommendation that the Federal government needs to develop a massive campaign to implement the educational goals enunciated in their report. A budget of $1 billion dollars, annually, by 1990 is a reasonable estimate for the multidimensional programs that are warranted if we are to prevent the transmission of this lethal disease.

AIDS EDUCATIONAL PROGRAM
FOR
SCHOOL-AGED YOUNGSTERS

January 20, 1987

The Teacher's Curriculum Guide on AIDS has been designed and developed to prepare middle and high school teachers to provide current and accurate information on AIDS for classroom instruction. This curriculum development is part of a pilot project, a joint effort between the San Francisco Unified School District and the San Francisco Department of Public Health. The pilot project also includes a comprehensive Family Life Education/AIDS Teacher Training program for elementary, middle, and high school teachers, as well as monitored field testing of the curriculum guide by trained teachers. Funding for this project has been provided by a grant from the Centers for Disease Control. This collaborative endeavor has served to strengthen the efforts of the School District and the Health Department to educate youth about AIDS and related risk behaviors.

The Teacher's Curriculum Guide on AIDS is divided into four units and presents information about AIDS within the context of other communicable diseases. It is designed to be taught as either part of a comprehensive health curriculum or in social studies, civics, history, contemporary social problems, and/or science class. It has been written with a special focus on factual information, as well as a focus on prevention behaviors and cognitive processes. The prevention behaviors are identified and reinforced through the use of age-appropriate activities. There will be both a middle school and high school edition of this guide.

Teachers held responsible for delivering lessons based on this curriculum guide require adequate preparation. Preparation should provide a background on teaching human sexuality, responsible decision-making and specific strategies for the reduction of risks associated with particular intimate (person-to-person) activities.

Regardless of the prevailing social mores, it must be acknowledged that, in any given adolescent population, some are likely to be sexually active or approaching sexual activity which places them at risk for sexually transmitted infections. Consequently, AIDS education in schools should be designed to cover basic factual information to add to the student's knowledge base, and elucidate specific behavioral strategies for avoidance of infections transmitted through sexual and parenteral means. The specific strategies should include, but not be limited to, choices such as abstinence, mutual monogamy, and the use of condoms as barriers to infected sexual fluids.

On the following pages, you will find a detailed description of the Table of Contents, as well as examples of two activities from the Teacher's Curriculum Guide on AIDS.

TABLE OF CONTENTS

Unit 2 - AIDS as a Communicable and Sexually Transmitted Disease

This unit is designed to offer basic information about AIDS, AIDS virus transmission, symptoms of AIDS, transmission categories and risk behaviors.

Unit 3 - Risk Reduction and Prevention of AIDS

This unit is designed to introduce risk reduction and prevention concepts, identify risk reduction and prevention behaviors, and promote discussion of these behaviors.

Unit 4 - AIDS and Our Community

This unit is designed to enable the student to understand the impact of AIDS in his/her community and to learn how to locate and utilize community resources and services.

Resources

This section will need to be adapted for each city. The guide will describe AIDS-related resources locally and nationally, and provide an explanation of how to develop this section for a particular area.

Recommended Readings

Suggested readings on AIDS and related risk behaviors, sexually transmitted diseases, family life education, sex education in the schools, and special concerns for adolescents will be included in this section for the teacher requiring more background on these subjects.

EXAMPLE ACTIVITY (high school)

Unit 3

Video - Sex, Drugs and AIDS (high school)

Purpose

To introduce age-appropriate behavioral strategies for reducing or preventing the risk of infection with AIDS and other sexually transmitted diseases.

Time

One class period
Video viewing time: 20 minutes
Discussion: 30 minutes

Materials

Video camera recorder (VCR)
Monitor
Video - Sex, Drugs and AIDS (nigh school)

Preparation

Review the lecture on Risk Reduction and Prevention.
Preview the video to be used in your class.
Developing the activity:

1. Explain to the class they will be seeing a video which will present information on AIDS and highlight the essential points. Explain that some of the people in the video are actors, but the representation of people with AIDS is accurate.

2. After the screening, discuss the concept of risk as it was demonstrated in the video.

Suggested questions for Sex, Drugs, and AIDS

1. Think about the first montage of clips showing people sharing food, lipstick, hairbrushes, and soft drinks, using a pay phone and massaging --are people at any risk for AIDS with these activities? What activities do put people at risk for AIDS?

2. In the scene with the two people using intravenous needles, what could they do to avoid getting AIDS or any other bloodborne disease?

3. For the woman who passed AIDS on to her baby, how might she have prevented getting infected before she got pregnant?

4. The other people with AIDS - what can they do to protect their sex partners?

5. How would you describe this video to a friend? What information would you want to be sure to include?

EXAMPLE ACTIVITY (middle school)

Unit 3

Dear Abby-Dear Me letters.

Purpose

To provide students with an opportunity to practice using AIDS information as a tool in prevention and for structured problem solving.

Time

One class period

Materials

Dear Abby - Dear Me

Preparation

Copy Dear Abby - Dear Me examples for each student

Developing the Activity

1. Distribute copies of the Dear Abby letters.
2. Instruct students to write brief responses to each letter. Allow 15 minutes for writing time.
3. Have students share and discuss their suggested solutions in pairs, small groups or in a large class group.
4. Emphasize the prevention and risk-reduction aspects of the answer.

Dear Abby - Dear Me

Dear Abby,

I've had it with my boyfriend. I'm afraid to break up with him because that means I'll have to find someone else. How will I be able to find someone who won't give me any diseases?

Signed, Dear Me!

Dear Abby,

I've been seeing this person for a long time. I've gone out with other people all along, but this guy is special and I want to make a commitment to him. Do you think that I should tell him about the other guys?

Signed, Dear Me!

Dear Abby,

What am I going to do? I really like this new girl in my class. We have gone out a few times and I can tell she likes me, too. Do we have to talk about having sex? What should I say to start the conversation? Help me soon — we have a date Friday night!!

Signed, Dear Me!

Dear Abby,

I have a friend who told me she has been shooting up. I heard a person can get AIDS from using IV drugs. Is this true? What should I tell my friend?

Signed, Dear Me!

D. Print RAP Neatly Below-Good Luck!

D-I-S-E-A-S-E x3
DISEASE, GET PROTECTION AND USE SEX SAFELY, USE CONDOM, USE JELLS, OR JUST SAY NO, AIDES IS CLAIMING VICTIMS. LIKE THE COCAINE BLOW ITS A HEAVY SITUATION SO DONT TAKE THIS LIGHT, DONT THROW YOUR LIFE AWAY FOR A TOSS IN THE NIGHT. RESPECT YOURSELF, PROTECT YOURSELF AND ACT LIKE YOU CARE JUST BECAUSE YOU USE PROTECTIC DOESN'T MEAN YOUR A SQUARE CONTRACEPTIVES MAKE A DIFFERENCE THEY MIGHT KEEP YOU ALIVE, SO IF SEX S WHAT YOUR INTO YOU SHOULD KEEP A SUPPLY. AND DONT RELY ON LUCKY VIBES CAUSE THE ODDS ARE AGAINST ANY TEAM THAT TRIES TO PLAY WITHOUT A SOLID DEFENSE. YOUR BLOWING CRACK, BLOWING CRANE AND YOUR BLOWING THE PIPE YOUR BLOWING BANK. BLOWING MONEY AND YOUR BLOWING YOUR LIFE. IF YOU INSIST ON USING DOPE AND YOU USE A SYRINGE JUST USE THE NEEDLE ONCE AND NEVER USE IT AGAIN!

WRITTEN BY: LEROY PALMER
AND
JOHNNY WILLIAMS
(ALSO CALLED RIFF RAFF)

IF YOU HAVE ANY QUESTIONS PLEASE CALL KIM SLADE AT 822-1124

Carlos DuBose (16)
308 Eddy Street #606
San Francisco, CA 94112
673-3750

People in the world you've got to understand,
the life that you lead is beheld in your hands.
I know you like big things the life that is yours,
there's nothing here bigger, close to or more.

There's organs in your body that must be used right,
your brain is the first it controls all your might.
It's captive education that all people need,
it wouldn't want cocaine, heroin or weed.

You like to get high it makes one bez
foolish in the mind unable to work.
You see every day in life's society,
tt destroys and voids your immunity.

The next in line the vagina and the penis,
these parts of the body should be kept the cleanest.
And the fellas when your horny and usin' your erection,
the condoms in the world are meant for protection.

Birth control stops babies for unwanting mothers,
rubber stops diseases carried by others.
AIDS a disease by sex it's transmitted,
sharing needles with another is how it's permitted.

So I've said my rhyme so very well,
I'm not playin' when I'm sayin' - in life don't fail.

No name

MY MISSION

My M-I-S-S-I-O-N is to make sure you never use drugs again.
But that's not all that I'm gonna say,
I'm gonna talk about the ways that you can catch AIDS.

Listen up people this is not a game,
I'm gonna put it to you straight and very plain.
See we got a problem going on in the world,
and it's killing young boys and lots of young girls.

It's drugs and AIDS they kill everyday,
and to catch the AIDS virus you don't have to be gay.
Drugs can kill you hope your hearing me well,
all drugs will do for you is put you in jail.

So don't shoot up and least of all share,
I'm tellin' you this cause I really do care,
because it's only two ways that you can catch AIDS,
by sharing needles and unsafe sex play.

Sex, respect it, so before you inject it,
you should wear a condom so you don't get infected
with the AIDS virus that's easily collected.

This rapp is fact not intuition,
and I'm tellin you this because it is my mission.

He's master "D" and I'm rappin "J"
and on the microphone now I'm Easy Drea
and we're the RUSH - IT CREW rappin hear today.

Mr. WEISS. Thank you very much, Ms. Stroud and Ms. Gebbie. Your testimony was very impressive and comprehensive. We're grateful to you both for taking the time to travel all the way from the west coast to give us the benefit of your experience and your knowledge.

I have one question for each of you.

Ms. Gebbie, as of March 2, 1987, the State of Oregon has had a total of 126 AIDS cases; and yet, you've been active in setting up State education programs. Have you had any difficulty gaining public and financial support for these programs?

Ms. GEBBIE. Yes, we've had some. We started asking for AIDS programs at a time when Oregon as a State was still barely recovering from a very deep recession. We've cut into State government programming over the last 5 years, and it is very awkward to show up between legislative sessions, when agencies are pinching, and to say, "And by the way, I'd like some additional general funds to fight this disease at which we have barely yet seen in our State."

Fortunately, we've had a lot of cooperation from the community-based AIDS organizations, from the gay community, from our local health departments, so it is not just me delivering that message. And I think we've been quite successful in the message that we can keep Oregon a low AIDS State only if we invest in education. And even the physicians in Oregon who are caring for our AIDS patients, and might be expected to plead first for research or treatment money, almost always preface their speeches with a plea for education funding within the State. That kind of support across the community did make it possible for us to get some State economic support. It's still not sufficient for what we want.

And I suspect if I can accurately count our budget, it would come close to increasing between 50 and 100 percent through the volunteer hours that have been spent by community-based groups, private practitioners of medicine and nursing, public health people working far beyond whatever paid hours they put in. It's impossible to calculate what effect that has. But in a relatively small State where you can almost get everybody—in numbers not necessarily geography—where you can almost get everybody in the same room face to face when you need them, you develop a personal commitment to conquer a problem that expands the dollar resources considerably.

Mr. WEISS. Thank you.

Ms. Stroud, have parents generally been receptive to AIDS education for their children? Have any asked that their children be kept away from AIDS curriculum? What has been the parental response?

Ms. STROUD. Very few parents. In May of last year when we did the one class sessions we had three parents who decided their children should not participate in that session. There were 24,000 students who participated in the session, and only three parents who dissented.

I might mention, also, that we sent our materials and have been in communication with the Catholic Diocese of San Francisco, as well as independent schools in San Francisco; and they—the independent schools have asked for our consultation. And so far with the Catholic Diocese they have been attending our joint meetings,

but we have yet to learn whether or not the materials are being implemented. I would anticipate more resistance there than we experienced in the public schools.

Mr. WEISS. I thank you both very, very much, and want to compliment you and your respective governmental organizations for the work that you've been doing in this area.

Thank you.

Appearing on our fourth and final panel will be individuals whose organizations provide a range of services including health care, housing, public education, and counseling for persons with AIDS and our communities. They are Richard Dunne, executive director of Gay Men's Health Crisis, New York City; Gilberto Gerald, director of minority affairs, National AIDS Network; Dr. Michael J. Rosenberg, executive director of American Social Health Association; and, George Swales, master of arts, director of Sunnye Sherman AIDS Education Project, Whitman Walker Clinic, Washington, DC.

Please remain standing and raise you right hand. Do you affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

Let the record indicate that all the witnesses have responded in the affirmative.

Let me welcome each of you and express our appreciation for your participation and for having the commitment to stay on through the earlier panels' testimony.

We will start with you, Mr. Dunne, and then go on to the others. We have your prepared statements and they will be entered into the record in their entirety. Please summarize them or present them as you think most appropriate.

STATEMENT OF RICHARD DUNNE, EXECUTIVE DIRECTOR, GAY MEN'S HEALTH CRISIS

Mr. DUNNE. Thank you, Mr. Chairman, for the opportunity to testify this afternoon before this subcommittee and for your leadership over the years on this issue.

I would like to talk today about AIDS information and education and the role voluntary community-based organizations such as Gay Men's Health Crisis have played and continue to play in this important activity.

I believe that when future historians look back on this period, it will be the consensus judgment that AIDS was the most important event in this country in the second half of the century. Barring one or more medical miracles, by the year 1991, there will be 270,000 cumulative cases of AIDS; 180,000 people will have died of AIDS by then. Eighty percent or more of these cases have already been diagnosed or are already infected. For almost all of those 300,000 people, in other words, it is already too late. Those 180,000 almost certain fatalities by the year 1991 are more than three times the number of Americans who died in the Vietnam war.

I also believe that this epidemic has been ahead of us and certainly ahead of the Federal Government since the moment this virus arrived on these shores some 8 years or more ago. Despite remarkable progress on the biomedical front, despite changes

in the sexual behavior of the primary risk group, and despite the heroic effort of many individuals, this epidemic is still out of control more than 5 years after it was first recognized.

One need only look at the mortality figures in New York City where AIDS is now the leading cause of death for all men between the ages of 25 and 49 and for women between the ages of 25 and 29. In certain health districts in New York City, as many as one of every four deaths in the last 5 years was caused by AIDS.

Even after nearly 6 years of an epidemic, we still look for national leadership from the administration. We have heard today, as we have heard in the past, of the administration's plans to begin a national education campaign. Yet, despite the best efforts of the scientific community, biomedical research cannot eliminate AIDS in the short term and education is the only preventive tool.

The fact is, however, that we require no new technological breakthroughs to limit the spread of AIDS. We already understand enough about the cause and transmission of the AIDS virus to give people the knowledge they need to protect themselves.

Every segment of society needs to know enough about AIDS so that each individual can make informed decisions about his or her behavior. We have had considerable success in informing health care workers and gay and bisexual men and yet compared to what needs to be done, we have only really begun.

Every youth old enough to engage in sexual relationships or to experiment with intravenous drugs needs to be educated about drugs. Every adult sexually active outside a mutually monogamous relationship, every gay and bisexual man, every intravenous drug user, needs to know the tools that can protect them and others, and those tools are the condom and the sterile needle.

Special efforts need to be made in minority communities. We usually perceive AIDS as an illness that mostly affects gay men and intravenous drug users. From another perspective, AIDS is an illness of people of color. Blacks and Hispanics represent 53 percent of the cases in New York City and 45 percent nationally. According to a recent report from the Centers for Disease Control, blacks and Hispanics are overrepresented in every single risk group for AIDS except hemophiliacs. Clearly, the minority community should be targeted for special education efforts.

I would like to outline for you some of Gay Men's Health Crisis education and information programs. We established the first telephone hotline in the world which answers questions and provides counseling to over 60,000 people every year. About 40 percent of the callers to our hotline are not gay.

We have a wide range of literature in English, Spanish, and Chinese, targeted to the general public and to specific populations. Over 38 different brochures are distributed through the mail, the public library system, churches, schools, street fairs, hospitals, and outpatient clinics.

In 1987, GMHC will reach 2.5 million people with our literature. Note that in contrast with Dr. Dowdle's statement, that he thought their brochure would reach some 100,000 people around the country.

Outside of the New York metropolitan area, GMHC's brochures are distributed by a number of voluntary and Government agencies throughout the country.

We have an active speakers bureau that addresses Government employees, professional associations, businesses, nurses, home care workers, students and other groups. In 1986, GMHC reached over 11,000 people through our speakers bureau.

We have specific risk reduction programs targeted to gay and bisexual men. We take these programs to wherever the audience is, bars, bath houses, college campuses, shelters for the homeless, substance abuse programs, and resorts. We have professional education programs for mental health professionals, both in hospitals and community-based clinics. These programs are designed to sensitize and train social workers to the discrete needs of persons with AIDS and their families and friends.

We have conducted behavioral research to find more effective ways of communicating AIDS information in such a way that people will understand and act on the information. Certain behaviors are associated with the transmission of the AIDS virus and we need to understand how to motivate people to change behaviors that pose the risk of viral transmission.

We have prepared public service announcements that promote understanding of what AIDS is and what it is not. Together with organizations such as AIDS Project Los Angeles and the San Francisco AIDS Foundation, Gay Men's Health Crisis has produced and distributed more than 60 different radio, television, and newsprint public service announcements to major markets throughout the United States.

We have heard this morning of the administration's plans to fight the AIDS epidemic. Why has there been so little action in the face of this mounting disaster? Part of the answer to that question is that AIDS was first evident in gay men and intravenous drug users. Part of the answer is that we had mistakenly come to believe that we had conquered infectious diseases in this country. Part of the answer is that the focus of health policy and planning has shifted from the provision of comprehensive services to the containment of health care costs.

I believe the answer lies deeper still. No one likes bad news and the worse the news is, the less we like it. AIDS is the worse possible news. There is a natural tendency to deny what is a terrible reality. The human suffering we see around us is often too much to bear.

AIDS is not going away and every time we look, it looms larger so that the shadow of this disease will darken all of our days. The human tendency is to hope somehow we ourselves are going to be spared, but the more we learn about AIDS, the harder it is to maintain the fiction that AIDS is something that happens to them and not to us.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Dunne follows:]

Testimony before the House Subcommittee
on Human Resources and Intergovernmental Relations

March 16, 1987
Richard D. Dunne
Executive Director
Gay Men's Health Crisis

Thank you for the opportunity to testify before this subcommittee.

I would like to talk today about AIDS information and education and the role voluntary, community-based organizations such as Gay Men's Health Crisis have played and continue to play in this important activity.

I believe that when future historians look back on this period, it will be the consensus judgment that AIDS was the most important event in this country in the second half of the century. Barring one or more medical miracles, by the year 1991 there will be 270,000 cumulative cases of AIDS in the U.S.; 180,000 people will have died of AIDS by then. Eighty percent or more of these cases have already been diagnosed or are infected. For almost all of those 270,000 people, in other words, it is already too late. Those 190,000 almost certain fatalities by the year 1991 are more than three times the number of Americans who died in the Vietnam War.

I believe that this epidemic has been ahead of us from the moment the AIDS virus arrived on these shores eight years or more ago. Despite remarkable progress on the biomedical front, despite sea changes in the sexual behavior of the primary risk group, despite the heroic efforts of many individuals, this epidemic is still out of control more than five years later. We need only look at the mortality figures in New York City: AIDS is now the leading cause of death for men between the ages of 25 and 49 and for women between 25 and 29. In certain health districts of New York, as many as one of every four deaths in the last five years was caused by AIDS.

Even after nearly six years, we still look for national leadership from the Administration. We have heard today, as we have in the past, of the Administration's plans to begin a national education campaign. Despite the best efforts of the scientific community, biomedical research cannot eliminate AIDS in the short term. The fact is, however, that we require no new technological break-throughs to limit the spread of AIDS. We understand enough about the cause and transmission of AIDS to give people the knowledge they need to protect themselves.

Every segment of society needs to know enough about AIDS so that each individual can make informed decisions about his or her behavior. We have had some success in informing health care workers and gay and bisexual men. Yet compared to what needs to be done, we have only begun.

Every youth old enough to engage in sexual relations or to experiment with intravenous drugs needs to be educated about AIDS. Every adult sexually active outside a mutually monogamous relationship, every gay and bisexual man, every intravenous drug user, needs to know the tools that can protect them and others -- those tools are the condom and the sterile needle.

Special efforts need to be made in minority communities. We usually perceive AIDS as an illness that mostly affects gay men and intravenous drug users. From another perspective, AIDS is an illness of people of color. Blacks and Hispanics represent 53 percent of the cases in New York City and 45 percent nationally. According to a recent report from the Centers for Disease Control, blacks and Hispanics are overrepresented in every single risk group for AIDS except hemophiliacs. Clearly, the minority community should be targeted for special education efforts.

I would like to outline for you GMHC's education and information programs:

- The first telephone hotline in the would which answers questions and provides counseling to over 60,000 people every year. About 40% of the callers to GMHC's hotline are non-gay.

- A wide range of literature in English, Spanish and Chinese targeted both the general public and specific populations. Over 38 different brochures are distributed through the mail, the public library system, churches, schools, street fairs, hospitals and outpatient clinics. In 1987, GMHC will reach 2.5 million people with our literature. Outside of the New York metropolitan area, GMHC's brochures are distributed by a member of voluntary and government agencies throughout the country.

- An active speakers' bureau that addresses government employees, professional associations, businesses, nurses, home care workers, students and others. In 1986, GMHC reached over 11,000 people through our speakers' bureau.

- Specific risk reduction programs targeted to gay and bisexual men. We take these programs to wherever the audience is -- bars, bathhouses, college campuses, shelters for the homeless, substance abuse programs and beach resorts.

- Professional education programs for mental health professionals in hospitals and community-based clinics. These programs are designed to sensitize and train social workers to the discrete needs of persons with AIDS and their family and friends.

- Behavioral research to find more effective ways of communicating AIDS information in such a way that people will understand and act on the information. Certain behaviors are associated with the transmission of the AIDS virus and we need to understand how to motivate people to change behaviors that reduce the risk of viral transmission.

- Public service announcements that promote understanding of what AIDS is and what it is not. Together with AIDS Project Los Angeles and the San Francisco AIDS Foundation, GMHC has produced and distributed more than 60 different radio, television and news print public service announcements to major markets in the United States.

Why has there been so little action in the face of a mounting disaster? Part of the answer to that question is that AIDS was first evident in gay men and in intravenous drug users. Part of the answer is that we had mistakenly come to believe that we had conquered infectious diseases in this country. And part of the answer is that the focus of health policy and planning had shifted from the provision of comprehensive services to the containment of health care costs. But I believe the answer lies deeper still.

No one likes bad news and the worse the news is, the less we like it. AIDS is the worst possible news. There is a natural tendency to deny a terrible reality. The human suffering we see around us is often too much to bear.

But AIDS will not go away. Every time we look, it looms larger so that the shadow of this disease will darken all our days. The human tendency is to hope that somehow we ourselves will be spared. But the more we learn about AIDS, the harder it is to maintain the fiction that AIDS is something that happens to "them," not to "us."

voloff(qq)

Mr. WEISS. Thank you, Mr. Dunne. Mr. Gerald.

STATEMENT OF GILBERTO GERALD, DIRECTOR OF MINORITY AFFAIRS, NATIONAL AIDS NETWORK

Mr. GERALD. Mr. Chairman and members of the Human Resources and Intergovernmental Relations Subcommittee, my name is Gil Gerald and I'm the director of minority affairs for the National AIDS Network. I appreciate this opportunity to present my views on how the Federal Government should respond to the need for educational programs on AIDS prevention, targeted toward minority communities.

I have professional experience with the desperate need for educational efforts on AIDS and AIDS prevention for minority communities. I wish to convey to the Chair and the subcommittee the thanks and appreciation of community-based AIDS service providers for your recognition of the seriousness of the AIDS problem early in the crisis and for having continued to pursue an end to this health problem.

As this committee knows, AIDS does not discriminate. Nevertheless, the minority community has been disproportionately affected by this devastating health crisis. The AIDS weekly surveillance reports for the Centers for Disease Control show that while blacks make up only 12 percent of the Nation's population, blacks comprise 25 percent of all people with AIDS. Similarly, Hispanics make up 6 percent of the population yet represent 14 percent of all people with AIDS. Minority children represent 80 percent of all children with AIDS in this country and black women constitute one-half of all women with AIDS—statistically, a black woman is 13 times more likely than a white woman to contract AIDS.

These staggering statistics have led more than one observer to note that among minorities, AIDS is a heterosexual disease. This pattern combined with a health system that puts minorities at a great disadvantage is documented in the Federal Government's report of the Secretary's Task Force on Black and Minority Health of January 1986, creates a very bleak picture for the future of the minority community with respect to the AIDS crisis.

Fears of increased societal stigma and discrimination and the persistent myth that AIDS is a white gay male disease reinforces the perception within the minority community that AIDS is of no particular concern to people of color.

Homophobia and racism and the resulting lack of adequate funding for minority targeted AIDS education efforts prevent access within the community to desperately needed risk reduction information. Even in the face of statistics found in their own investigations, the Federal Government's response has been, as stated before, woefully inadequate to meet the challenge to stop the spread of the AIDS virus within the minority community.

Several corrective measures can and should be undertaken in response to the situation as I have outlined it. In the time allotted to me, I would like to elaborate on three points. First, educational strategies must account for specific linguistic, cultural, and ethnic characteristics. As well, these campaigns must be sensitively waged to account for various literacy levels among audiences if they are

to be effective in changing behaviors within minority communities, which like in other communities, places individuals at higher risk for AIDS.

Funding must be specifically allocated for targeted campaigns, otherwise affected minority communities will not be reached.

Second, too few community-based minority institutions are receiving Federal or State support for AIDS prevention programs. Minority AIDS service providers are among the poorest organizations affiliated with the National AIDS Network. Yet they have the best access to their respective communities.

For the health of the community, the Government must find creative ways to see that minority organizations with broad access to their community receive support for their work.

Third, the Federal Government should monitor the impact and efficacy of educational programs with respect to targeted groups including minorities.

The National AIDS Network has just completed a study that demonstrates there is practically no evaluation of the effectiveness of existing educational programs in terms of their ability to reach minority communities to change high risk behaviors.

The AIDS crisis poses an additional burden on minorities who are already economically, politically and socially disadvantaged. It will take concerted and immediate action by the Federal Government to insure that these factors do not contribute to the continued spread of the AIDS virus in our society, but it will first require understanding.

For this reason, the National AIDS Network appreciates the attention that you are giving the matter today and calls upon you to take the necessary steps to respond to this epidemic. We ask you to hold hearings in congressional districts where minority people are disproportionately affected by this virus. In order to understand the importance of education, we feel it is important for you to hear firsthand the human suffering brought on by AIDS.

Thank you.

[The prepared statement of Mr. Gerald follows:]

STATEMENT

by

Gilberto Gerald
Director of Minority Affairs, National AIDS Network

before the
Committee on Government, Intergovernmental Operations
and
Human Resources Subcommittee

March 16, 1987
Washington, DC

Statement by Gilberto Gerald
Director of Minority Affairs
NATIONAL AIDS NETWORK

Mr. Chairman and members of the Intergovernmental Relations and Human Resources Subcommitte , my name is Gil Gerald, and I am the Director of Minority Affairs for the National AIDS Network. I appreciate this opportunity to present my views on how the Federal Government should respond to the need for educational programs on AIDS prevention targeted towards Minority Communities. I have professional experience with the desperate need for educational efforts on AIDS and AIDS prevention for minority communities. I wish to convey to the chair and the subcommittee the thanks and appreciation of community based AIDS service providers for your recognition of the seriousness of the AIDS problem early in the crisis and for having continued to pursue an end to this health problem.

As this committee knows, AIDS does not discriminate. Nevertheless, the minority community has been disproportionately affected by this devastating health crisis. The AIDS Weekly Surveillance Reports for the Centers for Disease Control show that while Blacks make up only 12% of the nation's population, we comprise 25% of all people with AIDS. Similarly, Hispanics make up 8% of the population, yet represent 14% of all people with AIDS. Minority children represent 88% of all children with AIDS in this country and Black women constitute fully one half of the women with AIDS. Statistically, a Black woman is thirteen times more likely than a white woman to

contract AIDS. These staggering statistics have led more than one observer to note that among minorities AIDS is already a heterosexual disease. This pattern, combined with a health system that puts minorities at a great disadvantage, as documented in the federal government's Report of the Secretary's Task Force on Black and Minority Health (Jan 86), creates a very bleak picture for the future of the minority community with respect to the AIDS crisis.

Fears of increased societal stigma and discrimination, and the persistent myth that AIDS is a white, gay male disease reinforces the perception within the minority community that AIDS is of no particular concern to us. Homophobia and racism and the resulting lack of adequate funding for minority-targeted AIDS education efforts prevent access within the community to desperately needed risk-reduction information.

Even in the face of statistics found in their own investigations, the Federal Government's response has been woefully inadequate to meet the challenge to stop the spread of the AIDS virus within the minority community. Several corrective measures can and should be undertaken in response to the situation as I have outlined it. In the time allotted to me, I would like to elaborate on three points.

First, educational strategies must account for specific linguistic, cultural, and ethnic characteristics. As well, these campaigns must be sensitively waged to account for various literacy levels among audiences if they are to be effective in changing behaviors within minorities communities, which like in other communities, place individuals at higher-risk for AIDS. Funding must be specifically allocated for targeted campaigns; otherwise, affected minority communities will not be reached.

Second, too few community based minority institutions are receiving federal or state support for AIDS prevention programs. Minority AIDS service providers are among the poorest organizations affiliated with the National AIDS Network, yet they have the best access to their respective communities. For the health of the community, the government must find creative ways to see that minority organizations with broad access to their community receive support for their work.

Third, the Federal Government should monitor the impact and efficacy of educational programs with respect to targeted groups, including minorities. The National AIDS Network has just completed a study that demonstrates that there is practically no evaluation of the effectiveness of existing educational programs in terms of their ability to reach minority communities to change high risk behaviors.

-3-

The AIDS crisis poses an additional burden on minorities who are already economically, politically, and socially disadvantaged. It will take concerted and immediate action by the federal government to insure that these factors do not contribute to the continued spread of the AIDS virus in our society. But it will first require understanding. For this reason, The National AIDS Network appreciates the attention that you are giving this matter today, and calls on you to take the necessary steps to respond to this epidemic. We ask you to hold hearings in congressional districts where minority people are disproportionately affected by this virus. In order to understand the importance of education, we feel it is important for you to hear first hand the human suffering brought on by AIDS.

Thank you.

74-444 0 - 87 - 6

Mr. WEISS. Thank you very much, Mr. Gerald. Mr. Swales.

STATEMENT OF GEORGE SWALES, M.A., DIRECTOR, SUNNYE SHERMAN AIDS EDUCATION PROJECT

Mr. SWALES. Mr. Chairman and members of the Human Resources and Intergovernmental Relations Subcommittee, good afternoon.

My name is George Swales. I am the director of the Sunnye Sherman AIDS Education Project of the Whitman-Walker Clinic located in Northwest Washington, DC. The Whitman-Walker Clinic is pleased and honored to have been asked to participate on a panel to provide information and perspective on the subject of AIDS education. On behalf of the president, Dr. Mary Jane Wood, and the administrator, Mr. Jim Graham, I thank you.

The Whitman-Walker Clinic is a community-based, nonprofit clinic organized in 1983 to respond to the specialized health needs of members of the gay and lesbian community. It has won local, regional, and national awards and recognition for its service to the community as a whole. It is operated by a total of 650 people, only 32 of which are paid staff. It is financed by the generosity of the community, contracts for service, and grants; successfully raising one private dollar for each public dollar or grant dollar.

While AIDS program work is by any measure the largest share of our work at this time, the Whitman-Walker Clinic delivers a full array of specialized services to its constituent community.

The Whitman-Walker Clinic AIDS Program consists of four services: AIDS Medical Services, AIDS Support Services, the Robert N. Schwartz, M.D. Housing Services for Persons with AIDS, and the Sunnye Sherman AIDS Education Project.

The AIDS Education Project is the educational arm of the clinic. In May 1986 under contract with the District of Columbia Department of Human Services, the Whitman-Walker Clinic undertook a much expanded health education program. The expansion in this project came about as a result of the Whitman-Walker's and D.C. Commission on Public Health's recognition and perception of an urgent need for expanded educational efforts towards people who are at high risk for AIDS. The project, then, represents a multifaceted approach to health education among gay and bisexual men, intravenous drug abusers, and prostitutes in Washington.

That element of our service, which has as its target IV abusers and commercial sex groups, is the focus of my testimony today, the AORTA Project, the AIDS-education Outreach to the Alienated.

The AORTA Project is funded in part by the District of Columbia Commission on Public Health, by a grant from Montgomery County in Maryland, by community-based fundraising efforts and by individual donations. Many of our visions for risk reduction education, aimed at stigmatized and alienated populations are limited by lack of financial resources. The AORTA Project's major focus is to educate persons who are drug abusers, drug and substance abusers, especially IV abusers, but also persons who are alcoholics and oral drug abusers, prostitutes—females, males, transpersons, cross-dressers—homeless persons who have been displaced and are now living on the street and from time to time in shelters, incarcerated

men, women, and youth in prisons, jails, detention centers, and community-based halfway facilities and youth who are on the streets or in restricted institutional settings.

Beyond education, we hope to bring about changes in attitudes regarding at-risk behaviors, which will result in behavior changes, safer sex, and non-needle-sharing.

There are several means used in the AORTA Project to reach the alienated, one of which is the Community Street Outreach Effort. We contract with men and women who are of the streets, something that Heath and Human Services now calls eloquently "indigenous personnel." These are people who live on the streets, who are from the streets, ex-abusers, ex-prostitutes, ex-offenders, who know what they're talking about and know their way around the streets. It is their job to get information to the abuser population or prostitute population, whatever population they are attempting to reach. They are very effective at it.

They have 3 to 5 quick minutes to a group who live fast and travel light. If you get 3 minutes of their time, you've had a lot. In that 3 minutes, they are to give the message of what the potential dangers are to the individual, that he or she as a result of their behavior may be at risk, what they can do about it. They are left with a piece of literature, two condoms, and the hope that they will look at their lives and look at their style to take control of their lives.

The first message in each case is, that your first option is to get off of drugs. But if you are not yet ready, if you cannot get off of drugs, your second message is, you must not share needles.

Wherein our street outreach efforts are having an impact on those who are alienated, such a program cannot be maximally effective unless some educational focus is also in place at all the institutions and systems that those who are alienated are likely to encounter—court and probation outreach efforts. We have developed and are now delivering educational seminars for probation officers, judges, and court personnel to focus on AIDS and seropositive issues in relationship to persons they are likely to come in contact with.

We are entering an agreement with the District of Columbia Probation Department and the District of Columbia courts to refer persons who are identified as engaging in at-risk behavior, drugs, and/or prostitution to an AIDS education seminar, which will be conducted by the Sunnye Sherman AIDS Education Services at the Whitman-Walker Clinic.

It is anticipated that several ongoing monthly seminars will be developed to accommodate persons' schedules—evenings, days, weekends. The seminar presenters will certify that persons referred to the education seminars did indeed attend.

In incarceration outreach efforts, we have developed and are now implementing AIDS education seminars for uniformed and nonuniformed corrections staff and for inmates. Currently, we have ongoing monthly AIDS education seminars in the District of Columbia correctional facilities, the District of Columbia Jail, Lorton, halfway houses, the Montgomery County Detention Center in Maryland, and the Arlington County Jail in Virginia.

All of our AIDS education seminars included not only information about AIDS, but also information about substance abuse and human sexuality.

Because we live in a tristate area, much of our focus beyond the streets of Washington, DC, includes the institutions in Maryland as well as Virginia. Once we have delivered AIDS education seminars to the staff in correctional facilities, we then set up ongoing AIDS education seminars for the inmates.

Because some jurisdictions are isolating inmates who merely test HIV-positive, we set up special education seminars for seropositive inmates to focus on such anxiety issues as education. The outcome of focusing on this population is that buddy systems are established that enable us to provide community resources to people who need, upon release, medical followthrough, housing, employment, and other support services.

We also have plans to deliver AIDS education seminars to the metropolitan police department personnel. We have included persons from various police precincts and divisions in our training sessions and have scheduled meetings to discuss conflicts with the police department.

In our residential drug treatment outreach, we have developed and are now delivering AIDS education seminars at private and governmental residential drug and alcohol treatment programs in northern Virginia, southern Maryland, and the District of Columbia.

Because of the transition of residents and staff, we often agree to set up ongoing AIDS education seminars for the residents and several sessions for the staff at 6-month intervals, thus allowing us to keep the staff updated on whatever new information or media focus that may be circulating and to address anxiety issues.

We do ongoing educational seminars twice a month to the District's detoxification program and the District's 28-day residential treatment program.

We are also providing quarterly AIDS seminars to residents in the District's long-term residential treatment programs. All of these programs are part of the Alcohol, Drug and Substance Abuse Administration under the Commission on Public Health.

The District of Columbia is the home of thousands of homeless women and men and youth, who because of mental illness, substance abuse, chemical dependency, or economic hardship, find themselves without shelter and/or the means to support themselves. This population of people is at high risk for contracting and transmitting AIDS because of poor health care, poor nutrition, extreme psychic and environmental stresses, lack of rest, and chemical dependence. These cofactors to HIV infection make the homeless a particularly vulnerable group of people.

There have been cases of homeless persons who have been diagnosed with or who died from complications related to AIDS.

Outreach to prostitutes. Within any given month, it is estimated that there are 500 men, women, and transpersons who are on the streets of Washington, DC, involved in commercial sex. In the commercial sex industry, in teams of two, outreach workers approach persons working in the streets, talk to them one on one, give them literature and free condoms, and provide them with intervention

and referral information for AIDS services, drug and alcohol treatment services, and other community or public social service agencies, such as STD clinics.

We have found that most of the prostitutes are very receptive to our efforts, say they are using condoms—and there is evidence that they are—and are concerned about AIDS. Many of the street prostitutes and hustlers are also IV drug abusers. In the District of Columbia, that is estimated to be 40 percent.

Beyond the streets, the AORTA Project has attempted outreach to male prostitutes who work independently or through model/escort services and advertise in the classified sections of selected publications. By the fall of 1987, we hope also to implement an outreach to women who are in the commercial sex industry, but are not working on the streets.

Male prostitutes who advertise have been surveyed via telephone. We use a 12-item questionnaire which is attached to determine the level of knowledge about AIDS, safe sex behaviors, and compliance with safe sex guidelines. Initial data gathered indicates a high level of awareness, but only a moderate level of compliance with safe sex behaviors.

The rule-of-thumb seems to be, quote, "If the client is willing to pay for anything, that's what the client gets," unquote. The same seems to be true for most men, women, and transpersons working on the streets. Clients sometimes pay more to engage in unsafe or risky sexual activities which may expose both participants to HIV infection.

A more concerted outreach to male model/escorts is planned for the spring of 1987. Those male prostitutes who do participate in a safe sex seminar will be granted a safe sex certificate and may use that and negative antibody test information as part of their classified ads.

That concludes my oral presentation.

[The prepared statement of Mr. Swales follows:]

Whitman-Walker Clinic, Inc.
2335 18th Street NW • Washington, DC 20009 • (202) 332-5295

CONGRESSIONAL TESTIMONY

of

George A. Swales, M.A.

Director, Sunnye Sherman AIDS Education Project

before the

HOUSE OF REPRESENTATIVES

Human Resources and Intergovernmental Relations Subcommittee

Congressman Ted Weiss, Chairman

March 16, 1987

Mr. Chairman, Members of the Human Resources and Intergovernmental Affairs Subcommittee - Good Morning.

My name is George A. Swales. I am the Director of the Sunnye Sherman AIDS Education Project of the Whitman-Walker Clinic, located in Northwest Washington, D.C.

The Whitman-Walker Clinic is pleased and honored to have been asked to participate on a panel to provide information and perspectives on the subject of AIDS education.

On behalf of the President, Mary Jane Wood, her officers, and the Administrator, Mr. Jim Graham, I thank you.

The Whitman-Walker Clinic, Inc. is a community based non-profit, organized in 1973 to respond to specialized health needs of members of the gay and lesbian community. It has won local, regional, and national awards and recognition for its service to the community as a whole. It is operated by a total of some 650, only 32 of which are paid. Is is financed by the generosity of the community, contracts for services, and grants; successfully raising one private dollar for each public (or grant) dollar.

While A.I.D.S. Program work is by any measure the largest share of our work at this time, the Whitman-Walker Clinic delivers a full array of specialized services primarily to the gay community. Other services are: (1) Gay Men's Venereal Disease Clinic, (2) Alcoholism Services, (3) Lesbian Resource and Counselling Center, (4) Counselling Group. and (5) Gay Hotline.

The Whitman-Walker Clinic A.I.D.S. Program consists of four services; (1) A.I.D.S. Medical Services, (2) A.I.D.S. Support Services, (3) Robert N. Schwartz, M.D. Housing Services, and (4) the Sunnye Sherman A.I.D.S. Education Project.

The Sunnye Sherman A.I.D.S. Education Project is the educational arm of the Clinic. In May 1986, under contract with the District of Columbia Department of Human Services, the Whitman-Walker Clinic undertook a much expanded health education program. The expansion and this project came about as a result of Whitman-Walker's and the D.C. Commission of Public Health's perception of an urgent need for expaned educational efforts toward people who are at high risk for A.I.D.S. The project then represents a multifaceted approach to health education among gay and bisexual men, intravenous drug ab/users, and prostitutes in Washington.

That element of our service which has as its target I.V. ab/users, commercial sex groups is the focus of my testimony today; the A.D.R.T.A. Project.

OVERVIEW OF THE A.O.R.T.A. PROJECT

The AIDS-education Out Reach To the Alienated (AORTA) Project was established in June, 1986 as an education project of the Whitman-Walker Clinic's educational services (Sunnye Sherman AIDS Education Services). The AORTA Project is funded in part by the D. C. Commission of Public Health, by a grant from Montgomery County of Maryland, by community based fund raising efforts, and by individual donations. Many of our visions for risk-reduction education aimed at stigmatized and alienated populations is limited by lack of financial resources.

The AORTA Project's major focus is to educate persons who are:

--drug and substance ab/users (especially IV users, but also persons who are alcoholics or oral drug users)

--prostitutes (females, males, and transpersons (cross dressers who may be transsexuals, transgenders, or transvestites)

--homeless (persons who have been displaced and are now living on the streets and from time-to-time in a shelter)

--incarcerated men, women, and youth (prisons, jails, detention centers, and community based halfway facilities)

--youth (who are on the streets or in restricted institutionalized settings)

Beyond education, we also hope to bring about changes in attitudes (regarding at-risk behaviors) which will result in behavior changes (safe sex and not sharing needles).

In addition to the ALIENATED populations of drug and substance ab/users, prostitutes, incarcerated, homeless, and youth, we also focus on:

--family, partners, friends and neighbors of the ALIENATED

--persons living and working with the ALIENATED

--professionals who are most likely to be in touch with the ALIENATED (police and correctional officers, probation and parole officers, substance abuse counselors, ministers, VD/STD workers, et al)

--businesses, churches, and community based agencies which are physically in the commercialized sex districts and drug "strips"

There are several means used by the AORTA Project to reach the ALIENATED:

- Community/Street Outreach Efforts

We "contract" with men and women who are recovered substance ab/ users, former prostitutes, and ex-offenders. These "outreach workers" are instructed by the co-directors/health educators of the W-W Clinic's Sunnye Sherman AIDS Education Services on issues of AIDS, substance abuse, and human sexuality. The ou each workers are also trained in skills of peer counseling and communication.

In addition to "contracting" with some outreach workers, we also train and educate volunteers, appropriate court referrals, and student interns. We are considering the merits of having youth outreach workers from the District of Columbia's Summer Youth Program.

[SEE INSERT--PERSPECTIVES]

Wherein our street outreach efforts are having an impact on those who are ALIENATED, such a program cannot be maximally effective unless some educational focus is also in place at all of the institutions and systems that those who are ALIENATED are likely to encounter.

-- Court/Probation Outreach Efforts

We have developed, and are now delivering, educational seminars for probation officers, judges, and court personnel to focus on AIDS and seropositive issues in relationship to persons they are likely to come in contact with.

We are entering an agreement with the D. C. Probation Department and the D. C. Courts to refer persons who are identified as engaging in at-risk behavior (drugs and/or prostitution) to an AIDS education seminar which will be conducted by the SSAES of the W-W Clinic.

It is anticipated that several on-going monthly seminars will be developed to accomodate persons' schedules (evening and days; a weekend; and varying the week day). The seminar presentors will "certify" that persons referred to the education seminars did indeed attend.

-- Incarceration Outreach Efforts

We have developed, and are now implementing, AIDS educational seminars for uniformed and non-uniformed correctional staff and for inmates. Currently, we have on-going monthly AIDS education seminars in the D. C. Correctional facilities (D. C. Jail,

Lorton, halfway residents), Montgomery County Detention Center in Maryland, and Arlington County Jail/Detention Center in Virginia.

All of our AIDS education seminars include not only information about AIDS, but also information about substance abuse and human sexuality.

Because we live in a "tri-state" area, much of our focus beyond streets of WDC includes the institutions in Maryland as well as Virginia. Once we have delivered AIDS educational seminars to the staff in correctional facilities, we then set up on-going AIDS education seminars for the inmates.

Because some jurisdictions are isolating inmates who merely test HIV positive, we set up special education seminars for seropositive inmates to focus as much on anxiety issues as education. The outcome of focusing on this population is that a "buddy" system is established that enables us to provide community resources to persons who need, upon release, medical follow-thru, housing, employment, and other support services.

We also have plans to deliver AIDS education seminars to the Metropolitan Police Department personnel. We have included persons from various police precints and divisions in our training sessions, and have scheduled meetings to discuss conflicts with the police department (i.e. "jump outs," need for ID for outreach workers, police taking condoms from prostitutes or poking holes in them, etc.).

We also focus our educational efforts on juvenile detention programs in WDC, Southern Maryland, and Northern Virginia.

-- Residential Drug Treatment Outreach

We have developed, and are now delivering, AIDS education seminars at private and governmental residental drug and alcohol treatment programs in Northern Virginia, Southern Maryland, and the District of Columbia.

Because of the transition of residents (and staff), we often agree to set up on-going AIDS education seminars for the residents and several sessions for the staff at six month intervals (thus enabling us to keep the staff "updated" on whatever new information or media focus that may be circulating and to address anxiety issues).

We do on-going educational seminars (twice a month) to the Districts' detox program and the District's 28 day residential treatment program. We are also providing quarterly AIDS seminars to residents in the District's long term residential treatment programs (CADAC, ADERO House (for youth), ADAPT, et al). All of these programs are part of ADASA under the Commission of Public Health of DHS.

We have also set up quarterly AIDS educational seminars to all of the residential and non-residential drug treatment progr of KOLMAC, RAP, Second Genesis, and Phoenix House. We alt do seminars for the staff before we do seminars for the per ons in treatment.

-- Outreach To The Homeless

The District of Columbia is home to thousands of homeless women, men, and youth who because of mental illness, substance abuse/chemical dependency, or ecc xmic hardship, find themselves without shelter and/or the means to support themselves. This population of people is a high risk for contracting and transmitting AIDS because of poor health care, poor nutrition, extreme psychic and environmental stressors, lack of rest, and chemical dependency. These co-factors to HIV infection make the homeless a particularly vulnerable group of people. There have been cases of homeless persons who have been diagnosed with (or who died from) complications related to AIDS.

The AORTA Project of W-W Clinic's SSAES has identified over 30 homeless shelters, half-way houses, drop-in centers and transitional homes for homeless women, men, and youth. Since October of 1986, over 340 women, men, and youth who are staff or residents of these agencies have participated in AIDS educational seminars developed and delivered by staff and/or volunteers of the AORTA Project.

The staff of homeless facilities in Metropolitan WDC have received a basic introduction on HIV infection, HIV symptoms, risk-reduction activities regarding sex and drugs, and intervention/referral for those homeless who manifest symptoms of HIV infection. We also distribute risk-reduction literature and free condoms for the residents of the shelters and return for seminars as often as the staff requests follow-up visits.

-- Outreach To The Prostitutes

Within any given month, it is estimated that there are about 500 women, men, and transpersons who are on the streets of WDC and involved in the commercial sex industry as prostitutes (women and transpersons) or hustlers (men and transpersons).

In teams of two, outreach workers approach persons working on the streets, talk to them one-on-one, give them literature and free condoms, and provide them with intervention/referral information for AIDS services, drug/alcohol treatment services, and other community or public social service agencies such as STD clinics.

We have found that most of the prostitues are very receptive to our efforts, say they are using condoms (there is evidence that they are), and are concerned about AIDS. Many of the street prostitutes and hustlers are also IV drug ab/users.

[See Attached--Perspectives]

Beyond the streets, the AORTA Project has attempted outreach to male prostitutes who work independently or through model/escort services and advertise in the classified section of select publications. By fall of '87 we hope to also implement an outreach to women who are in the commercial sex industry but are not working on the streets.

Male prostitutes who advertise have been surveyed via telephone. We used a twelve-item questionnaire (see attached) to determine the level of knowledge about AIDS, safe sex behaviors, and compliance with safe sex guidelines. Initial data gathered indicates a high level of awareness but only a moderate level of compliance with safe sex behaviors. The rule of thumb seems to be, "If the client is willing to pay for anything, that's what the client will get." The same seems to be true for most men, women, and transpersons working on the street. Clients sometime pay more to engage in unsafe or risky sexual activities which may expose both participants to HIV infection.

A more concerted outreach effort to male model/escorts is planned for the Spring of '87. Those male prostitutes who do participate in a safe sex seminar will be granted a safe sex certificate and may use that and negative antibody status information as part of their classified ad.

/bj
03/13/87

STREET OUTREACH STATS

December 1986 to February 1987

	February 1987	3 month cummulative	3 month average
Contacts	1,043	5,244	1,748
One-on-one	640	2,452	817
Percentage	58%	47%	47%
Number of men	659	3,207	1,069
Percentage	63%	61%	61%
Number of women	384	2,037	679
Percentage	37%	39%	39%
Number Black	732	4,106	1,369
Percentage	71%	78%	78%
Number White	203	927	309
Percentage	19%	18%	18%
Number Latino/Asian	108	211	70
Percentage	10%	4%	4%

A.O.R.T.A. PROJECT - OUTREACH TO HOMELESS

SHELTER / HOME	Male / Female	#TRAINED
CC en's Shelter	M	4 (Staff)
La .. ada (Irving St.)	M (Latino)	36 (S & Residents)
Coalitio.. for Homeless	M/F	35 (S)
Isaiah House	M	17 (S & R)
Calvary Baptist (Women)	F	4 (S)
Allison Home	F (teenagers)	7 (S)
Luther Place	F	8 (S)
Dorother Day Catholic Worker	F/M (Families)	12 (S & R)
Park Road (CFH)	M	8 (R)
Rachel House	F	25 (S & R)
Webster House (CFH)	M	8 (R)
Florida Ave. Women's Cente:	F	8 (R)
CCNV Women's Shelter	F	26 (S & R)
Efforts for Ex-Convicts	M	48 (S & R)
Hannah House	F	20 (S & R)
Mt. Carmel House	F	26 (S & R)
Health Care for the Homeless	M	10 (S)
Calvary Drop-In Center	F/M	3 (S)
Christ House	M	15 (S)
Sasha Bruce	F/M (Youth runaways)	21 (S & R)
TOTAL # TRAINED (3/12/87)		341

A.I.D.S. INFORMATION
ASSESSMENT QUESTIONNAIRE

Hello! My name is _____. I'm a staff worker/volunteer with the Whitman-Walker Clinic's A.I.D.S. Education Project. We are trying to educate people at high risk for exposure to the virus that causes A.I.D.S. to help them lower their risk of getting the disease by knowledge of and practice of safe sex and safe I.V. drug methods. We do not need your real name, and all the information you give will be kept in strict confidence. We are concerned about your health and that of your customers. We are not concerned about the legal issues of your lifestyle.

Would you be willing to answer a few questions so we can find out what we can do to help you protect yourself and your customers.

1) Have you heard of the A.I.D.S. (acquired immune deficiency syndrome) disease?

/ / YES / / NO

2) What does the disease do to a person who gets it? (Check the answer that most corresponds to their response)

_____ It kills them.

_____ It causes swollen lymph nodes in the neck, armpits, groin.

_____ It causes them to loose weight.

_____ They get pneumonia (Pneumocystis carinii).

_____ They get some kind of skin cancer (Kaposi's Sarcoma).

_____ They get fevers, night sweats and have diarrhea.

_____ Other_____

3) Have you ever taken the HTLV-III Antibody Test in a hospital, doctor's office, or clinic to see if you have been exposed to the A.I.D.S. virus?

/ / YES / / NO

4) If yes, what result did you receive?

/ / Positive / / Negative / / No result

5) Do you use rubbers (condoms, trojans) when you have oral or anal sex (blow jobs, sucking, ass fucking) with your partners?

/ / YES / / NO / / SOMETIMES / / ALMOST ALWAYS

6) Can you tell me what "SAFE SEX" means and how is it practiced?

/ / YES (record response) / / NO

_____

_____

_____

7) Have you ever used drugs li eroin or cocaine that you injected with a needle?

/ / YES / / NO

IF YES, ASK THE NEXT TWO QUESTIONS

a) When was your most recent use of intravenous drugs? _____

b) How long have you used intravenous drugs? _____

c) How often did you or do you shoot up?

/ / daily / / once a week / / once a month / / other

8) Do you use alcohol, marijuana, poppers or other drugs when you are having sex with your partners?

/ / YES / / NO

9) If the Whitman-Walker Clinic offered a safe sex/safe I.V. drug program for you and your friends at one of the local bars (Brass Rail, Chesapeake House, LaCage Aux Follies, Lone Star, Shooters) or at the Clinic, would you attend?

/ / YES / / NO (Record reasons why not)

10) Would you use rubbers (condoms, trojans) and ask your clients to use them if they were provided at low cost or free of charge?

/ / YES / / NO

11) Would you purchase your own rubbers if they were not available free?

/ / YES / / NO / / I already purchase them

12) Would you be willing to distribute a small, wallet-sized card to your customers that describes safe sex methods and would you ask them to use these methods in their sexual encounters?

/ / YES / / NO / / I'd have to think about it some more

Thank you very much for your time in answering this questionnaire. Would you be willing to give us a fake or real name and your mailing address so we could send you some materials about safe sex/safe I.V. drug use?

_____

_____

_____

Mr. WEISS. Thank you, Mr. Swales. Dr. Rosenberg.

STATEMENT OF MICHAEL J. ROSENBERG, M.D., M.P.H., EXECUTIVE DIRECTOR, AMERICAN SOCIAL HEALTH ASSOCIATION

Dr. ROSENBERG. Thank you, Mr. Weiss.

My name is Michael Rosenberg, and I am executive director of the American Social Health Association. I'm also a practicing physician and researcher.

The American Social Health Association is one of the oldest nonprofit organizations in the country. Our programs focus exclusively on sexually-transmitted diseases and include the National AIDS Hotline, the National VD Hotline, the Herpes Resource Center, the Sexually-Transmitted Diseases Research Fund, and a variety of public and school-based education programs.

We have operated the National AIDS Hotline for about 2 months now, and with little advertising, we receive an average of 800 calls a day to live operators and about twice that many for recorded information. Based on that experience, we have some insight about the public's need for AIDS information.

First of all, there is a great lack of information and preponderance of misinformation which desperately needs to be corrected. This points up one component of the need for education.

The second part, I think, of that is that we need to reach a greater audience which is not presently served, not presently motivated enough to go to the trouble of calling an AIDS hotline.

I think a point for both of those, however, is that the Government's response to the need for education is clearly inadequate at this point. We are dismayed, in fact, that 6 years into the epidemic, we still haven't seen the long-promised plan for AIDS education. The fiscal year is almost half finished, and we heard Dr. Windom this morning testify to the fact that nearly $80 million will be made available for educational efforts. But I think that problem is that none of that money or very little of that is on the streets, and I think it's very unlikely that the Government will be able to spend all of that money this year.

The second point I'd like to make is that the Centers for Disease Control's track record on public education regarding sexually transmitted diseases is really a rather poor one. I think in contrast to the exemplary job they've done with getting our state of knowledge about AIDS to where it is today—at least from the scientific and epidemiologic perspective. There are project grants, for example, which the CDC go to the States for sexually transmitted disease control. Those include a component of public education, but as Mr. Gerald said earlier, there's really no provision for assessing how well those work, in other words, do they meet the needs? There's no feedback loop; there's no component to say, "These are the problems, and here's what we need to make them more effective."

A few pilot studies have been conducted regarding education, but there has really been no effort to institute these programs on a wider scale.

There are about 14 million Americans in this country who acquire a sexually transmitted disease every year, and I think it's

fair to characterize the Federal public education response as virtually absent.

The CDC's approach to sexually transmitted diseases so far has really been a very traditional one. It's been based on individuals: You find an individual, you test them, you treat them, and then you try to find their sexual contacts.

The situation that we have today, though, is very clearly different than that which has existed, which the CDC follows and has followed since the introduction of antibiotics. They are different for two reasons. One is that like AIDS, there are a number of untreatable sexually transmitted diseases—I'm referring primarily to the viruses such as AIDS and herpes. The second reason is the unprecedented magnitude of the number of people who get these diseases. And I think clearly that calls for a different kind of response.

In the last fiscal year, the CDC funded only two sexually transmitted disease public education projects. One was assistance to the VD National Hotline, which the American Social Health Association now subsidizes heavily, and the second was a $12,000 continuation grant.

One of the remarkable things that have happened in the last few months is that we have made remarkable strides in our ability to educate the public about STD problems. Specifically I am referring to the fact that condom advertisements are now openly permitted on network television, that condom advertising appears in major national magazines, that safe sex messages are commonly seen in public.

The private sector and voluntary groups have brought about much of this progress, and that has been helped, certainly, by the Surgeon General's report and the report of the National Academy of Sciences.

I think the areas of education, a couple of them have been underscored fairly heavily in testimony referred to earlier. I would only like to add to those the need for education for teenagers, which has been discussed earlier, that we need to include older adults in those, and particularly health professionals.

I don't want people to forget that 2.5 million teenagers in this country every year get a sexually transmitted disease and about 1 million teenagers become pregnant. So to advocate abstinence or marital monogamy is the only preventive measures for young people is, I think, to put our heads in the sand. In fact, it is easier to change behavior than it is morality.

The second group, though, is older adults, and I don't want us to forget that it is not only the teenagers we need to get to, it is older adults or parents who not only need to know how to talk to younger people but a lot of those older people find themselves single again after years of having been married, and it is important that they not be overlooked in these messages.

The third component of education is also one that has been referred to but I think deserves a little greater attention, and that is professional education. Our efforts at professional education, I think, are one of the cornerstones which need to be examined. There was a study in the Journal of the American Medical Association a few years back in which 127 medical schools were surveyed in the United States and Canada. Of those, 54 percent had no sexu-

ally transmitted disease clinic available for teaching, 69 percent offered no clinical training in sexually transmitted diseases to medical students, and 76 percent offered no training to residents.

The report also showed that instruction in sexually transmitted diseases within schools had actually declined over the previous 15 years.

I think there is another compelling reason for public education. That is what I referred to earlier. Fourteen million people in this country every year get sexually transmitted diseases. Like AIDS, some of those, in fact, all of them can be transmitted sexually and passed on to newborns.

Syphilis in women and congenital syphilis are increasing, and you might refer to the charts which I have included with my testimony. Since 1979, cases of gonorrhea which are resistant to antibiotic have increased thirtyfold. In fact, they have increased 90 percent just in the past year. There are 4.5 million new cases of chlamydia every year, which, like gonorrhea, can lead to pelvic inflammatory disease or ectopic pregnancy.

Herpes and human papiloma viruses affect millions of women and millions of men. Approximately 110,000 women are left sterile in the country each year from sexually transmitted diseases. I believe that if we had had effective public education programs for sexually transmitted diseases in the past, we would likely have prevented at least some of those sexually transmitted diseases, and I include AIDS, in that category.

At this point I think it is clear that the Government needs to make a clear commitment to public education for AIDS as well as other sexually transmitted diseases. The private sector has set the stage, the public health leaders have provided the script, the American public awaits in the audience, the curtain is up, and at this point we are all waiting for the action to begin.

I thank you for the opportunity to express our views.

[The prepared statement of Dr. Rosenberg follows:]

National Headquarters: 260 Sheridan Avenue, Palo Alto, CA 94306 • (415) 321-5134
Regional Offices: Atlanta, GA Columbus, OH Washington, DC

Reply to: 3701 Massachusetts Avenue, N.W., Washington, DC 20016 • (202) 362-2349

TESTIMONY

BEFORE THE

SUBCOMMITTEE ON INTERGOVERNMENTAL RELATIONS

AND HUMAN RESOURCES

OF THE

HOUSE GOVERNMENT OPERATIONS COMMITTEE

by

Michael J. Rosenberg, MD, MPH

Executive Director

March 16, 1987

Mr. Chairman, my name is Michael Rosenberg, and I am Executive Director of the American Social Health Association as well as a practicing physician and researcher. The American Social Health Association is one of the oldest non-profit organizations in the country. Our programs, which focus exclusively on sexually transmitted diseases, include the National AIDS Hotline, the National VD Hotline, the Herpes Resource Center, the Sexually Transmitted Diseases Research Fund, and a variety of public and school-based education programs.

We have operated the National AIDS Hotline for two months, and with little advertising we receive an average of 800 calls each day. We have gained some insight about the public's need for AIDS information. A lack of information and a preponderance of misinformation have led to concern, some of which approaches hysteria. A strong need exists for very basic information about the disease itself—what causes it, how it is transmitted, how it can be diagnosed. People also need to know how to access services in their communities, such as where testing is available, counselling and support groups, hospice care, and other services. The Hotline can only help meet some of the needs, but it is just a drop in the ocean. Thus far, however, it is one of the few AIDS education projects funded by the federal government.

We are dismayed that six years into this epidemic the Administration's long-promised plan for AIDS education has still not materialized. The fiscal year is almost half over, but funds appropriated for AIDS education have not been spent.

2

The Centers for Disease Control's track record on public education regarding sexually transmitted diseases is a poor one. Although project grants to the states for sexually transmitted disease control include a component for public education, there is little monitoring of the projects, and no evaluation of their effectiveness. A few pilot studies have been conducted regarding education, but there has been no effort to institute these programs on a wider scale. Although 14 million Americans acquire a sexually transmitted disease each year, I think it is fair to characterize the federal public educational response as virtually absent.

CDC's approach to sexually transmitted diseases has been directed at individuals: testing them, treating them, and finding their sexual contacts. This strategy has been used since the introduction of antibiotics for the control of the classical sexually transmitted diseases, syphilis and gonorrhea. But the problems today are different and of unprecedented magnitude that sexually transmitted diseases, including AIDS, must be considered from a larger perspective. There are other sexually transmitted diseases, such as chlamydia, herpes, and human papilloma viruses, which are far more prevalent than syphilis and gonorrhea, but CDC has never initiated national education programs. In fact, in FY 1986 CDC funded only 2 sexually transmitted disease public education projects—assistance to the VD National Hotline and a $12,000 continuation grant.

We cannot cure AIDS, we can only prevent it. Education is the most important tool we possess. In the past few months remarkable strides have been made in our ability to communicate preventive messages regarding

AIDS and other sexually transmitted diseases. Condoms are openly discussed on network television; condom advertising appears in major national magazines; safe sex messages are commonly seen in public. The private sector and voluntary groups have brought about much of this progress. The Surgeon General's Report and the report of the National Academy of Sciences have supported these efforts as well as major public education initiatives.

There are three areas of education I would like to address: teenagers, older adults, and health professionals. Although we all agree we would hope teenagers delay sexual activity, the reality is that sex is occurring at younger ages and marriage occurring at later ages. Another reality is that 2.5 million teenagers get a sexually transmitted disease each year and one million become pregnant. To advocate abstinence or marital monogamy as the only preventive measures for all young people is to put our heads firmly in the sand. It is easier to change behavior than to change moralities.

Young people in high school, college, and those who do not attend school are not the only people we need to educate. Their parents, many of whom find themselves single after divorce, need to know not only how to talk to their children but need to deal with these new social realities themselves.

The third component of education I would like to stress is professional education. A study published in the Journal of the American Medical Association showed that of the 127 medical schools surveyed in the United States and Canada, 54% had no sexually transmitted disease clinic available for teaching, 69% offered no clinical training in sexually transmitted diseases to medical students, and 76% offered no training to residents. The survey also showed that instruction in sexually transmitted

diseases in medical schools has actually declined over the past fifteen years.

Finally, Mr. Chairman, there is another compelling reason for public education. Fourteen million people in this country each year get diseases which, like AIDS, are transmitted sexually and can be passed on to newborns. Syphilis in women and congenital syphilis are again increasing. Since 1979 cases of gonorrhea resistant to antibiotic have increased 30-fold, increasing 90% in just the past year. There are 4.5 million new cases of chlamydia each year, which like gonorrhea, can lead to pelvic inflammatory disease or ectopic pregnancy. Herpes and human papilloma viruses affect millions of Americans. Approximately 110,000 women are left sterile each year from sexually transmitted diseases. I believe that had effective public education programs for sexually transmitted diseases been in place, we would have had the mechanisms and expertise to initiate AIDS education and we probably would have prevented some cases of AIDS.

The government must make a clear commitment to public education for AIDS and other sexually transmitted diseases. The private sector has set the stage; public health leaders have provided the script; the American public awaits in the audience; the curtain is up; and we are all waiting for the action to begin.

Thank you, Mr. Chairman, for this opportunity to express our views.

THE NEW YORK TIMES, SATURDAY, NOVEMBER 22, 1986

Letters

AIDS: Opportunity for Wider Public Education

To the Editor:

The Surgeon General, C. Everett Koop, is to be commended for his forthright report to the nation on acquired immune deficiency syndrome ("Top Health Official Urges Frank Talks to Young on AIDS," news story Oct. 23). He is absolutely correct that our young "are not receiving information that is vital to their future health and well-being." His views were strongly reinforced by the report on AIDS research by the Institute of Medicine of the National Sciences Academy (Oct. 30). But our concern must not be limited to AIDS alone.

Had this country addressed the epidemic of sexually transmitted diseases appropriately in the past with adequate funds and support for research, prevention and control, including professional and public education, perhaps we would be better prepared to deal with AIDS. If the country had faced the problem of sexually transmitted diseases with sufficient funds and programs perhaps some cases of AIDS could even have been prevented.

At least 2.5 million American teenagers will contract a sexually transmitted disease this year. At least 50,000 young women under the age of 25 will be rendered sterile this year by sexually transmitted diseases.

The traditional public response to such diseases has been one of indifference because "no one ever dies from V.D." AIDS, however, is not the only sexually transmitted disease that kills Americans. Gonorrhea and chlamydia, diseases that infect roughly six million Americans annually, cause approximately half of the 75,000 ectopic pregnancies each year, which kill the fetus and can cause maternal death. Congenital syphilis, which is again on the rise, kills infants, as can herpes. Papilloma viruses transmitted from mother to baby can have life-threatening consequences for the baby. Papilloma viruses have also been associated with cervical cancer, which kills approximately 7,000 women each year.

Teen-age girls are at especially high risk for chlamydia, a disease which is asymptomatic in a high proportion of women, and can lead to sterility, ectopic pregnancy and can cause pneumonia and blindness in newborns.

We agree with Dr. Koop that initiatives must be begun to adequately inform the public, including youths, about AIDS. But AIDS is just the tip of the iceberg. There are 10 million new cases of sexually transmitted diseases each year. Many of those cases go untreated; others are diseases for which there is no cure. No vaccine exists for any sexually transmitted diseases except hepatitis B.

We must not lose this important opportunity to educate the public, especially young people, about the full spectrum of sexually transmitted diseases for which they might be at risk.

WENDY J. WERTHEIMER
MICHAEL J. ROSENBERG, M.D.
Washington, Nov. 1, 1986

The writers are, respectively, director of public policy, American Social Health Assn., and director of the Reproductive Epidemiology Division, Family Health International.

FIGURE 7: CONG[illegible] SYPHILIS UNDER ONE YEAR OF AGE
UNITED [illegible] ISCAL YEARS 1968-1986

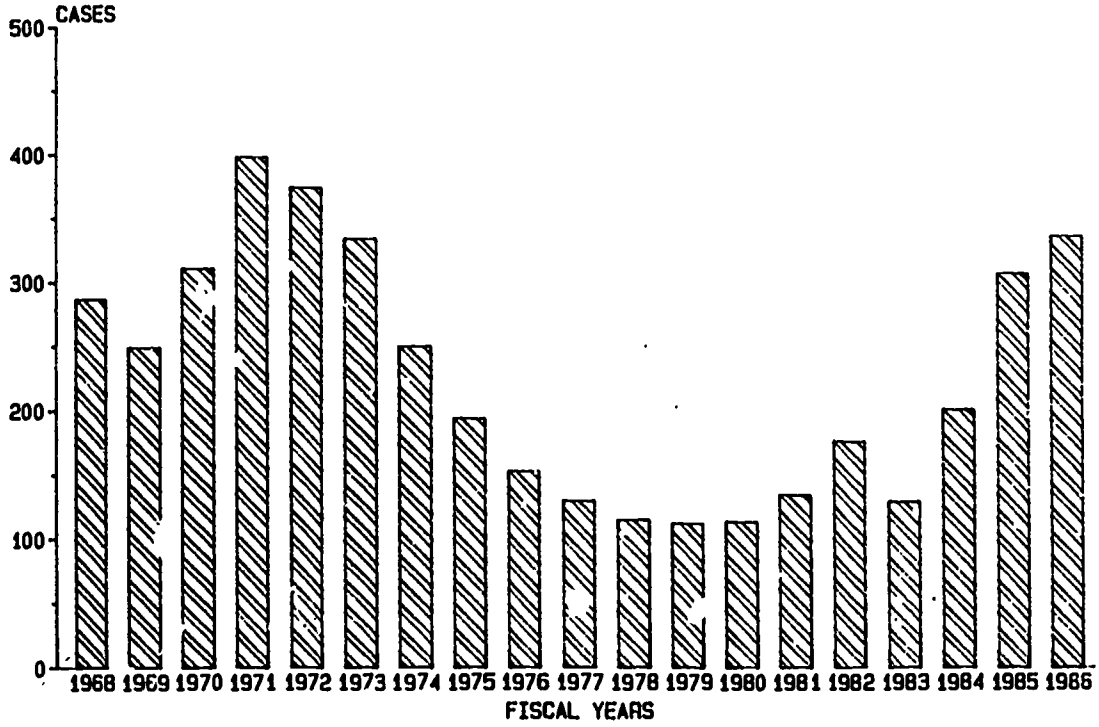
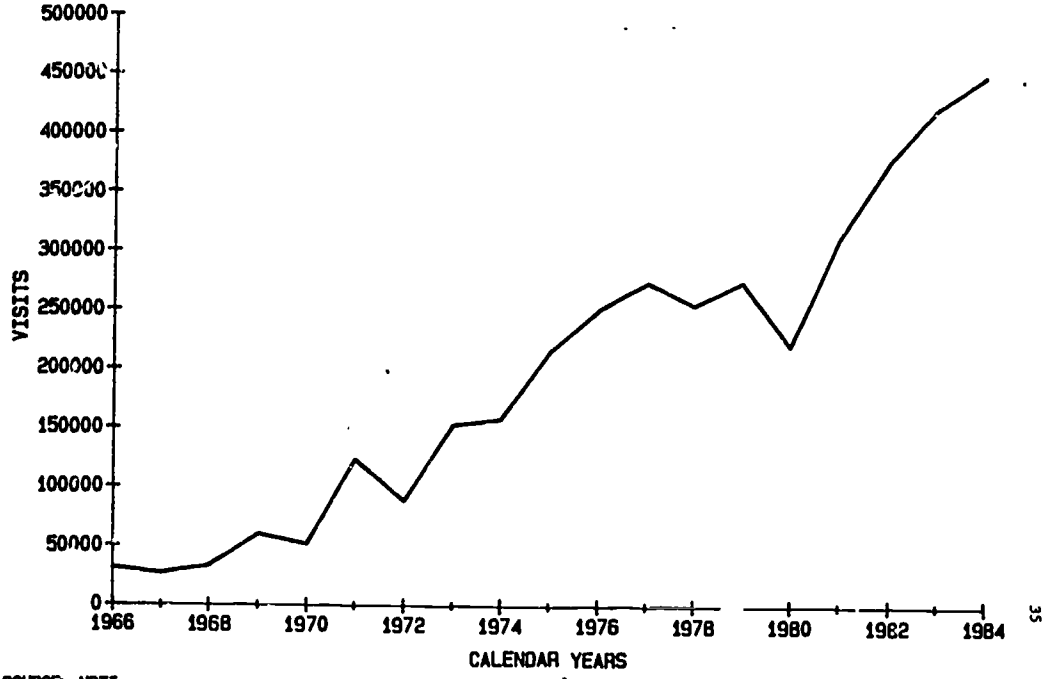


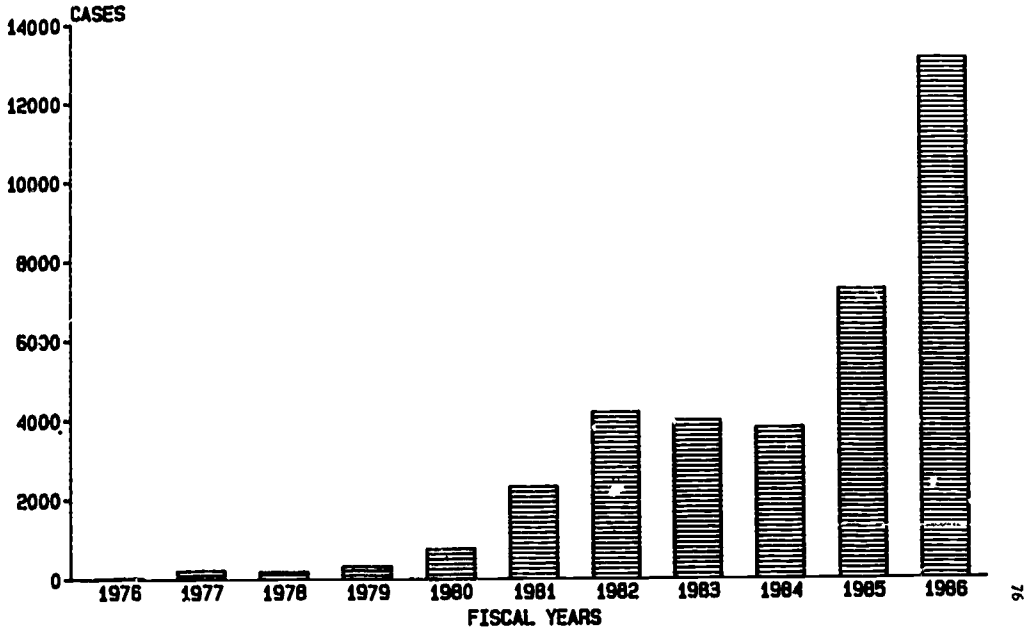
FIGURE 9: GENITAL HERPES SIMPLEX VIRUS INFECTIONS
NUMBER OF VISITS TO PRIVATE PHYSICIAN'S OFFICES
UNITED STATES, CALENDAR YEARS 1966-1984



SOURCE: NDTI

35

FIGURE 1: RESISTANT STRAINS OF GONORRHEA
UNITED STATES, FISCAL YEARS 1976 - 1986



SOURCE: CDC 79.000

Mr. WEISS. Thank you, Dr. Rosenberg. I want to thank all of you not only for your testimony but also for the tremendous work you are doing in the field.

Mr. Dunne. I understand that you brought a few of your public service announcements to show. We are going to see those now.

Mr. DUNNE. There are two sets, Mr. Chairman, one that is running currently that was produced by a television station in San Francisco along with San Francisco AIDS Foundation and is being distributed, at least in the major markets, and then a second one that was done over a year ago funded jointly by AIDS Project Los Angeles, San Francisco AIDS Foundation, and Gay Men's Health Crisis.

[Video presentation.]

Mr. DUNNE. Those are four 30-second television PSA's. There are also radio and newsprint ones. They ran in the New York City, Los Angeles, and San Francisco marketplaces.

There is a second set of 64. We are not going to show you all of them, but there will be representative spots that have been done and are now running in those marketplaces and are being distributed under the auspices of the National AIDS Network around the country.

[Video presentation.]

Mr. DUNNE. If I might, Mr. Chairman, I find it interesting that the Centers for Disease Control a few weeks ago released a national media campaign, RFP. We found it absolutely easy to get the cooperation of people like Bob Hope and the President's son, who were more than willing to come forward and do these public service announcements for us. So frankly, I think that they have created the resistance in their own head.

I think when a friend of the President and when the President's own son are willing to come forward and to do these public service announcements for community-based organizations, I can't imagine that they would turn down a request from the Department of Health and Human Services.

Mr. WEISS. Will public service announcements be enough? What are your thoughts on the mass media campaign?

Mr. DUNNE. No. I think in response to that, I have the same answer that Dr. Joseph from New York City gave, which is that it is one piece of a very large and very complex mosaic. It certainly ought to include public service announcements, and we ought not to have to depend on them being contributed by the networks and by the stations; we ought to be prepared to buy time for them. But it certainly also has to include education that takes place in the schools, at the workplace, at colleges and universities, in shooting galleries, indeed wherever we can find an audience that needs either targeted or general education.

In New York City, for example, the Gay Men's Health Crisis is distributing millions of pieces of literature through the public library system. I find it curious that we are doing that without any Government support whatsoever, although most people would think of libraries as a kind of a public service, and it certainly is a wonderful place to engage people and to give them information.

Mr. WEISS. Approximately a year and a half ago, your organization was awarded a grant of $240,000 from the Centers for Disease

Control, which was subsequently held up due to Federal concern with the explicit sexual content of the printed and video materials which would be developed. Would you please describe what occurred and what was the resolution?

Mr. DUNNE. Yes. It was in August 1985 that we submitted a proposal along with a number of other organizations around the country, and it was announced shortly after, that the Gay Men's Health Crisis proposal had been approved but that the funding would be held up. We went, then, from August until April of the following year before we received additional information. Obviously, there were a lot of phone calls back and forth in between, but we never really got a response.

Finally we did get a response and there were essentially two sets of conditions. One was that any graphical material we used had to be such that it would not be offensive to the general population. The materials we were preparing were not intended for the general population. They were intended for a specific population.

The second condition was that we have an advisory group to review all of our materials and approve it before it was used. Now, previously, we had already put together an advisory group because that, frankly, makes sense, but there was an additional element to that, and that was that once again the members of that advisory group not come predominantly from the community for whom the educational message is intended. In essence, it would be the equivalent of putting together a program to educate black Americans and saying that a majority of your advisory group must be white Americans. What they said to us in essence was that you need to have an advisory group but it cannot be made up of gay men, it must consist predominantly of nongay people.

So all of these things slowed down our progress and became elements that we had to work around.

Mr. WEISS. Thank you very much.

Mr. Gerald, up to this time what has been the Federal response to the AIDS epidemic occurring among black and Hispanic Americans?

Mr. GERALD. I would say practically nothing. The problem is that there has been no overall coordinated program. There are bits and pieces, a project here, a project there. Our survey of our community-based organizations show that money has trickled down, perhaps, through some of the States, and you can uncover a piece of literature here, and a video elsewhere.

The Government spoke earlier today about specific components of NIMH programs, NIDA programs, and HRSA programs, but basically the Government is just not up to the work that we need to get done in this country as far as educating the minority community.

The results have been that there has been very little minority input into the design or control of these projects. I think that the analogy that Mr. Dunne just made about community input into these programs is appropriate—it is even worse when it comes to minorities. There has been a lower priority for such programs because of the little funding that has gone out to the community for education, little to no staffing for targeted programs, and very limited materials.

We get calls from community-based service providers across the country asking us for materials that have been proven to be effective. They tell us that the materials that they have on hand are not adequate in serving the needs of minority communities or to get the word across.

The vernacular or language of the community is ignored. Literal translation into Spanish or other languages is made, and that is, of course, inappropriate. As a result, there is a perpetuation of myths and misinformation.

There is use of more general materials, and programs in minority communities. The agencies have to scramble for funds in the private sector, and of course, again here, there is a lower priority in terms of the funds that are made available.

Mr. WEISS. What do you think are the specific types of programs that have a chance of reaching that segment of the minority community which seems to be most at risk, that is, the IV drug users?

Mr. GERALD. I first want to say that while it is true that the IV drug use does exacerbate the problem in the minority community, minorities are disproportionately affected in terms of all risk groups, and that there are geographic differences. Take this local area of the District of Columbia. It is different than, let's say, Baltimore, or Newark, or New York. Still, when we talk about the transmission of the HIV virus in this particular area, for example, bisexual and gay men still account for the majority of the black cases.

So that there is no one model program in the ideal sense that will work in any community. What we need to have is funding to minority organizations that are set up and are being set up across the country to respond to this issue. We need to have within local community-based AIDS service providers more staffing of these kinds of targeted programs—dollars.

Mr. WEISS. Thank you.

Dr. Rosenberg, you said in your testimony that CDC's approach to handling sexually transmitted disease has been testing, treating, and finding sexual contacts. Obviously, you cannot treat and cure AIDS. However, does it seem that CDC is approaching AIDS with testing and tracing as if it were curable syphilis or gonorrhea?

Dr. ROSENBERG. I'm sorry. I missed the last part of that.

Mr. WEISS. Is it your impression that CDC is approaching AIDS with testing and tracing as if it were curable sexually transmitted disease?

Dr. ROSENBERG. I think the limited efforts that they have made have been in that direction. The initial suggestion of contact tracing was offered by the CDC in a conference a few weeks ago about mandatory testing. I think that has been—at least if that was a suggestion, I think that has been largely overruled by the public health community.

I think the problem is really that they are not doing much on AIDS right now. I think that they do recognize that contact tracing is probably not the most effective means of getting at AIDS, but at the same time, I think that there are fairly clearly other means—I am talking about education—that are, and those have yet to be instituted.

Mr. WEISS. On February 11 of this year, Attorney General Meese, as Chairman of the Domestic Policy Council, issued a memorandum which stated that any health information provided by the Federal Government that might be used in schools should teach that children should not engage in sex. In light of your knowledge of STD rates in adolescents, is this a realistic position? Is it sufficient?

Dr. ROSENBERG. I certainly think it unrealistic to believe that solely that approach will work. I think it is a reasonable starting point, but at the same time, you cannot write off the other people who choose not to subscribe to that viewpoint.

Mr. WEISS. Mr. Swales, Dr. Windom's testimony indicates that the Public Health Service plans to reach IV drug abusers, their sex partners and other close associates with radio, television and print media techniques. In your experience, how effective will this be in educating and changing behavior?

Mr. SWALES. With all respect to Dr. Windom, I think that the effect will be moderate, at best. This population is affected by a range of factors which make it very difficult to reach them because they are not reliable readers of the Washington Times, nor are they reliable viewers of channel 4, nor are they reliable, in many instances, anything, and therein may lie one of the problems.

As I said in my earlier testimony, which might have sounded like a smart remark, these people move fast and travel light. If we are going to conduct information to them, we had better be prepared to move fast and travel light, and we had better be prepared to pack a wallop with the information that we intend to give them. That needs to be in the shape that those people are accustomed to finding their information: the language, the sounds, the smells, the environment, the whole 9 yards.

One of the problems as I see it, quite obviously, is—and as I observed, largely these people are people of color—it is interesting to note that people of color start to occur down here at the functional levels. When we were up at the policy and planning levels earlier this morning, I did not see us. I think that may have something to do with the way information is put into the system from the Government's perspective.

One of the ways we like to look at ourselves at Sunnye Sherman is as a proactive star in a galaxy of reactivity. We cannot afford, from where I sit, to take the time or to be boggled down in the policy development and the planning. There is work to be done. We operate basically on the motto of "Lead me, follow me, or get out of my way; there is work to be done."

Mr. WEISS. What role might the Federal Government provide in helping to educate high-risk groups such as the drug addicts and street people that you have described?

Mr. SWALES. I missed the very early part of your question.

Mr. WEISS. What do you think the Federal Government could appropriately do to provide help to those high-risk groups you are working with?

Mr. SWALES. To begin with, the people of the Federal Government could provide leadership that is obviously outspoken, forthright leadership. While it was music to our ears to hear Dr. Koop respond in October, and a very effective response it was, Dr. Koop

is an employee of the leadership that we have elected and set in place and designed as an emblem of what we represent.

Second, where I am in the business of delivering information, I have to deliver information on the street presently with two paid teams of outreach workers, I would love to have 22 teams out there in all sectors. The concept of volunterism isn't very prevalent in the population of people that I have to reach and draw from to give education to that population: Prostitutes, IV substance abusers. They need to be paid. That is the system that they operate on. They need to be paid something akin to respectable wages. We presently pay ours $7.50 an hour. The Government or somebody could provide funding for that.

We hear all manner of people who can—I heard one man in marketing boast about how he could "sell two milking machines to a guy who only had one cow, and then take the cow in downpayment." Where are those marketing skills when it comes to marketing health education and the preservation of life in the face of a threat from AIDS?

Somebody needs to do the research around the issues of communication. The majority group has a responsibility here, since it controls the resources, to effectively learn how to communicate with the minority group because the minority groups, whether they be abusers, people of color, sexual minorities, are a part of the whole society.

Mr. WEISS. That's good. I thank you very much.

Within the context and as a followup to that last response, have you seen anything by way of public education or mass education efforts which has reflected the increased breakout of the disease from the prime risk areas? Mr. Dunne, Dr. Rosenberg, either of you.

Mr. DUNNE. I wish I could say I thought there was, but I'm afraid the news is discouraging. NBC commissioned a poll in January 1987, and among the questions that they asked is, "Since you became aware of AIDS, have you changed your sexual behavior in any way?" They asked that question in January 1986 and they asked it again in January 1987, and only 7 percent of the respondents indicated that yes, they had changed their sexual behavior. I would hazard a guess that probably the majority of those 7 percent are gay or bisexual men, so it is clear to me that the message has not gotten to heterosexuals that they are at risk, and we have certainly seen evidence in New York and other places where we have seen a dramatic decline in the gonorrhea rate for, again, gay and bisexual men, but during that same period of time, it has either stayed the same or risen somewhat for heterosexual men and women.

Mr. WEISS. Dr. Rosenberg.

Dr. ROSENBERG. By way of agreeing with that, I think that the calls that we get for the AIDS hotline, for example, are predominantly from heterosexuals. I think that, unlike the statistics for the gay hotline that we heard earlier, I think that when people perceive themselves to be at high risk is when they go ahead and call in, and largely we have not impressed upon the straight community that AIDS is a disease for which they are at risk as well.

Mr. GERALD. From the perspective of minorities, I am extremely concerned. I was just in the State of Alabama 2 weeks ago, and I got information that 40 percent of the people with AIDS in the State of Alabama are people of color. You have the States of Connecticut, the District, Florida, Maryland, New Jersey, New York—all of these States—reporting that over 50 percent of their cases are people of color.

You have the States of Michigan, North Carolina, Pennsylvania reporting that more than 40 percent of their people with AIDS are people of color. And again, in the States of Illinois, Delaware, Louisiana, Virginia, more than 30 percent of their cases of AIDS occur among people of color.

And again, there is a myth out there. There is a perception that people are not at risk and that those at risk are confined to New York and San Francisco. I think that this reinforces the real need for doing an effective and coordinated national campaign.

Mr. WEISS. I want to thank all of you very much for your testimony because I think it underscores the tremendous gap that is out there and the tremendous gap between what is suggested that the administration or the Federal Government has been doing and the reality of what, in fact, is happening.

Today we have reviewed what is being done to inform and educate the American people on how to protect themselves and others from AIDS. We have heard about the creative work and the dedicated workers trying to teach people, including San Francisco youth, New York City drug users, Oregon migrant workers, the alienated in Washington, DC, and gay and bisexual men in the New York metropolitan area.

We applaud these efforts and hope that city and State agencies and organizations around the country will follow their lead. However, what has been done up to now has been done with little leadership, output or funding from the Federal Government. The Federal response in this crucial area of the fight against AIDS has been slow, limited, and ultimately impotent. How many more people must die before the administration takes heed and something really gets done?

Public health experts estimate that 74,000 new cases of AIDS will be diagnosed in 1991 alone. Of these, 37,000, or half, are people already infected with the AIDS virus. The other 37,000 are presently uninfected. If a massive education campaign against AIDS began this afternoon, many of these people and their family and friends could be spared the suffering and tragedy of AIDS.

Unhappily and unfortunately, we do not see the beginning of that massive effort this afternoon. We are pleased a long-delayed superplan has finally been signed off on and released. However, we have reviewed the various components of the plan this morning and early this afternoon with the administration people. Tragically, it seems that many of the components of this plan are matters which have been talked about for years and barely implemented.

Hardly any of these components are ready to go into effect before another 6 or 9 months or longer. There is a desperate need for a sense of urgency. We hope that today's hearing may have helped in some small way to create a greater sense of urgency within the Federal Government.

We thank all of our witnesses very much for their participation and all of their work.

The meeting of the subcommittee is now adjourned subject to the call of the Chair.

[Whereupon, at 2:45 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

APPENDIXES

APPENDIX 1.—DOCUMENTS REFERRED TO IN THE RECORD

SECTION A — OMB No. 0990-0115

9 AWARD /CONTRACT | 1. THIS CONTRACT IS A RATED ORDER UNDER DPAS (15 CFR 350) | RATING | PAGE OF PAGES 1 | 2

2. CONTRACT (Proc. Inst. Ident.) NO. | 3. EFFECTIVE DATE: September 26, 1986 | 4. REQUISITION/PURCHASE REQUEST/PROJECT NO.: NIDA CONTRACT NO. 271-86-8408

5. ISSUED BY — CODE

Small Business Administration
Washington District Office
1111 18th Street, N.W., 6th Floor
Washington, D.C. 20036

6. ADMINISTERED BY (If other than Item 5) — CODE

National Institute on Drug Abuse
Contracts Management Branch, OA
5600 Fishers Lane, PKLN Bldg., Room 10-49
Rockville, Maryland 20857

7. NAME AND ADDRESS OF CONTRACTOR (No., street, city, county, State and ZIP Code)

PROFESSIONAL MANAGEMENT ASSOCIATES, INC.
15825 Shady Grove Road, Suite 190
Rockville, Maryland 20850

8. DELIVERY: ☐ FOB ORIGIN ☐ OTHER (See below)

9. DISCOUNT FOR PROMPT PAYMENT: N/A

10. SUBMIT INVOICES (4 copies unless otherwise specified) TO THE ADDRESS SHOWN IN: BLOCK 6 (6 copies)

CODE — FACILITY CODE

11. SHIP TO/MARK FOR — CODE: SEE SECTION F

12. PAYMENT WILL BE MADE BY — CODE:
Accounting & Finance Section
Fiscal Branch, OFM, HRSA - Room 16-36
5600 Fishers Lane. Rockville, MD 20857

13. AUTHORITY FOR USING OTHER THAN FULL AND OPEN COMPETITION: ☐ 10 U.S.C. 2304(c)( ) ☒ 41 U.S.C. 253(c)(5) — 41 USC 627(a)

14. ACCOUNTING AND APPROPRIATION DATA: SEE SECTION G

15A. ITEM NO.	15B. SUPPLIES/SERVICES	15C. QUANTITY	15D. UNIT	15E. UNIT PRICE	15F. AMOUNT
1.	AIDS and Drug Education - Market Research and Materials Development CONTRACT TYPE: Cost-Plus-Fixed-Fee EXPIRATION DATE: September 25, 1987 OBLIGATED AMOUNT: $165,786				

15G. TOTAL AMOUNT OF CONTRACT ▶ $165,786

16. TABLE OF CONTENTS

(X)	SEC.	DESCRIPTION	PAGE(S)
		PART I — THE SCHEDULE	
X	A	SOLICITATION/CONTRACT FORM	1-2
X	B	SUPPLIES OR SERVICES AND PRICES/COSTS	3-5
X	C	DESCRIPTION/SPECS./WORK STATEMENT	6-13
	D	PACKAGING AND MARKING	
X	E	INSPECTION AND ACCEPTANCE	14
X	F	DELIVERIES OR PERFORMANCE	15-16
X	G	CONTRACT ADMINISTRATION DATA	17-19
X	H	SPECIAL CONTRACT REQUIREMENTS	20
		PART II — CONTRACT CLAUSES	
X	I	CONTRACT CLAUSES	21-23
		PART III — LIST OF DOCUMENTS, EXHIBITS AND OTHER ATTACH.	
X	J	LIST OF ATTACHMENTS	24
		PART IV — REPRESENTATIONS AND INSTRUCTIONS	
X	K	REPRESENTATIONS, CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS	25
	L	INSTRS., CONDS., AND NOTICES TO OFFERORS	
	M	EVALUATION FACTORS FOR AWARD	

CONTRACTING OFFICER WILL COMPLETE ITEM 17 OR 18 AS APPLICABLE

17. ☒ CONTRACTOR'S NEGOTIATED AGREEMENT (Contractor is required to sign this document and return ___ copies to issuing office.) Contractor agrees to furnish and deliver all items or perform all the services set forth or otherwise identified above and on any continuation sheets for the consideration stated herein. The rights and obligations of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, if any, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (Attachments are listed herein.)

18. ☐ AWARD (Contractor is not required to sign this document.) Your offer on Solicitation Number ___, including the additions or changes made by you which additions or changes are set forth in full above, is hereby accepted as to the items listed above and on any continuation sheets. This award consummates the contract which consists of the following documents: (a) the Government's solicitation and your offer, and (b) this award/contract. No further contractual document is necessary.

19A. NAME AND TITLE OF SIGNER (Type or print)

20A. NAME OF CONTRACTING OFFICER

19B. NAME OF CONTRACTOR	19C. DATE SIGNED	20B. UNITED STATES OF AMERICA	20C. DATE SIGNED
BY (Signature of person authorized to sign)		BY (Signature of Contracting Officer)	

NSN 7540-01-152-8069 — 26-107 — STANDARD FORM 26 (REV. 4-85) Prescribed by GSA FAR (48 CFR) 53.214(a) — PREVIOUS EDITION UNUSABLE

(193)

SPECIAL 8(a) SUBCONTRACT CONDITIONS (APR 1984)

(a) The Small Business Administration (SBA) has entered into Contract No. 271-86-8408 with the National Institute on Drug Abuse to furnish the supplies or services as described therein. A copy of the contract is attached hereto and made a part hereof.

(b) Professional Management Associates, Inc. hereafter referred to as the subcontractor, agrees and acknowledges as follows:

(1) That he will, for and on behalf of the SBA, fulfill and perform all of the requirements of Contract No. 271-86-8408 for the consideration stated herein and that he has read and is familiar with each and every part of the contract.

(2) That the SBA has delegated responsibility for the administration of the subcontract to the National Institute on Drug Abuse with complete authority to take any action on behalf of the Government under the terms and conditions of this subcontract.

(3) That he will not subcontract the performance of any of the requirements of this subcontract to any lower tier subcontractor without the prior written approval of the SBA and the designated Contracting Officer of the National Institute on Drug Abuse.

(c) Payments including any progress payments under this subcontract will be made directly to the subcontractor by the NIDA.

SECTION A

OMB NO. 0990-0115

AWARD/CONTRACT	1. THIS CONTRACT IS A RATED ORDER UNDER DPAS (15 CFR 350)	RATING	PAGE OF PAGES 1 | 25
2. CONTRACT (Proc. Inst. Ident.) NO. 271-86-8408	3. EFFECTIVE DATE September 26, 1986	4. REQUISITION/PURCHASE REQUEST/PROJECT NO.	

5. ISSUED BY — CODE

National Institute on Drug Abuse
Contracts Management Branch, OA
5600 Fishers Lane, PKLN Bldg., Room 10-49
Rockville, Maryland 20857

6. ADMINISTERED BY (If other than Item 5) — CODE

7. NAME AND ADDRESS OF CONTRACTOR (No., street, city, county, State and ZIP Code)

SMALL BUSINESS ADMINISTRATION
Washington District Office
1111 18th Street, N.W., 6th Floor
Washington, D.C. 20036

8. DELIVERY
☐ FOB ORIGIN ☐ OTHER (See below)

9. DISCOUNT FOR PROMPT PAYMENT
N/A

10. SUBMIT INVOICES (4 copies unless otherwise specified) TO THE ADDRESS SHOWN IN ▶ BLOCK 5 (6 copies)

CODE — FACILITY CODE

11. SHIP TO/MARK FOR — CODE
SEE SECTION F

12. PAYMENT WILL BE MADE BY — CODE
Accounting & Finance Section
Fiscal Branch, OFM, HRSA - Room 16-36
5600 Fishers Lane, Rockville, MD 20857

13. AUTHORITY FOR USING OTHER THAN FULL AND OPEN COMPETITION:
☐ 10 U.S.C. 2304(c)( ) ☒ 41 U.S.C. 253(c)(5)
15 USC 637(a)

14. ACCOUNTING AND APPROPRIATION DATA
SEE SECTION G

15A. ITEM NO.	15B. SUPPLIES/SERVICES	15C. QUANTITY	15D. UNIT	15E. UNIT PRICE	15F. AMOUNT
1.	AIDS and Drug Education - Market Research and Materials Development CONTRACT TYPE: Cost-Plus-Fixed-Fee EXPIRATION DATE: September 25, 1987 OBLIGATED AMOUNT: $165,786				

15G. TOTAL AMOUNT OF CONTRACT ▶ $165,786

16. TABLE OF CONTENTS

(X)	SEC.	DESCRIPTION	PAGE(S)	(X)	SEC.	DESCRIPTION	PAGE(S)
		PART I — THE SCHEDULE				PART II — CONTRACT CLAUSES	
X	A	SOLICITATION/CONTRACT FORM	1-2	X	I	CONTRACT CLAUSES	21-23
X	B	SUPPLIES OR SERVICES AND PRICES/COSTS	3-5			PART III — LIST OF DOCUMENTS, EXHIBITS AND OTHER ATTACH.	
X	C	DESCRIPTION/SPECS./WORK STATEMENT	6-13	X	J	LIST OF ATTACHMENTS	24
	D	PACKAGING AND MARKING				PART IV — REPRESENTATIONS AND INSTRUCTIONS	
X	E	INSPECTION AND ACCEPTANCE	14	X	K	REPRESENTATIONS, CERTIFICATIONS AND OTHER STATEMENTS OF OFFERORS	25
X	F	DELIVERIES OR PERFORMANCE	15-16		L	INSTRS., CONDS., AND NOTICES TO OFFERORS	
X	G	CONTRACT ADMINISTRATION DATA	17-19		M	EVALUATION FACTORS FOR AWARD	
X	H	SPECIAL CONTRACT REQUIREMENTS	20				

CONTRACTING OFFICER WILL COMPLETE ITEM 17 OR 18 AS APPLICABLE

17. ☒ CONTRACTOR'S NEGOTIATED AGREEMENT (Contractor is required to sign this document and return 6 copies to issuing office.) Contractor agrees to furnish and deliver all items or perform all the services set forth or otherwise identified above and on any continuation sheets for the consideration stated herein. The rights and obligations of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, if any, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (Attachments are listed herein.)

18. ☐ AWARD (Contractor is not required to sign this document.) Your offer on Solicitation Number ____ including the additions or changes made by you which additions or changes are set forth in full above, is hereby accepted as to the items listed above and on any continuation sheets. This award consummates the contract which consists of the following documents: (a) the Government's solicitation and your offer, and (b) this award/contract. No further contractual document is necessary.

19A. NAME AND TITLE OF SIGNER (Type or print)

20A. NAME OF CONTRACTING OFFICER
Robert L. David, Contracting Officer
Chief, Contracts Management Branch, OA
National Institute on Drug Abuse

19B. NAME OF CONTRACTOR — 19C. DATE SIGNED
BY _____ (Signature of person authorized to sign)

20B. UNITED STATES OF AMERICA — 20C. DATE SIGNED
BY _____ (Signature of Contracting Officer) SEP 26 1986

NSN 7540-01-152-8069 — 26-107 — STANDARD FORM 26 (REV. 4-85)
PREVIOUS EDITION UNUSABLE — Prescribed by GSA

SPECIAL 8(a) CONTRACT CONDITIONS (APR 1984)

The Small Business Administration (SBA) agrees to the following:

(a) To furnish the supplies or services set forth in this contract according to the specifications and the terms and conditions hereof by subcontracting with an eligible concern pursuant to the provisions of section 8(a) of the Small Business Act, as amended (15 USC 637(a)).

(b) That in the event SBA does not award a subcontract for all or a part of the work hereunder, this contract may be terminated either in whole or in part without cost to either party.

(c) Delegates to the National Institute on Drug Abuse (NIDA) the responsibility for administering the subcontract to be awarded hereunder with complete authority to take any action on behalf of the Government under the terms and conditions of the subcontract; provided, however, that National Institute on Drug Abuse shall give advance notice to the SBA before it issues a final notice terminating the right of a subcontractor to proceed with further performance, either in whole or in part, under the subcontract for default or for the convenience of the Government.

(d) That payments to be made under any subcontract awarded under this contract will be made directly to the subcontractor by the National Institute on Drug Abuse.

(e) That the subcontractor awarded a subcontract hereunder shall have the right of appeal from the decisions of the Contracting Officer cognizable under the "Disputes" clause of said subcontract.

SECTION B

B.1 To conduct market research to ascertain best means of reaching target audience of IV drug users and close associates with messages about AIDS and drug use, and to develop, produce and distribute materials to target audience.

A complete description of the required services is contained in Section C.

B.2 Consideration

This is an fully-funded, 1 year, cost-reimbursement completion type contract.

a. Estimated Cost and Fixed Fee (APR 1984)

It is estimated that the total cost to the Government for full performance of this contract will be $165,786, of which the sum of $155,668 represents the estimated costs and $10,118 represents the fixed fee.

b. Payment

For the performance of this contract the Government shall pay to the Contractor:

(1) The cost thereof determined by the Contracting Officer to be allowable in accordance with Clause FAR 52.216-7, "Allowable Cost and Payment," (APR 1984).

(2) The fixed fee shall be payable in accordance with Clause FAR 52.216-8, "Fixed Fee" (APR 1984). The fixed fee is subject to an equitable reduction in the event the requirements of Section F are not satisfactorily completed.

c. Indirect Cost

(1) The allowable indirect costs under this contract shall be established in accordance with the procedures set forth in Clause FAR 52.216-7 "Allowable Cost and Payment" (APR 1984).

(2) Unless otherwise specified by amendment of the contract, during the first 90 days of this contract indirect costs shall be reimbursed at the following rates:

Type	Billing Rate
*Fringe Benefits	25.45% (c)
*Overhead	50.00% (a)
*General & Administration	14.00% (b)

Bases:

(a) Direct salaries and wages, oid and proposal salaries, and including applicable fringe benefits

(b) Total expenses less oid and proposal and less fringe benefits associated with oid and proposal.

(c) Direct salaries, overmead salaries, B&P salaries, and G&A salaries.

*The above rates are approved for billing purposes only.

Within the first 30 days of this contract the Contractor agrees to submit an indirect cost rate proposal to the Financial Advisory Services Officer, ALAMEDA with the information required to negotiate provisional indirect cost rates. The Government will enter into negotiations with the Contractor for the purpose of establishing provisional indirect cost rates.

(3) Notwithstanding the foregoing, the Contractor shall, in the case of an upward adjustment of the provisional rates, comply with the requirements of Clause FAR 52.232-20, "Limitation of Cost" (APR 1984) of the contract, and provide timely notification to the Contracting Officer, where such increase in costs causes operation of that clause.

8.3 PROVISIONS APPLICABLE TO DIRECT COSTS

a. Items Unallowable Unless Otherwise Authorized

Notwithstanding the clauses FAR 52.216-07, "Allowable Cost and Payment" (April 1984), FAR 52.244-02, "Subcontracts Under Cost-Reimbursement and Letter Contracts" (APR 1984), and HHSAR 352.247-70, "Foreign Travel" (APR 1984), unless authorized in writing by the Contracting Officer, the costs of the following items or activities shall be unallowable as direct costs:

(1) Any fee or other payment for consultation in excess of $150/day/consultant or where the services of any consultant will exceed ten days during the period of this contract.

(2) Acquisition, by purchase or lease, of any interest in real property;

(3) Special rearrangement or alteration of facilities;

(4) Purchase or lease of any item of general purpose office furniture or office equipment regardless of dollar value (General purpose office equipment is defined as any items of

personal property which are usable for purposes other than research, such as office equipment and furnishings, pocket calculators, etc.);

(5) Purchase or rental of any items of personal property having a unit value of $200 or more;

(6) Travel to attend general scientific meetings;

(7) Foreign travel.

b. Travel Costs

Travel expenses incurred by the Contractor exclusively in direct performance of this contract shall not exceed:

1. Cost of air travel by most direct route, using "air coach" or "air tourist" (less than first class) unless it is clearly unreasonable or impracticable (e.g., not available for reasons other than avoidable delay in making reservations, would require circuitous routing or entail additional expenses offsetting the savings on fare, or would not make necessary connections); or

2. Cost of rail travel by most direct route, first class with lower berth or nearest equivalent; or

3. Cost of travel by privately owned automobile. However, reimbursement for transportation by this means shall not exceed the cost of 1. or 2. above, whichever is less.

4. The cost of travel by privately owned automobiles, and subsistence costs shall be reimbursed pursuant to the Government travel policy in effect at the time such costs are incurred. The Contractor shall cite in any claim for reimbursement of travel costs the source of the rates used.

c. Any costs incurred prior to the effective date of this contract shall be considered unallowable and not reimbursable under this contract.

SECTION C
Description/Specification/Work Statement

A. Background

AIDS (Acquired Immune Deficiency Syndrome) is a condition characterized by a defect in the body's natural immunity to disease. The causative agent of AIDS is the human T-lymphotrophic virus or HTLV-III. The virus is transmitted principally by sexual contact with infected individuals and by the shared use of intravenous needles and/or other drug-related paraphernalia. It can also be spread from mother to child before, during, or shortly after birth and through the direct transfusion of contaminated blood or blood products. People with AIDS are vulnerable to severe illnesses which are not typically a threat to anyone whose immune system is intact. Eighty percent of all AIDS patients die within two years of diagnosis. No patient is known to have recovered from the disease.

The Centers for Disease Control report over 20,000 cases of AIDS (May, 1986). Moreover, it has been estimated that there may be one million people in the U.S. who have been infected with AIDS virus, but are currently asymptomatic. Individuals with a history of intravenous drug use make up approximately 27 percent of the total number of AIDS cases. HTLV-III-positive drug users are disproportionately responsible for heterosexual transmission of the disease. The vast majority of known cases of adult heterosexually-transmitted AIDS cases are also traceable to IV drug users. Concern with containing the spread of AIDS within and from the IV drug-using community is obviously well founded. Pediatric cases represent less than 1 1/2 percent of the total AIDS cases; however, 52 percent of these children are the offspring of IV drug users.

B. Objective

The objective of this contract is first to conduct market research in order to ascertain the best means of reaching the target audience of intravenous (IV) drug users, their sex partners, and other close associates, such as family members, with messages about AIDS and drug use. Second, in accordance with the results of the research, the contractor will develop, produce, and distribute appropriate materials which will carry the messages to the target audience in such a way as to halt or slow the spread of AIDS. The Statement of Work specifies radio and print materials for technical approach and pricing purposes only. The market research will determine the specific materials to be developed. The contract thus comprises a Market Research part and a Materials Development part.

The basic ideas to be brought to the target audience are intended to provide intervention at different stages of drug use: first, to get users to seek treatment for drug use; and second, if treatment is not possible, to get users to avoid sharing needles. As part of the messages, the target audience will be encouraged to call a NIDA "800" telephone number for referral to drug abuse treatment programs in their local community.

NIDA is targetting ten (10) cities in its AIDS and Drugs Public Education Program where there are large populations of intravenous heroin users. NIDA will not be targetting those areas already heavily involved in public education activities, such as New York, New Jersey, San Francisco, and Los Angeles, but will be working with representatives of these programs to capitalize on their successful approaches to share with other cities who are in the incipient stages of planning their programs. A preliminary list of proposed target cities includes: Atlanta, Boston, Chicago, Cleveland, Detroit, Houston, Dallas, Miami, St. Louis, and Washington/Baltimore. Most target audience members are Black inner-city IV heroin users. The exact make-up of the target audience varies somewhat from city-to-city.

II. Services to be Performed

Independently, and not as an agent of the Government, the contractor shall furnish all the necessary labor, materials and facilities to mount a public service educational program which shall reflect the basic standards of integrity, public acceptance and general appropriateness by which public service educational programs are judged in determining their fitness for national and local media support.

Specifically, the contractor shall perform and complete the following tasks:

Task A. Program Orientation; Market Research

Week 1

1. The Contractor shall meet with the Project Officer and other Government personnel in order to discuss and clarify the purpose of the contract, and to orient the contractor in general on the relationship between AIDS and IV drug use, as it relates to the contract.

Week 3

2. The Contractor shall perform background research, in order to learn what is known about education of the target audience on AIDS. The Project Officer shall provide the Contractor with relevant NIDA research reports on the demographics of the target audience as well as news clippings and other resources on the AIDS and IV drug use problem. The Contractor shall consult with the National Association of Broadcasters in Washington, D.C., to learn as far as possible what radio stations would be likely to reach the target audience. The Contractor shall also consult with radio stations

that have been determined to be likely channels of approach to the target audience, in order to explore what types of AIDS-related messages would be in acceptable taste for broadcast. The contractor shall talk to drug treatment personnel in the 10 target cities to find out whether they know of radio stations which might reach the target audience. The Contractor shall prepare a preliminary report, based on its findings, to serve as the basis of discussion by the work group to be convened in Subtask 4, below.

3. The Contractor shall organize and convene two meetings at geographically diverse sites to be determined by the Project Officer. The participants shall consist of members of the target audience, and members of agencies (such as street workers) who deal with them. In order to encourage full participation, a $10 honorarium shall be paid to each participant of the target audience attending the meeting. There shall be no more than nine participants, all to be recruited locally (no travel or per diem to be paid), plus necessary contractor staff. The participants shall explore their media habits -- the ways in which they acquire information through press, radio, and personal contact - and the ways in which AIDS messages could best reach them. The findings from the two meetings shall be incorporated into the preliminary report prepared in Subtask 2, above.

4. The Contractor shall organize and convene a work group of up to 20 people, to meet for one day at the Parklawn Building, Rockville, Maryland. The work group shall comprise experts from state and local organizations on AIDS and IV drug use (the Project Officer shall provide their names and addresses to the Contractor); experts on radio and print as related to the target audience; members of Government agencies (e.g., the Office of Public Affairs/Public Health Service, and the Centers for Disease Control) who have worked with AIDS public education and/or IV drug users (names and addresses to be furnished by the Government to the Contractor); and appropriate personnel of NIDA and the Contractor. The work group shall consider in detail the media habits of the target audience in the target cities; past successes and failures in reaching these audiences with AIDS messages; conventional and unconventional means of reaching the target audiences; formats and approaches for radio and print materials; and any other topics to promote the objectives of the contract. The Contractor shall pay for 10 attendees, honoraria at $125, travel and per diem and make all travel arrangements.

5. The Contractor shall summarize the findings of the work group meeting and combine the information with the preliminary report for a final market research report. This report shall be used as the basis for determining the specific materials to be developed in Task 8, Materials Development.

Task 8. Materials Development

In accordance with the results of the market research, NIDA in consultation with the contractor will determine the specific materials to be developed. All materials to be developed will need to reinforce the themes of the campaign.

Radio and print materials are included in the Statement of Work for technical approach and pricing purposes. All materials are subject to review and approval by NIDA, and by PHS and DHHS.

It is expected that the radio spots and print materials will be released in two waves. The first wave will be released by the end of week 37 of the contract, and the second, by the end of week 50. Each wave will consist of half the total number of radio spots and half of the print items.

PMA Suggs. but Houston + St. L. w/ focus groups too —

1. The Contractor shall organize and lead two focus group meetings, at two sites to be approved by the Project Officer. The focus groups shall consist of members of the target audience of IV drug users, their sex partners, and close associates such as family members. The two groups shall total nine people. In order to encourage full participation, a $10 honorarium shall be paid to each participant of the target audience attending the focus group meetings. All will be recruited locally (no travel or per diem to be paid). The focus groups shall explore beliefs, attitudes, and possible resistance to messages concerning AIDS and IV drug use, and (in particular) possible refinements of content of such messages, and the best styles of radio and print materials to reach the target audience. The Contractor shall prepare a report of findings from the meetings; this report, together with the market research report prepared in Task A.5, shall serve as the basis for discussion at the Creative Development Meeting, Subtask 2 below.

Week 6 [before Wk. 8]

Sugg. John French, Hennessy, Randy Wiehler, et al. Question — how to overcome denial?

2. The Contractor shall organize and lead a one-day Creative Development Meeting, to be held at the Parklawn Building, Rockville, Maryland. Up to 20 people shall attend. Participants shall include up to four experts from the work group (Task A.4); up to four representatives of the radio and print media; representatives of OPA/PHS, the Contractor's creative staff and the staff member responsible for creative and copy-test research; and NIDA project personnel. The Contractor shall pay honoraria for 6 participants at $125, travel and per diem for up to 14 participants. The basis for discussion shall be the two reports from Tasks A.5 and B.1.

Week 9

Variety of target groups? Channels, messages,

3. The Contractor shall develop a Creative Plan, incorporating the ideas and concerns expressed at the Creative Development Meeting (Task B.2 above), covering the entire program, and outlining a schedule of production, launching, and distribution in two waves. The plan shall include (but not be restricted to):

a. Proposed themes and sub-themes, and the rationale behind each.

o. A plan for distribution of radio materials to up to 500 radio stations.

c. A plan for distribution of print materials to organizations (such as fliers or handouts) or to the media (such as print ads).

d. A plan for writing and placement of up to 10 magazine and newspaper articles on AIDS and IV drug use, intended for indirect reach to the target audience; the newspaper articles to be placed in the target cities.

The plan shall be submitted to the Project Officer. The Project Officer shall have 5 working days to review and approve the Creative Plan. The Project Officer shall also select one of the proposed themes and sub-themes to be the theme for the program. Week 12

4. The Contractor shall develop and produce radio materials as indicated below:

a. Develop treatments for 20 or more radio spots. Submit a sufficient number of treatments to allow the Government to select and approve treatments for (total 12) eight 30-second spots and four 20-second spots. Treatments shall be multiculturally sensitive. Week 18)

b. Upon selection and approval by the Government of the 20 radio treatments as specified in 1(a) above, write draft scripts. (. wk 20.

c. Undertake creative and copy-test research for the program, as required to ensure attainment of program objectives. Special attention shall be made toward developing ways to ensure that the program reaches the primary target audience.

The research is to include informal roundtable discussions, with an unstructured format, to assess the effectiveness of the program.

The Contractor shall submit the results of creative and copy-test research to the Government, and shall incorporate the best suggestions from the research into the draft scripts and other materials, acting on the recommendations of the Government.

d. Concurrently with Step c., submit draft scripts and live announcer copy to the four (4) members of the work group (see Task A.4) for review. Contractor shall pay honoraria to the four work group members. The work group will have five working

getting smarter"

days from receipt of the materials, for review. The contractor shall submit a summary of the work group's suggestions to the Government. The contractor shall incorporate the best suggestions of the work group into the materials, acting on the recommendations of the Government.

e. Submit the revised draft materials, incorporating the suggestions from Steps c. and d., to the Government for review and approval. Week 24

f. Upon review and approval of the draft scripts by the Government, write final scripts; develop descriptions of the background, character, and profile of each person who will be the basis for the characters; submit a list of suggestions for talent. In addition, submit specifications for recording locations and a production schedule, write live announcer copy in formats of several lengths (e.g. 60, 30, 20 seconds); prepare live announcer copy in both English and Spanish as necessary. Submit all material to the Government. THESE MATERIALS WILL BE THE BASIS FOR REVIEW BY PHS AND THE DEPARTMENT AND MAY REQUIRE MODIFICATION. Week 26

g. Upon review and approval of the spots by the Government, select the narrator or announcer, select the locations for recording, and make all other preparations for actual production. Talent fees for spots shall apply for a two (2) year period from the recording date. Submit results of preparations to the Government.

h. Upon review and approval by the Government, perform sound recording.

i. Upon review and approval by the Government, edit sound track for 8:30-second and 4:20-second radio spots. Submit rough edit to Project Officer for approval.

j. Upon review and approval by the Government, fine edit the spots. Submit to Project Officer for approval. THIS MATERIAL WILL BE SUBJECT TO REVIEW BY PHS AND THE DEPARTMENT AND MAY REQUIRE MODIFICATION.

Upon review and approval by the Government, make discs and/or tapes of the radio spots for two waves, not to exceed 500. The first wave items are to be packaged appropriately and submitted to the Project Officer. Deliver 50 copies to NIDA Project Officer, in addition to the 500 above; total, 550 spots.

l. Release the first wave radio and print materials. It is contemplated that all, or nearly all, the materials will be radio because of the time needed to print the other materials.

m. Release the second wave of materials.

n. Submit the following items to the Government before the end of the contract period:

1. Master mixed track (magnetic) for radio
2. Final narration scripts for each of the radio spots
3. Talent and music releases

5. The Contractor shall develop and produce print materials based on the Creative Plan (Task B.3). The print materials shall include: (1) Pamphlets, fliers, posters, and handouts (final product-camera-ready copy); (2) Articles for magazines, and for newspapers in the target cities; and (3) Materials for radio kits: packages, labels, fact sheets, cover letters, scripts and live copy, and user reply cards, for up to 550 radio distribution kits. THIS MATERIAL IS SUBJECT TO REVIEW BY PHS AND THE DEPARTMENT AND MAY REQUIRE MODIFICATION.

The materials shall be submitted to the Project Officer.

a. Rough sketches and treatment copy; (Week 20)

b. Draft layout and draft copy of all materials including magazine and newspaper articles;

c. Final layout and final copy.

d. Mechanicals. (Week 32)

Task C. Launching and Distribution

Since this program is targetted to a limited audience, a full-scale "launch event", with press conference, is not indicated. Marketing of the campaign will be conducted under a separate contract, which will involve regional meetings, training of local drug abuse community groups, and the use of the materials of this contract in conducting AIDS and drug abuse education programs at the local level. The contractor will work with the Project Officer to prepare for the marketing activities.

Distribution shall be in two waves. Thus, there will be two kits for broadcasters, each one containing half of the radio materials, and two sets of print materials, each set consisting of about half the total produced. The Contractor shall:

1. Meet with the Project Officer to discuss marketing plans and specific arrangements for launching the program. The Contractor shall work with the Project Officer to plan these activities and have the materials ready for the marketing events.

2. Develop kits of radio materials and print materials for distribution (550 radio kits and 500 print materials kits).

3. Distribute the radio kits to broadcasters according to plan; distribute the print materials to cooperating groups according to plan.

SECTION E
Inspection and Acceptance

E.1 Inspection and Acceptance

a. All work under this contract is subject to inspection and final acceptance by an authorized representative of the Government.

b. The Government Project Officer is responsible for inspection and acceptance of all items to be delivered under this contract.

c. The Contractor's attention is directed to the contract clause FAR 52.246-5 "Inspection of Services" (APR 1984), which is hereby incorporated in this contract by reference.

SECTION F
Deliveries or Performance

F.1 The Contractor shall submit the deliverable items, described in the Work Statement (Section C), in accordance with the following schedule:

Item		Quantity	By End of Weeks After Contract Award
1.	Orientation meeting (Task A.1.)	N/A	1
2.	Background research and consultation (Task A.2.); preliminary report	5	3
3.	Media habits meetings (Task A.3.)	N/A	5
4.	Work group meeting (Task A.4.)	N/A	6
5.	Report on market research (Task A.5.)		8
6.	Focus group meetings reports (Task B.1.)	5	6
7.	Creative development meeting (Task B.2.)	N/A	9
8.	Creative plan (Task B.3.)	5	12
9.	Radio and print treatments and rough sketches (Task B.4.a.)	5	18
10.	Draft scripts and print texts and art work (Task B.4.b. and B.5.a.)	5	20
11.	Results of copy-test research (Task B.4.c.)	5	23
12.	Results of work group review (Task B.4.d.)	5	23
13.	Revised draft scripts, print texts, etc. (Task B.4.e. and B.5.b.)	5	24
14.	Final scripts, print texts, *camera-ready copy, art work (Task B.4.f. and B.5.c.) 4 weeks for PHS and DHHS review 2 weeks for modification/reworking and review	5	26
15.	Radio preproduction preparations (Task B.4.g.)	N/A	32

Item		Quantity	By End of #eeks After Contract Award
16.	Radio sound recording (Task B.4.n.)	N/A	33
17.	Radio rough edit (Task B.4.i.)	N/A	34
18.	Radio fine edit (Task B.4.j.) 2 weeks PHS and DHHS review	N/A	35
19.	Final radio spots; print mechanicals (Task B.4.k. and B.5.d.)	1 each	38
20.	Release first wave materials (Task B.5.l.)	N/A	39
21.	Release second wave radio and print materials (Task B.4.m.)	N/A	50
22.	Master mixed track; scripts releases (Task B.4.n.)	1	52
23.	Financial Report of Individual Project/Contract - HHS Form 646 to be prepared in accordance with accompanying instructions (Section G) (Attachment 3)	3	Quarterly. Delivery to be within 15 days after end of the period reported. A final report for the last three months due on or before expiration of the contract
24.	Final report, to include a review of the project; analysis of impact of the first wave; and recommendations for improvements	5	On or before contract expiration.

Note: Five working days are allotted to the government for review and approval except for after Items 14 and 18, when additional weeks are allotted for DHHS review and possible modification.

*A camera-ready original is specified to mean a single spaced, reproducible original typed on white paper with a carbon ribbon, complying with all Government Printing Office orthographic requirements for printing by NIDA by the photo offset process.

Two copies of the Final Report shall be forwarded directly to the Contracting Officer.

F.2 Contract Expiration Date

This contract shall expire SEP 25 1987

MARKET RESEARCH AND HEALTH COMMUNICATIONS PLAN ON AIDS AND IV DRUG ABUSE

April 30,

Submitted to:

National Institute on Drug Abuse
Division of Prevention and Communications
Communications Services Branch

Submitted by:

PROFESSIONAL MANAGEMENT ASSOCIATES, INC.
Oak Grove Center
15825 Shady Grove Road, Suite 190
Rockville, Maryland 20850
(301) 921-0010

MARKET RESEARCH AND HEALTH COMMUNICATIONS PLAN ON AIDS AND IV DRUG ABUSE

I. BACKGROUND AND EXTENT OF PROBLEM

The purpose of this background paper is to outline a communications plan aimed at preventing and reducing the transmission of Human Immunodeficiency Virus (HIV) within and from the intravenous (IV) drug abusing community. After Gay or Bisexual men, IV drug abusers are the second largest risk group for AIDS. Sharing of contaminated needles has been implicated as the likely means of HIV transmission within the IV drug abusing population. IV drug abusers are a bridge to two other groups: children and heterosexual partners. The majority of reported heterosexual transmission cases have involved a link to IV drug abusers, most of them male drug abusers who transmit the virus to non-drug abusing females through sexual contact.

Currently, 25 percent of the approximately 33,000 reported cases of AIDS are identified as being associated with IV drug use as a risk behavior (as of March 23, 1987). Of these cases, 32 percent (8% of the 33,000) were found to be Gay males while 68 percent (17% of the 33,000) were heterosexual IV drug users. Transmission of the HIV virus by heterosexual contact, believed to be mainly transmitted by those infected by IV drug use, presently accounts for 4 percent of the cases. In utero or perinatal transmission to children has been determined to be the cause in about one percent of the existing cases of AIDS.

Table 1 presents the growth of the AIDS problem relative to the transmission categories. This table provides the yearly number of cases (December 9 of one year to December 8 of the following year) and percent increase from the end of 1982 to the end of 1986. According to these data, the percentage increase of cases for overall male and female IV drug users has diminished in the 1986 period relative to the comparable period in 1985. (Males: 78% increase in the 1985 period vs. 52% in the 1986 period; and females: 82% increase in 1985 vs. 56% in 1986). The exception to this, in the IV drug use transmission category, is among Gay males who also use drugs intravenously where the yearly percentage increase is actually increasing (45% in the 1985 period vs. 61% in the 1986 period). This anomaly is understandable, however, since that group is at risk relative to two of the primary high risk behaviors.

TABLE 1: Acquired Immunodeficiency Syndrome (AIDS) Cases Reported for Three Transmission Categories (IV Drug Use, Heterosexual Contact, and Pediatric) with Percentages of Yearly Increases (inc.) - United States, through December 8, 1986.

Transmission Category	Before 12/8/82	12/9/82-12/8/83	12/9/83-12/8/84	12/9/84-12/8/85	12/9/85-12/8/86	TOTAL
ADULT MALE:						
All IV drug[1]	172	489	957	1,708	2,599	5,925
(% inc.)*		(184)	(96)	(78)	(52)	
IV drug user only	98	295	561	1,132	1,674	3.760
(% inc.)		(201)	(90)	(102)	(48)	
IV drug user homosexual	74	194	396	576	925	2,165
(% inc.)		(162)	(104)	(45)	(61)	
All heterosexual contact	41	69	106	131	195	542
(% inc.)		(68)	(54)	(24)	(49)	
U.S. contact	1	1	10	20	49	81
(% inc.)		(0)	(900)	(100)	(145)	
Non U.S. born[2]	40	68	96	111	146	461
(% inc.)		(70)	(41)	(16)	(32)	

* Percent increase

1 Includes both heterosexual and homosexual IV drug users.

2 Includes persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

(Table continued)

TABLE 1 (Cont.) Acquired Immunodeficiency Syndrome (AIDS) Cases Reported for Three Transmission Categories (IV Drug Use, Heterosexual Contact, and Pediatric) with Percentages of Yearly Increases - United States, through December 8, 1986.

Transmission Category	Before 12/8/82	12/9/82-12/8/83	12/9/83-12/8/84	12/9/84-12/8/85	12/9/85-12/8/86	TOTAL
ADULT FEMALE:						
IV drug user	26	79	152	276	430	963
(% inc.)*		(204)	(92)	(82)	(56)	
All heterosexual contact	16	32	60	131	275	514
(% inc.)		(100)	(88)	(118)	(110)	
U.S. contact	7	20	47	100	230	404
(% inc.)		(186)	(135)	(113)	(130)	
Non U.S. born[2]	9	12	13	31	45	110
(% inc.)		(33)	(8)	(138)	(45)	
PEDIATRIC	1	41	50	124	178	394
(% inc)		(4000)	(22)	(148)	(44)	

* Percent increase

2 Includes persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role.

The apparent decrease in the year-to-year percentage increase in the overall IV drug use category is hardly a consolation, as the absolute number of cases continues to increase. Empirical models employed by CDC estimate that the proportion of AIDS cases related to IV drug use will remain about the same in 1991.[1] Since the total number of cases is projected to be 270,000 by 1991, this implies that over 60,000 cases will be related to IV drug use.

This degree of growth in the number of AIDS cases due to transmission by IV drug use is supported by other epidemiologic evidence. For example, CDC estimates that approximately 750,000 Americans inject heroin or other drugs intravenously at least once a week with a similar number injecting drugs less often.[2] This estimated total number of intravenous drug users (1.5 million) is independently substantiated using treatment statistics and other studies. Specifically, the National Institute on Drug Abuse (NIDA) estimated that more than 305,000 clients were admitted to State monitored drug abuse treatment programs in the United States in FY 1985.[3] Of those clients in treatment, over half (57%) report the use of needles as a route to drug administration.[4] Combining these data with findings in epidemiological studies which estimate that nine to twelve percent of all IV drug users are in treatment suggests that there are about 1.45 million of this type of drug user in the United States (using 12% in treatment).[5] Thus, it could be a reasonable assertion that there are about 1.5 million IV drug users in the U.S.

Using this total prevalence as a base, seropositivity and infection can be used to project the number of IV drug use related AIDS cases in 1991. Studies of the rate of seropositivity have shown a range of prevalence rates, from 10 to 87 percent.[6,7] But the most recent findings suggest that, overall, IV drug abusers have an infection rate which already exceeds 50 percent[8]. Seropositivity denotes exposure but not necessarily the presence of the virus, although the growing rate of seropositivity probably reflects the growth of infection. When blood samples of seropositive cases were cultured for the presence of the virus, at least 62 percent of the samples were found to contain the virus. Given the limitation in the culturing technology relative to the HIV virus (e.g., it would not identify the presence of the virus in the neural tissue in the brain), the true rate of viral infection is probably higher in seropositive cases.[9]. However, using the 50 percent seropositivity rate among IV drug users and a 62 percent rate of actual infection in this group, one can conclude that about 31 percent of IV drug users are carriers of the virus. Combining this infection rate with the prevalence of IV drug use (i.e., 1.5 million individuals), it could be estimated that there are presently about 465,000 IV drug users

infected with the virus. Since CDC projects the 20 to 30 percent of those presently infected will develop AIDS by 1991, the foregoing data suggests that 93,000 IV drug users will have AIDS at that time. This estimate could be seen as being high because all of the estimated 1.5 million IV drug users may not have the same degree of risk. However, this estimate for 1991 (93,000) does tend to substantiate the CDC estimate of over 60,000 IV drug use related AIDS cases for that year. These are only the cases related to individuals who are presently infected and does not consider the future spread of infection.

Results relating behaviors to seropositivity are presently fragmented. This fragmentation should be soon remedied since NIDA and CDC are sponsoring numerous studies to investigate behaviors related to viral transmission. In the interim, although evidence is partial, some aspects of behavior related transmission are relatively clear. For example, in San Francisco, where the rate of seropositivity among IV drug users was low (10%), seropositivity was found to be clearly related to the number of individuals with whom an IV drug users shared needles. [10] The table presented below shows the degree of seropositivity and the relative risk experienced by 209 IV drug users in San Francisco.

Seropositivity Related to the Number of Persons with whom Needles are Usually Shared (1984-1985)

Number of Persons Sharing Needles	N	Percent Positive	Relative Risk (Odds Ratio)
Rarely	65	3%	1
1	76	9	3.2
2 or more	68	15	5.4

These data show that for those individuals who share needles with two or more people the risk of being seropositive is more than 5 times that of individuals who rarely share. This finding, however, should be considered as a description of relative risk in a city where infection is somewhat minimal (i.e., 10% seropositivity) compared to other communities and factors which are conducive to reduced transmission (i.e., a lack of shooting galleries and little overlap between the Gay and heterosexual drug using population).

Conditions for transmission are more present in the east. In New York, the pool of infected IV drug users is over 50%; shooting galleries, where needles are purchased and shared, are common, and there is more sharing with the Gay population. In one study, the majority of heterosexual IV drug users with AIDS or AIDS related complex had shared needles with Gay men. [11] In circumstances such as this, one would have to conclude that the relative risk associated with multiple person needle sharing would exceed that described in San Francisco.

While needle sharing behavior has been studied among AIDS patients and clients in treatment, as was stated, little comprehensive evidence is available for all IV drug users both in and out of treatment. Relative to this, a study was conducted in Washington, D.C. in 1986 where samples of IV drug users who were in treatment and not in treatment were surveyed. [12] The following results were found:

Needle Sharing Behavior Among IV Drug Users In and Not In Treatment - Washington, D.C. (1986)

No. Persons Shared With (Last Month)	In treatment (n=159)	Not in Treatment (n=63)
0	49%	39%
1	35	21
2	10	24
3	2	9
4 or more	3	8

These two groups are shown to have marked differences in risk in two ways. For those not in treatment, not only do they share needles more often (61% in comparison to 51%), but they share needles with more individuals (40% not in treatment share with two or more persons in comparison to 15% of those in treatment). While no clear data are available describing seropositivity rates in Washington, D.C., preliminary information indicates that the rate is about 30 percent - somewhere between the rates in San Francisco and New York. Given that there are more individuals not in treatment than in treatment, it could be expected that rates will rise, as the use of shooting galleries is prevalent in Washington, D.C.

While studies are underway to determine more precisely the behavioral correlates of infection, it is not necessary to await their findings to understand how rapidly the virus can spread among IV drug users. Retrospective studies of blood samples from various populations of IV drug users clearly indicate that once the virus is introduced into a community, it can diffuse to infect a majority of users. In New York City, for example, the prevalence of seropositivity in samples of IV drug users increased from 11 percent in 1977 to 27 percent in 1979, and to 58 percent in 1984.[13] In Edinburgh, Scotland, a similar pattern was observed with seropositivity rising to more than 50 percent among IV drug users in a two year period.[14] In addition, rapid rises in the proportion of seropositivity have been documented in Spain and Italy where rates among tested addicts have gone from zero to one-half to three-fourths in the space of several years. With growth rates such as these which broaden the pool of infected IV drug users, it may not be a matter of how often an individual shares a needle, nor with how many others, but if they share at all. As the infected pool in a community includes the majority of IV drug users, the probability of being infected in a single sharing experience (without disinfecting the needle) becomes maximized.

As previously noted, there is grave concern that the pool of HIV infection due to transmission among IV drug users could act as a conduit to spread the virus to the general heterosexual population. This concern is supported by the epidemiological data. As of March 23, 1987, four percent of the 32,696 cases of AIDS among adults and adolescents reported heterosexual transmission as the probable cause for being infected with the virus.[15] Of these 1230 cases, 608 persons (114 men, 494 women) reported having heterosexual contact with a person with AIDS or at risk for AIDS and 622 (500 men, and 122 women) were without other identified risks but were born in countries where heterosexual transmission is believed to play a major role. The yearly growth of heterosexually contracted cases of AIDS from 12/9/82 to 12/8/86 is given in Table I for males and females as all heterosexual contact, contact among those born in the U.S., and contact among those not born in the U.S. Note that percentage increase in the last period, for all heterosexual contact, either increases above the previous period (for males: 49% in the 1986 period versus 24% in the 1985 period) or stays relatively the same (for females: 110% in the 1986 period versus 118% in the 1985 period). This type of increase is an anomaly relative to other transmission categories (IV drug use, Gay/Bisexual) where the yearly percent increases are diminishing. This anomaly is even more pronounced if one examines the category of U.S. heterosexual contact where for both males and females the last period increase is larger than the previous period which

was a decline from the period before that (males: 1984 - 900%; 1985 - 100%; 1986 - 145%; and females: 1984 -135%; 1985 - 113%; 1986 - 130%). This data indicates that heterosexual transmission is the category which is experiencing the most rapid growth in cases.

Linking heterosexual transmission explicitly to IV drug use is problematic since individuals who contract AIDS usually only report one risk factor. As of the week of March 23, 1987, 88.4 percent reported one risk factor.[16] However, among the cases which reported multiple risk factors and one of them was IV drug use among heterosexuals, 68 percent also reported heterosexual contact as another risk factor. This does not clearly demonstrate a link because the preponderance of those contracting AIDS by heterosexual transmission "don't report", or "don't know", that their partners were IV drug users. Viewing this from a different standpoint, where among those reporting multiple risk factors including heterosexual contact, only about 10 percent indicated factors other than IV drug use. Again, this does not show the link conclusively; but these data together make a rather compelling argument about the link between heterosexual transmission and IV drug abuse.

The final aspect of the problem involves transmission of the virus to children, either as a fetus or perinatally, from mothers who have AIDS or are at risk of contracting AIDS. The focus relative to this discussion has to do with the mother contracting AIDS by IV drug use or heterosexual contact with an IV drug user. Here again, there is no precise information describing the link between IV drug use and transmission to children but the data do indicate that the preponderant number of children with AIDS contracted the virus as a fetus or during the perinatal period. Specifically, as of March 23, 1987, 80 percent of the 462 children under 13 with AIDS has a parent with AIDS or was at risk.[17] Since 51 percent of the women with AIDS acquired the virus by IV drug use and 28 percent by heterosexual transmission, one would expect these modes of transmission to play a corollary role in transmitting the virus to children.[18]

IV drug abusers, therefore, occupy a pivotal position in the developing AIDS epidemic, and efforts to control the spread of the disease must focus, at least in part, on this risk group. In the absence of either effective treatment or vaccines, reducing transmission-related behavior (in all risk groups) is the most practical means of trying to control the AIDS epidemic. Public health education has been suggested as a means of

reducing the spread of the infections among IV abusers, their children, and sexual partners, and has been credited by many with already having had an impact on high-risk sexual activity among Gay and Bisexual men.

An effective health education campaign should, therefore, be concerned with two (2) types of risk behaviors:

- o sharing of contaminated body fluids (i.e., blood) through the use of unclean, shared needles and works, and
- o sexual transmission of HIV to uninfected partners.

Of the two, sharing of contaminated blood through the sharing of needles and/or "works" is the risk behavior most often associated with IV drug abusers. Both IV drug abusers and the general public appear to perceive that IV drug abusers are among the primary groups at high-risk for infection, due to sharing behaviors. The second risk factor, sexual transmission from the IV drug abusing population to non-IV drug abusers, is clearly documented. The general perception of this "link" and risk among IV drug abusers and the general population is somewhat unclear. The ability to control and prevent HIV infection among all population groups strongly depends upon the understanding of the two risk behaviors, as well as an individual's ability to respond to AIDS health messages targetted to the modification of high-risk practices (e.g., "safer" sexual practices, disinfection of needles and "works", etc.).

Education campaigns aimed at eliminating or reducing HIV transmission through the modification of, primarily, IV drug abuse behaviors, and, secondarily, sexual behaviors, need to be directed to a broad range of individuals. Specific target populations include:

- o Current and ex-IV drug abusers
- o Sexual partners of current and ex-IV drug abusers
- o Family and significant others of current and ex-IV drug abusers
- o All sexually active heterosexuals

All target populations would benefit from AIDS education materials and messages based on both past and current IV drug use and/or sexual behaviors, and those of their sexual partners.

In developing an educational campaign for the target groups mentioned above, it will be necessary to be sensitive to various demographic aspects underlying the target groups. In particular, it will be necessary to recognize the disproportionate representation of minorities among those who may be at risk. For example, among AIDS cases whose only risk factor was IV drug use, 51 percent are Black, 30 percent Hispanic, with only 19 percent White. A similar disproportionality is found in relation to seropositivity. In a study conducted in San Francisco, Blacks and Hispanics were found to have almost three (3) times the risk of becoming seropositive even though Whites had a higher mean number of persons with whom needles were shared.[19] This difference was also found in New York and New Jersey.[20] There was no evident behavioral or other demographic characteristic to explain the higher prevalence of infection in this population. While needle sharing is no more prevalent among Blacks and Hispanics than among Whites, the risk of infection is clearly greater for individuals who share needles with minority group members due to the relatively higher seroprevalence within those populations.

Similar ethnic differences occur in relation to heterosexual transmission. As of March 23, 1987, among AIDS cases reported in that category, 74 percent are Black, 13 percent Hispanic, and 14 percent White. In addition, among female AIDS cases, most of which are related to IV drug use or heterosexual transmission (79% of all female AIDS cases), 73 percent of these individuals are Black or Hispanic. Moreover, 81 percent of childhood cases are Black or Hispanic.

The other demographic focus is age. The various target groups discussed above are most predominently betwen the ages of 20 and the mid to upper 40's. Relative to AIDS cases virtually 90 percent of the individuals are between 20 and 49 and the predominent proportion of admissions to drug abuse treatment are between 21 and 44.[21]

IV drug abusers have a potential to practice both drug abuse and sexual high-risk behaviors in relation to AIDS. This is not the case with other high risk groups. Thus, from an overall education standpoint which will impact and effect both IV drug abuse and sexual high risk behaviors, there are substantial but different communication problems in relation to the compound risk behaviors associated with IV drug abusers. In addition, important questions remain on the effectiveness of educational interventions, the relationship of knowledge to behavior change, and the persistence or decline of risk behavior in the IV drug abusing population.

74-444 0 - 87 - 8

A significant amount of future infection can be prevented through current intervention and education strategies. It is in this course of action that the greatest opportunities for altering the course of the epidemic lie. Retrospective studies of blood sera from populations of IV drug abusers suggest that once HIV is introduced into a community, it spreads rapidly to infect the majority of drug addicts. The opportunity for slowing HIV infection in the IV drug abusing population does exist through AIDS education. A primary goal of AIDS education and intervention strategies is to modify or eliminate drug abuse and sexual high risk behaviors. Both behaviors are difficult to alter. Sexual behaviors are fixed early in life and are rarely modified without some external influence. Drug use behaviors are also difficult to modify, in great part due to the addictive process, the ritualistic nature of IV drug abuse which encourages needle sharing, and laws against IV drug abuse which hinder access to sterile equipment. These are just a few of the potential barriers to effecting behavior change in IV drug abusers and their sexual partners. Barriers to education, behavior change, and intervention lie on numerous bases, such as the nature of the target groups, effective material and message development, and dissemination through the different communications channels which are most likely to reach the target groups, as discussed below.

II Barriers to Education and Behavior Change

a) Nature of Target Groups

The primary target group for NIDA's AIDS education activities should be current IV drug abusers, to positively impact high-risk drug abuse and sexual behaviors. This is not to say that the other target groups (e.g., ex-IV abusers, sexual partners of current and ex-IV drug abusers, etc.) are less important, but the current IV drug abuser is potentially (and directly) practicing high risk behaviors which are both drug and sexual behaviors. In addition, the fact that one is an illicit IV drug abuser creates problems such as receptiveness and access to risk-reduction messages, as detailed below.

1) Current IV drug abusers

Control of the AIDS epidemic among drug abusers, and subsequent sexual transmission to others, will be dependent upon an elimination or reduction of the sharing of contamined needles and works by IV drug abusers. "Traditional" images of IV drug abusers leads one to expect little or no risk reduction. Although some reports indicate

increased demand for sterile needles and/or works, and a small number of IV abusers reporting regularly cleaning needles with alcohol, bleach, or boiling, significant high risk drug behaviors are still prevalent in this population.

Recent literature, NIDA sponsored research and AIDS education publication pretesting, and surveys of IV drug abusers in treatment and not in treatment (r recently conducted in the District of Columbia) provide important insight into the level of knowledge, attitudes, beliefs, and behaviors of the IV drug abusing population concerning AIDS and risk behaviors. This population generally knows about the high risk behaviors associated with HIV transmission, is knowledgeable of AIDS high risk group composition and etiology, and is aware of preventive (risk avoidance and risk-reduction) behaviors.

Based on focus group and survey data from Cleveland, Detroit, Washington, D.C., Miami, Houston, and St. Louis, current and former IV drug abusers identified how they believed "AIDS is spread".

Mode of Transmission	% Responding Yes
o Sharing needles	92.8%
o Through sex	92.5%
o Semen	78.8%
o Getting blood at hospital	78%
o Broken skin, such as sore, cut or tracks	46.8%
o Toilet seats	9%
o Casual contact	3.5%

Respondents also accurately defined high risk population groups:

Gay men	91%
IV drug abusers	86.3%
Bisexual men	87.5%
Prostitutes	84.8%
Children born to mothers with the AIDS virus	67.3%

"High risk" behaviors were believed to be sex with multiple partners (90.8%), exchange of blood or semen (86%), and IV drug abuse (85%). Behaviors which helped prevent HIV-transmission were also relatively well known. Respondents noted that preventive behaviors included "stop shooting drugs" (82.8%), engaging only in "safer sex" (58.5%), restricting sex to a closed relationship (58.5%), and cleaning "works" (57.8%).

Despite knowledge of AIDS and high-risk and preventive behaviors among IV drug abusers, however, personal behavior does not reflect this knowledge. Data from a recent survey of current and former IV drug abusers in Washington, D.C., indicates that over 52% are sharing needles and/or "works", and over 22% did not consistently clean borrowed works prior to using them. In addition, among those who clean works immediately prior to personal use, over 50% use ineffective cleaning techniques such as rinsing in tap water only. Similar data on sexual practices indicate continued high-risk sexual practices with over 60% of survey respondents having continued sexual relations with more than one partner (10% having sex with six (6) or more different partners). Over 85% never use condoms during vaginal intercourse.

Based on these findings, it can be noted that IV drug abusers recognize high-risk behaviors in relation to HIV-transmission, but continue to practice high-risk sexual and drug abuse behaviors. They recognize risk, but their actions do not reflect a personal response to this risk. IV drug abusers, therefore, comprehend the theoretical risk but do not personalize the risk as indicated by the continued practice of high-risk behaviors. Clearly knowledge alone does not translate into behavior change. It appears that the lack of perceived risk, either due to comprehension issues or personal denial, must also be overcome to effect behavior change.

Non-comprehension of the risk as opposed to denial of the risk are thus two potential issues effecting behavior change. One must undertand the risk, before denial of the risk can occur. Based on IV drug user focus group pretesting of two (2) NIDA publications, the following was determined in relation to comprehension and understanding of AIDS and AIDS etiology.

a Many IV drug abusers had reading and comprehension difficulties with terms which they felt were "too technical". These terms included "HTLV-III/LAV", "HIV", Kaposi's Sarcoma, and "Pneumosystic Carinii Pneumonia". Many respondents stated that they wouldn't continue reading written materials, or listen to audio messages, after being "tripped up" over these terms.

- There was often confusion about the meaning of the AIDS anti-body test. Respondents were confused about the differences between the AIDS virus, HIV, HTLV-III/LAV, and the AIDS antibody, what the AIDS antibody test was for, and why someone should get the test.

- The link between AIDS virus transmission via IV drug abuse and sexual activity was unclear to many focus group members. Often, respondents felt that it was only possible to transmit AIDS through one of these behaviors, but not both. In general, respondents understood how AIDS could be transitted through the sharing of their works, but were unsure what the role of specific sexual activities was, and were relatively uninformed about high risk sexual behaviors as a mode of AIDS transmission.

Denial is an issue even when AIDS transmission and the role of high risk sexual and drug abusing behaviors is comprehended. Denial is a personal but undefined function which is unique to each person. Given the fact that the pre-test, survey, and some anecdotal data reflect a relatively "sophisticated" level of knowledge about HIV-transmission among IV drug abusers, denial is clearly evident as evidenced by behaviors as well as data on perceived personal risk for AIDS. Combined NIDA pre-test and Washington, D.C. survey results indicate that over 50% of current and recent IV drug abusers do not think that they are personally at risk for AIDS, with almost 15% unsure or don't know. This is clearly inconsistent with data from the same respondents which indicates a knowledge of how AIDS is transmitted and personal practices of continued high-risk drug and sexual behaviors.

Other factors inherent in the "make-up" of the IV drug abuser and the drug abusing community must be considered in terms of knowledge, messages receptiveness, and personal denial. These factors include:

- If drug abusers continued IV drug use but elected the risk avoidance behaviors (of not sharing works, cleaning "borrowed" works before personal usage, or using condoms), they would possibly alienate themselves from their support network. For drug abusers, altering social norms within the drug community would imply "mistrust", or be contrued as a negative reflection on "drug buddies" or sexual partners. Many IV drug abusers would not wish to practice "safer" behaviors if it would threaten the few support networks they have of fellow drug users and sexual partners, and

- IV drug abusers are traditionally nonreceptive to all kinds of health education messages. The AIDS issue is yet another of many problems which they have avoided facing or denied by continuing the use of IV drugs. AIDS may simply be "added to the list", along with overdosing, hepatitis, endocarditis, etc. A 1986 California study conducted by J. Newmeyer and H. Feldman on IV drug user receptivity to AIDS risk. "These individuals view AIDS as just one of many life-threatening risks in pursuing a career in

heroin use." Similar sentiments were expressed by Mr. Robert Baxter, an epidemiology consultant at the New Jersey Department of Health, who is quoted in the February 16, 1986 New York Times as stating, "The life of a drug addict is so fraught with danger - overdosing, hepatitis, getting busted or ripped off, AIDS is just one more hassle, an occupational hazard."

The most effective strategy to prevent HIV infection in IV drug abusers is to eliminate IV drug abuse altogether. For individuals who continue to inject drugs, a cessation of needle sharing and the use of sterile needles and syringes, in addition to increased use of condoms, as an example, is essential. The following characteristics of IV drug abusers also hinder the adoption of these important behaviors to stop AIDS transmission:

- Drug abusers in general (and IV abusers in particular) do not have an organized constituency, or support, self-help, or advocacy groups.
- IV drug abuse is traditionally regarded as being associated with self-destructive activities.
- IV drug abusers are generally recognized and identified only when they make contact with the criminal justice or drug treatment/rehabilitation systems. They are difficult to reach through traditional health communication channels.

More specifically, factors inherent in the severely addictive, illegal, and ritualist process of IV drug abuse also hinder efforts to get IV drug abusers to stop using drugs, stop sharing works, or sterilize equipment used to administer drugs. These include:

- An inability to legally obtain sterile equipment for administering drugs, often resulting in sharing behaviors.
- The expediency and desperation to take drugs, particularly in times of acute withdrawal, increasing sharing behavior or the use of non-sterile "works".
- Misinformation in the IV drug abusing community about high-risk sharing behaviors within a small or closed group, and sexual transmission of HIV.

2) Ex-IV drug abusers, sexual partners of current and ex-IV drug abusers, their significant others, and sexually active heterosexuals.

These target groups present some of the same issues regarding AIDS education and high-risk behavior intervention that are evident in current IV drug abusers. The most significant barrier to education and behavior change is providing accurate information about the sexual transmission of AIDS, the "link" of high risk drug abuse behavior and sexual transmission, and overcoming misinformation and false beliefs about high-risk sexual behaviors. In particular, heterosexuals, particularly those wi) multiple partners, must be made aware of the risk to themselves.

Barriers to education and behavior change for these populations are often the same as one would expect to find for other issues of major public health concern. The same problems of comprehension, denial, and social/personal "pressure", as discussed in relation to IV drug abusers, is also an issue with non-IV drug abusers. These barriers include a lack of information, overcoming false/incorrect information, and overcoming various moral, personal, and often religious beliefs, as AIDS education touches upon many social "taboos" (such as drug use and sexual practices) which are often not well received by many people.

For populations who are not in clearly defined high-risk groups (such as non-IV drug abusing heterosexuals), denial is also difficult to overcome. They must understand the risk before they can clearly deny it. Blacks and Hispanics, as an example, comprise a disproportionately high percentage of AIDS cases, in spite of the media's frequent portrayal of the disease as a white, middle-class, Gay male disease. Many of the ethnic minority groups do not even recognize their risk, so therefore do not recognize the risk reduction activity. Similar problems are generally reported among women, and non-drug abusing heterosexuals of both sexes and all races.

The perception of risk due to heterosexual transmission has heightened, but perhaps not as acutely as it should. Recent surveys of public attitude seem to indicate that many have altered their sexual behavior, and the use of condoms (as an example) is increasing. However, the receptiveness of these populations to the message, and the strength of the message, is still somewhat uncertain.

b) Problems with Different Materials and Media

Not all media reach all potential target groups for the AIDS messages. Some populations are more receptive, as an example, to visual response, while others are more receptive to, as examples, one-to-one counseling and education. Barriers to the use of different AIDS education materials and media are on two levels:

(1) The receptiveness of different target groups to particular media and materials, and

(2) An unwillingness (or refusal) of different media to distribute, broadcast, reproduce, etc., AIDS education materials (often due to the connection with illegal drug use and/or sexual practices). These barriers not only negatively effect the potential distribution of materials through all available channels, but hinders essential pre-testing (or "market testing") necessary for the development of effective messages.

Clearly, the materials must be in a form that will be received by the potential target groups. Given the unique nature of these target groups (most particularly current IV-drug abusers), little research is available to determine which materials are the "best" for each population.

c) Problems With the AIDS Message Focus and/or Form

As stated, particularly graphic or specific AIDS education messages and information may be determined to be "inappropriate" for distribution or dissimenation through particular communications channels or media. This clearly impedes the ability to target unique and particular messages. As an example, the message "Don't Shoot Drugs" may be deemed acceptable or appropriate for posters on subways--but "Don't Come Inside Him/Her" may be inappropriate for this medium. This example (albeit simplistic) illustrates the barriers to message development without even considering what the focus of AIDS education messages should be. More specifically, the basic question with regard to the message is still unclear--what should be advocated? What should the "official posture" be?

The AIDS high-risk behavior change messages are a subject of often heated debate. Some potential alternatives include:

- Risk-reduction messages--(i.e., get into treatment, clean works, reduce the number of sexual partners, increase the use of condoms).
- Risk-avoidance messages--(i.e., don't use drugs, avoid sexual relations).
- A "mix" of the above--generally of the nature of "don't shoot drugs, but, if you must, don't share works".

The messages to be developed and distributed will often be impacted by their form (as materials), and their distribution through different health education/communication channels and media. This creates a barrier to message development which would not be at issue if they were not dependent upon the ability to use different materials and channels of communication. Should the messages be "educational" in a general sense? Strongly coercive? "Graphic"? or unique and directed to one target group only, and their specific behaviors?

The form, content, and desired output (as expected behavior change) of the message or messages is not consistent among the various groups who are currently developing and conducting AIDS education strategies directed to these target groups. This can create a problem of "mixed messages" perceived by the populations who need to practice high-risk behavior changes the most. The present set of messages often include the concept of "risk", but "risk" is comprehended differently by current IV drug abusers and others in the target groups. There is often uncertainty surrounding the degree of risk given personal, sexual, health and other practices. This, in turn, creates a great deal of confusion among the recipients of AIDS prevention messages.

d) **Problems with Channels of Communications (Dissemination Network)**

There are numerous potential means to reach the target populations. Historically, an accepted method of reaching IV drug abusers was through the drug treatment/rehabilitation network. Evidence seems to indicate that only nine to twelve percent of this group ever enter the drug treatment system, with the remainder a largely (and continued) hidden population. Clearly, large portions of the IV drug abusing population may be difficult to reach through traditional health communication channels.

Despite this low figure, there is still a strong reliance on the drug treatment system to provide essential AIDS and other health education. To confound this problem, the drug treatment system is often quite separated from the more general medical/health/social service delivery systems.

Although there is expected to be "overlap", the means to reach the current IV drug abusing populations and others defined as target groups for AIDS education messages will be different. Certain modes of communication will not reach certain groups; even if the target group "gets" the message, they may not be receptive to it.

AIDS messages need not be directed only to a defined audience, such as Gay/Bisexual males, making all communication channels for the dissemination of AIDS information potential channels for the messages. All channels are not "ready" for the role, however. The issues of AIDS and IV drug abuse are not particular media "grabbers"--they are perceived to be problems of a small (and "undesirable") audience.

Despite the existance of national television and radio networks, and newspapers and magazines distributed across the country, channels of communication and education are strongly based on the local level. Local communities have their own forms of media, and locally based organizations, which have a strong impact in a smaller, defined area. The problem is that local areas often do not recognize the importance of larger concerns such as AIDS and IV drug abuse, or do not even recognize the problem. Communications and organizational networks based at the community level can be an excellent vehicle for transmitting health education messages, but they are currently not performing that function to their highest potential.

e) **Barriers to NIDA in the Development/Dissemination of AIDS Education**

In the most direct sense, the problems and barriers discussed above with respect to the target audiences materials, messages, and channels of communications are the barriers which NIDA faces in the development and dissemination of AIDS education materials. Complicating these problems is the lack of available treatment programs and facilities for IV drug abusers. Drug treatment programs are currently operating at, or over capacity, and campaigns that inspire widespread efforts at treatment/rehabilitation among IV drug abusers could swamp already strained facilities.

Fear of AIDS will undoubtedly lead significant numbers of IV drug abusers to seek treatment for their drug abuse. To some degree, an increase in treatment seeking behavior is already occurring. Unfortunately, many who seek treatment discover that it is not available. Therefore, if materials developed for dissemination contain statements urging abusers to seek treatment, and it is not widely available, then the recognition of

this by the target group could cause them to doubt the veracity of the entire message. This may seriously undermine the efficiency of the campaign.

Other barriers are faced by NIDA in the development of a broad campaign to reduce the risk of transmission due to needle sharing behaviors and heterosexual contact internal to and external from the target populations. A significant first step will be the overcoming of false beliefs and misinformation held by many and significant segments of society about all facets of the AIDS epidemic. The problem is found everywhere in the country.

Following is a discussion of the materials, messages, and channels of communications which may be potentially utilized in a NIDA campaign aimed at reducing the risk of AIDS transmission for the defined target groups. Also included is a discussion of the recommended materials, messages, and health education communications channels which will best meet NIDA's mandate and needs for an effective AIDS eduation campaign.

III. Materials, Messages, and Communications Channels

a) Types of Potential Materials

National and local efforts specific to AIDS education for these target groups have used a wide variety of different materials, with different degrees of success. These include:

- Pamphlets, brochures, fact sheets
- Posters/billboards (in public locations such as the street, subways, busses)
- Photo novels/comic books
- Movies
- Videotapes
- Audiotapes
- Newsletters
- Wallet cards
- T-shirts, lapel buttons, etc.
- "Rap" (and other) musical tapes/records
- Magazines articles and news releases
- Television spots
- Radio spots
- Print advertisements
- Discussion guides for talk shows and group discussions
- Training materials for person-to-person risk reduction information diffusion

- o Documentotories
- o Curriculum guides for courses

Moteriols have been developed in response to various messages, to utilize oll passible communicotion channels, and address oll target groups. These "traditional" ond "non-traditional" materiols meet the need for multi-directional communications. All can be adopted to be culturolly, ethnicolly, and educotionolly-sensitive, and be developed in different languages.

b) Types of Potential Messages

In generol, the messages that are currently being disseminated, and which potentiolly could be disseminoted, olso show greot voriotion, showing significont differences in tone, focus, level-of-detoil, "explicitness", and use of "scare tactics" or coerciveness. Some generol types of messoges include:

- o Generol informationol/educotionol messages
- o Non-morolistic/non-judgementol messages
- o Messages which emphosize that AIDS is deadly, painful, non-curoble
- o Messages which emphasize risk-avoidonce: "Don't Shoot Drugs"
- o Messages which emphasize intermediote behavior change: "Sterilize Your Works"
- o Information oimed ot over-coming folse beliefs or misinformation
- o Messoges which emphosize the epidimiology of spread to other populotions
- o Messoges specific to IV drug use and AIDS
- o Messoges specific to sexuol behaviors ond AIDS
- o Messoges which are o "mix" of informotion about IV drug obuse and sexuol tronsmission

Other messoges are clearly directed specificolly to women, particular minorities, families and significont others of those in the target groups, or particular geogrophic regions. In fact, most messages contoin o variety of messoges, and may be dire ted to more than one target group.

c) Types of Potential Communications Channels

It is often difficult to clearly separate the material, messages, and communication channel as distinct entities. Certain communication channels lend themselves to particular messages and materials. It would be, as a simplistic example, difficult if not impossible to distribute video messages in a street setting. Communication channels are both national and local in scope. To develop and execute a broad campaign aimed at a variety of target groups (both specific and broadly defined), a wide spectrum of communication channels may be utilized. The scope of the channels could range from nation-wide mass media to person-to-person contact, and include:

- o Television and radio
- o Newspapers, periodicals, and magazines
- o Specialized print medium (i.e., for ethnic groups or special interest groups)
- o Public visual displays (e.g., billboards, bus posters, etc.)
- o Telephone hotlines
- o Public health organizational network (e.g., health clinics, V.D. clinics, hospitals, drug and alcohol abuse clinics, CMHC's, etc.)
- o Community and civic organizations (e.g., sports booster clubs and teams, political clubs, interest groups, business groups, etc.)
- o Churches
- o Schools
- o Criminal justice system
- o Local merchandizing networks and stores
- o Businesses and corporations
- o Outreach into neighborhoods and areas where hard-to-reach target groups exist (e.g., IV drug users).

The media has been labeled the most influential source of information in this country. Advantages to using media for health education include its immediate access to a mass media audience that is comfortable with the medium and may appreciate its anonymity for some types of health education. While its effectiveness may not match that of more personal education settings, the very size of the audience makes media a

highly effective approach is absolute numericol terms. However, there is no known single medio channel powerful enough by itself to make an effective AIDS educotion progrom. It has been shown that the most effective compaigns need o mix of medio channels. In post communicotions, findings support the use of broadcost medio (radio and television) for reoching people quickly with foirly simple ideas, and then use print medio for providing complex informotion or informotion people may wont to reread ot the time it is actually needed. Interpersonol communication channels, group meetings, and community organizations are best for reinforcing and developing credibility for the information, but o combination of broadcast, print and interpersonol components are needed to make o truly effective progrom. Lorge number of people need to be reached quickly, they need a remirder about what they have been told, and they must believe in the integrity and worth of the programs if they ore to follow the recommendotions ond informotion received.

The challenge in developing an effective communicotion methodology is to orchestrote the various inputs to moximize their totol impact and to minimize costs. Not all channels con be used oll the time becouse costs would be exorbinant. Elements must be selected from each of the medio groups ond integroted in o manner thot results in achieving a totol impact that is greater than the sum of the individual efforts.

In making o rotional combination of choices, the following questions can be roised: How many people will be exposed to the message (medio coveroge or readership); to what extent will porticulor target oudiences be reoched; to what extent will the prestige ond credibility of the medio channel contibute to the effect of the message (medio authority); ond what ore the economic consequences of the use of certoin medio (cost effectiveness considerotions).

To further support recommendotions for an effective communicotions methodology, doto collected directly from IV drug users in various cities oround the country have been onolyzed to guide the mix of informotion channels and messages to be employed. Communicotions doto were collected from 287 IV drug obusers in treatment settings in seven U.S. cities: Miami, St. Louis, Houston, Boston, Detroit, Cleveland, and the District of Columbia. Doto were collected os port of o pretest of AIDS informotional moteriols developed by the Notionol Institute on Drug Abuse (NIDA). As the following tobles (Tobles 2 ond 3) indicote, additional doto were collected from IV drug users, both in treotment and not in treotment in the District of Columbia. In this case, doto were

collected for the District's Commission on Public Health as part of a research study on attitudes, knowedge, and behaviors among AIDS high risk groups in D.C. In this latter study, a total of 159 IV drug users who were in treatment and 63 not in treatment were surveyed.

TABLE 2

Former/Current IV Drug Abusers Beliefs Regarding Action That Would Help Stop The Spread of AIDS

Actions	Combined NIDA Pretest Data (In Treatment) N=287 %	DC RESEARCH STUDY In Treatment N=159 %	DC RESEARCH STUDY Not In Treatment N=63 %
1. More treatment for drug users	71	60	27
2. Educating people on how to prevent the spread of AIDS	91	77	90
3. Having the government provide free needles	29	49	3
4. Teaching IV drug users how to clean their needles (works, rig)	37	59	18
5. Have the government stop trying to scare IV drug users	11	18	5
6. Teaching people to have safer sex	69	76	54
7. Legalizing drug use	8	12	3
8. Having the government help people to stop taking drugs with needles	NA	59	8
9. Other	--	5	2

TABLE 3

Former/Current IV Drug Abuser
Sources of Health Information

Source Of Health Information	Combined NIDA Pretest Data (In Treatment) N=287 %	DC RESEARCH STUDY In Treatment N=159 %	DC RESEARCH STUDY Not In Treatment N=63 %
1. Television	84	89	89
2. Radio	64	37	29
3. Gay Newspaper	10	0	0
4. Newspaper	77	69	56
5. Magazines	70	41	13
6. Churches	24	2	0
7. Schools	37	4	0
8. AIDS Hotline	31	1	0
9. Community Groups	38	3	0
10. Friends	48	28	14
11. Relatives	42	20	11
12. Health care worker/ professional	58	12	3
13. Other	5	0	0
14. Have not obtained AIDS health information	1	0	0

These findings, when viewed in the context of IV drug users general knowledge, risk behaviors, and perceptions of their own susceptibility present a perplexing dilemna. IV drug abusers are knowlegeable about AIDS and the general modes of transmission but are neither changing their risk behaviors nor perceiving themselves at risk. On the other hand, as shown in Table 2, of all the IV drug abusers surveyed, the majority (an average of 86%) felt that education would be effective in preventing the spread of AIDS and that teaching people to have safer sex was of particular importance (an average of 66%). Teaching IV drug users how to clean their needles appears to be of secondary importance across all IV abuser populations surveyed, (at an average of 38%). These finding present serious implications for the content of the education messages.

Upon review of health information sources, (Table 3), we find that television is the most common source (with an average of 87%) across all surveyed. Newspapers are second across all groups showing an average readership of 67%. Health information through radio is third most common, showing an average of 43%, (with the greater population being in-treatment, 64% and 37% vs. 29% not in treatment). Outside of D.C., it appears that interpersonal communication through churches, schools, and community groups, friends, relatives and health care workers plays a role in health education for about 40% of those surveyed.

An average of 11% of those in-treatment in D.C. reportedly receive health information on an interpersonal basis while 5% of those not in-treatment report these sources. The large discrepancy in interpersonal communication as a source of health information between the pretest and D.C. data is possibly due to the fact that at the time of the D.C. survey, street outreach to drug abusers had only just begun. In many of the pretest cities, however, street outreach activities as well as relatively sophisticated AIDS education referral networks were operating during the time the survey was administered.

a. Recommended Materials, Messages, and Communications Channels

Suggested themes and tones for messages have been developed based on the consideration of the following:

1. How do drug abusers feel about AIDS? How important or serious do they perceive it to be? Are they afraid to do anything about AIDS? Do they believe that preventive measures are effective?

2. Do the target group members know their own degree of risk or susceptibility? Does the target group know what actions should be taken? If so, would taking action conflict with their personal priorities or self image? What are the major barriers to taking action against AIDS?

3. What do people believe to be the consequence of not acting? What do they believe to be the benefits of taking action? Is is for their future well-being? For the well-being of their loved ones?

4. What are the characteristics of each groups' present needle sharing and sexual behaviors, knowledge, and attitudes respectively? Which behaviors contribute to the spread of AIDS? Which are most amenable to change?

Some of the answers to these questions have been discussed in the context of this report. In general it appears that IV drug abusers do not acknowledge personal risk. Furthermore, they do not fully understand the compound risk in needle sharing combined with unprotected sexual practices. It also has been suggested that drug users frequently underestimate the threat of AIDS and that they are a group who is least likely to change their behavior because of it.

Because IV drug abusers have basic knowledge of the modes of transmission, however, one is led to believe that denial plays a large part in their not perceiving themselves at risk. This denial may stem from a more immediate threat than AIDS-the loss of friends and possibly family. "Drug buddies" and their families are, in general, their only support systems. To openly acknowledge that one is at risk threatens those people with whom they have shared needles, and all those who had unprotected sex with him/her. It also means breaking long established behavior patterns. Futhermore, to openly acknowledge a loved one is at risk reflects suspicion, and to refuse to have unprotected sex and/or share needles may result in alienation. These latter problems, reflected in data collected by IV drug abusers, may very well reflect those of the general public.

Messages directed toward the IV drug abuser need to break through the denial barriers by creating a less threatening image of safe sex and reduced needle sharing. Condoms have already taken on a new image for many, one of being smart, protecting one's self and sexual independence. For the Gay population, safer sex practices have become a new and respected way of life for many in that safer sex demonstrates sexual responsibility.

Although IV drug abusers are traditionally a difficult group in which to effect behavior change, they, like the general public, are influenced by the media and social norms. Therefore, messages must work to change their attitudes toward unprotected sex and needle sharing; this is a first step in creating new norms and behavior change.

Following is a synoptic overview of the recommended materials, messages and communications channels necessary for an effective NIDA campaign to combat further HIV infection internal to and external from the IV drug abusing population. It should be stressed that, in all cases, the materials and messages to be disseminated through the communications channels have the following characteristics:

- Be culturally and ethnically sensitive.
- Be updated continually to reflect current information.
- Be reviewed by local area panels and committees to assure that they are sensitive to unique community characteristics, needs, and "standards".
- Be reinforced through constant use of different media and alternative forms, level of detail, etc.

RECOMMENDED
MATERIAL #1

TELEVISION "SPOTS"/PSA'S

Primary Audience: all current IV drug abusers

Secondary Audiences: sexual partners of current or ex-IV drug abusers; family, friends, and significant others of current or ex-IV drug abusers; sexually active heterosexuals.

Recommended Messages

1) Specific, direct, correct
2) Stop using drugs
3) "Catchy" slogans/phrases
4) Emphasize pain, suffering, isolation associated with AIDS
5) People can be "asymptomatic" carriers of HIV
6) Direct viewers to realistic places/resources for drug treatment and/or further information

Recommended Channels of Distribution

1) Network television, local television
2) Timing: during music, sports events, and/or evening/late evening hours

Discussion: Television stations will not air all types of AIDS messages, due to "appropriateness" and "community standards". Potential roles of television include general education and increasing AIDS awareness, and directing viewers to sources of drug treatment, medical care, and further information.

RECOMMENDED
MATERIAL #2

RADIO "SPOTS"/PSA'S

Primary Audience: all current IV drug abusers.

Secondary Audiences: sexual partners of current or ex-IV drug abusers; family, friends, and significant others of current or ex-IV drug abusers; sexually active heterosexuals

Recommended Messages

1) Specific, direct, correct
2) Stop using drugs
3) "Catchy" slogans/phrases
4) Emphasize pain, suffering, isolation associated with
5) People can be "asymptomatic" carriers of HIV
6) Direct listeners to realistic places/resources for drug treatment and/or further information

Recommended Channels of Distribution

1) Local radio stations
2) Types: Urban contemporary, Black contemporary Album oriented rock

Discussion: Radio stations will not air all types of AIDS messages, for reasons similar to those applied to television. They can be used for general public information and education, and some specific IV drug abuse and sexual behavior messages. A strong benefit to radio will be directing viewers to sources of drug treatment, medical care, and further information.

RECOMMENDED
MATERIAL #3

NEWSPAPER ARTICLES/ADVERTISEMENTS/PUBLIC SERVICE SPACE

Primary Audiences: "vetran abusers", "non/user users", "recreational users".

Secondary Audiences: sexual partners of current or ex-IV drug abusers; family, friends, and significant others of current or ex-IV drug abusers; sexually active hetersexuals.

Recommended Messages

1) Specific, direct, carrect
2) Stop using drugs/Don't use drugs
3) "Catchy" slogans/phrases
4) Emphasize pain, suffering, isolation associated with AIDS
5) People can be "asymptomatic" carriers of HIV
6) Direct readers to realistic places/resources for drug treatment and/or further nformation

Recommended Channels of Distribution

1) Local newspapers, community newspapers
2) Placement: community news, sports, entertainment sections

Discussion: Newspapers can provide very timely information about AIDS, and go into further and target group-specific detail than some other distribution channels. Local newspapers (including "dailies" and weekly community papers) have distinct advantages over some other channels of communication: they can be read and reread in privacy, they reach most homes, and they can be "passed on" or remain in one location for use by more than one person.

RECOMMENDED
MATERIAL #4

AIDS PAMPHLETS

Primary Audiences: "veteran users", "active adult abusers", "dual diagnosis abusers"

Secondary Audiences: "non user/users", sexual partners of current or ex-IV drug abusers; family, friends, and significant others of current or ex-IV drug abusers; sexually active heterosexuals.

Recommended Messages

1) Informational/educational
2) Stop using drugs
3) Sex and drug use behaviors
4) Specific, direct, correct
5) Emphasize pain, suffering, and social isolation often associated with AIDS
6) Direct readers to realistic plans/resources for drug treatment and/or further information

Recommended Channels of Distribution

1) Medical/social service programs and facilities
2) Drug treatment
3) Churches
4) Civic groups, community centers
5) Jails/criminal justice system

Discussion: Pamphlets can take many forms, be tailored to be culturally and ethnically sensitive, and be prepared in different languages. It is recommended that a "photobook" or "comic book" style be compiled for use by those with reduced reading abilities. Pamphlets can be graphic and provide (if warranted) specific detail on high-risk drug abuse and sexual behaviors, HIV anti-body testing, etc., and be tailored to community organizations through the use of specific and unique logos, telephone numbers, etc. Pamphlets also lend themselves to discussion, and distribution to more than one reader.

RECOMMENDED
MATERIAL #5

TRAINING MATERIALS FOR ONE-TO-ONE COUNSELING AND EDUCATION

Primary Audiences: "veteran abusers", "active, adult abusers", "dual diagnosis abusers"

Secondary Audiences: "non-users/users", sexual partners of current or ex-IV drug abusers

Recommended Messages

1) Coercive
2) Stop using drugs
3) Get into treatment
4) Specific, direct, correct
5) Emphasize transmission to loved ones
6) Cover sex and drug use behaviors
7) People can be "asymptomatic" carriers of HIV

Recommended Channels of Distribution

1) Streets
2) Health fairs
3) Medical/social services programs
4) Drug treatment

Discussion: Training materials for one-to-one counseling and education are essential for the conduct of street outreach and personalized information dissemination in numerous settings. They help the counselor/education provide information and advice which the person receiving the information can use in a practical and personal way. For many persons in these target groups, the "personal touch" is perceived to be highly effective, especially when provided by ex-addicts, ex-prostitutes, and/or respected community members of similar background.

RECOMMENDED
MATERIAL #6

POSTERS/BILLBOARDS

Primary Audiences: "active, adult abusers", "dual diagnosis abusers"

Secondary Audiences: all other target groups

Recommended Messages

1) "Catchy" slogan/phrases
2) Stop using drugs
3) Get into treatment
4) Specific, direct, correct
5) Emphasize transmission to loved ones
6) Direct readers to realistic places/resources for drug treatment and/or further information

Recommended Channels of Distribution

1) Public transportation
2) "Fast food", supermarkets
3) Streets
4) Prisons/jails/criminal justice system

Discussion: Posters and billboards are an established form of information dissemination. They work best when "catchy", highly visual, and quick to read and understand. A traditional use for posters and billboards is to engage the reader's interest enough so that they will find out more about the subject of the materials. Posters and billboards can also be used effectively to channel people to community resources for further information.

SUMMARY OF RECOMMENDED MESSAGES AND MATERIALS BY TYPE OF IV DRUG ABUSER

1) "Veteran Abuser"

MESSAGE:	Risk Reduction - Clean needles/don't share/seek treatment
MATERIALS	Short pamphlets, training materials for one-to-one counseling, community newspapers/newsletters, television, radio
INTERMEDIARIES:	Civic groups, drug treatment, criminal justice system, street outreach

2) "Active, Adult Abuser"

MESSAGE:	Risk Reduction - Clean needles/don't share/seek treatment
MATERIALS:	Short pamphlets, training materials for one-to-one counseling, posters/billboards, radio, television
INTERMEDIARIES:	Drug abuse programs, medical/social service programs, criminal justice system, street outreach

3) "Non User/User"

MESSAGE:	Risk avoidance - No further abuse/no experimentation
MATERIALS:	Radio, television, magazines
INTERMEDIARIES:	Community/civic groups, drug abuse prevention programs

4) "Recreational User"

MESSAGE:	Risk Avaidance - No further abuse/no experimentation
MATERIALS:	Television, radio, magazines/newspapers
INTERMEDIARIES:	Community/civic groups, drug abuse prevention programs, professional organizations/societies

5) "Dual Diagnosis"

MESSAGE:	Risk Reduction - Clean needles, don't share, seek treatment
MATERIALS:	Radio, television, print, training materials for one-to-one counseling, short pamphlets
INTERMEDIARIES:	Medical/social/mental health system, street outreach, neighborhood/civic/"block" associations

SUMMARY OF RECOMMENDED MATERIAL, MESSAGES, AND CHANNELS OF COMMUNICATION

MATERIALS

- Television "spots"/PSA's
- Radio "spots"/PSA's
- Newspaper articles/advertisements/public service space
- Pamphlets
- Training materials for one-to-one counseling and education
- Posters/billboards

MESSAGES

- Risk Avoidance - no further drug abuse/ no experimentation
- Risk Reduction - clean needles/don't share/seek treatment
- Combine high-risk drug abuse and sexual behavior messages
- Specific, direct, correct

CHANNELS OF COMMUNICATION

- Television, radio
- Newspapers
- One-to-one counseling and education
- Public areas - public transporation, streets, community centers
- Drug abuse prevention programs, drug abuse treatment and rehabilitation programs and settings.

IV. NIDA Role in Health Communications Plan on AIDS and IV Drug Abuse

NIDA is in an excellent position to act as a catalyst to promote a national campaign with local focuses. From an overall perspective, NIDA's role in this campaign should be both substantive and supportive. This dual role is necessary because there are certain fuctions which can be best performed by NIDA, with others requiring the active participation of individuals and organizations in local areas. Specifically, NIDA has the expertise in planning communication campaigns, conducting background and supportive research, developing materials and providing technical assistance, among other important functions necessary for a successful campaign. However, it is not recommended that NIDA be responsible for actually conducting the campaign, as the local, community focus requires the active participation of local elements as a legitimizing and strongly supportive factor.

Some specific recommended roles for NIDA with respect to an AIDS education campaign as described include:

a) Background Research/Needs Assessment in Collaboration With Local Resources

NIDA has already performed a good deal of background research for this campaign through pretesting materials with focus groups, contacting local organizations and individuals, and by holding workshops with local representatives and members of the media. However, more active and supportive effort is necessary.

In relation to IV drug users and those associated with them, a range of information has been collected. For this target group, several more focus groups should be conducted to refine information upon which messages will be developed. For other target groups who are at risk of transmission due to heterosexual contact, a breadth of information describing beliefs, attitudes and knowledge is needed. Some of this can be taken from data already collected at various sites across the country. However, more in-depth information is needed from the range of age and ethnic groups involved. A series of focus groups needs to be conducted to obtain this information. Persons who are best able to conduct these focus group would be sex educators who have dealt with the range of groups under consideration. It is suggested that NIDA obtain the expertise of these individuals, to collect the information which will be a seminal part of various messages.

b) **Messages and Materials Development**

NIDA has significant experience in this area. It should develop the messages, the formats for the materials, and in some cases produce the materials. The types of recommend messages and materials were discussed earlier; however, all materials or messages should be developed in partnership with expertise available at the local level. Alternative materials should also be developed as models or "templates" for local area use, so that they may tailor the materials and messages for local area use. This could be done simply with unique logos, specific information on "where to get help or more information" available at the local level, etc., or through more detailed modification of the materials and/or messages.

c) **Pretesting Materials and Messages**

The pretesting of materials should be initially conducted by NIDA, given its expertise and experience in this process. Technical assistance and training should be made available at the local level, so that communities can assume some of this responsibility in the future.

d) **Provision of Materials Clearinghouse**

NIDA is the logical choice for the collection, storage, and dissemination of materials. NIDA should assume the role of "gate-keeper" of information about AIDS and IV drug abuse, and not only distribute materials to local areas, but collect local area materials as well. This important resource would significantly assist areas which are beginning to experience problems with AIDS, and who would not be able to develop or research the use of other materials without a significant time delay. The clearinghouse could provide a quick response of high quality materials to meet local area needs.

c) **Developing Communications Channels**

The development of communication channels is an activity that should be performed by local organizations. Some areas (e.g., San Francisco) have shown that they are very effective in doing this. However, many of the cities which are the focus of the NIDA campaign are not progressing as rapidly as they should. Where this is the case NIDA must provide supportive assistance.

The development of local communication channels is a matter of interacting with the media and developing collaborative efforts involving local public and private organizations. As has been seen, some cities have not been able to mobilize relative to this health problem. The technical assistance that is required should be in the form of training those involved to do organizational, community, and resource development. Individuals who provide this technical assistance should have experience in these development processes as they relate to AIDS.

f) Funding

To be successful the health communications campaign will require significant funding. As important, if it is successful, there will be an increased demand for more health education, HIV testing, and drug treatment/rehabilitation. With respect to drug education and treatment, this financial responsibility will fall, in part, within the realm of NIDA responsibility. NIDA can also assist local communities by identifying alternative funding sources for the education and treatment initiatives, and potentially provide technical assistance to local areas in seeking out and successfully obtaining this alternative source funding.

g) Maintain Local Support

NIDA should rely on local areas to assist them with education on the local level. NIDA should develop a newsletter aimed at local supporting persons and organizations, to keep them up to date on new information initiatives, research, etc. Regional or national workshops and conferences involving local area organizations and coalitions to share information, expertise, and materials should be strongly considered as well. This will help maintain the network developed, and allow local areas to feel that they are an integral part to the important struggle to educate the public about AIDS and IV drug abuse.

H) Monitoring, Feedback, and Control

The monitoring and control of the campaign in the cities is a communication research activity that should be carried by local organizations. Past experience in some of these cities has shown that either expertise is not available in responsible organizations, or that it cannot be identified. This, therefore, is an area where NIDA can

provide technical assistance. Assistance should be in the form of training responsible organizations how to acquire communication data in this setting, and analyzing it so as to enhance the effectiveness of message diffusion.

REFERENCES

1. Public Health Reports, July-August, 1986, Vol. 101, No. 4, pp. 341-349.

2. Ibid.

3. NIDA Notes, March, 1987, Vol. 2, No. 1 (National Institute on Drug Abuse).

4. NIDA Report on Drug Abuse Treatment in the United States, 1984.

5. Estimates of the Prevalence of Drug Abuse in the State of Maryland: 1982 and 1986; Drug Abuse Administration, Maryland State Department of Health.

6. Chaisson, R.E., et al: Human Immunodeficiency Virus Infection in Heterosexual Intravenous Drug Users in San Francisco, AJPH February, 11987, Vol. 77, No. 2, 169-172.

7. Spira, T.S., et al.: Prevalence of Antibod. to Lymphadenopathy - Associated Virus Among Drug - Detoxification Patients in New York, N. Engl, J. Med., 1984, 311: 467.

8. Des Jarlais, D.C.: AIDS Among Intravenous Drug Users: Overview and Update, Presentation at the International Conference on AIDS. Atlanta, GA, April 14-17, 1985.

9. CDC Update, Public Health Service Workshop on Human T - Lymphotropic Virus Type III Antibody Testing - United States, M/MWR, 34(31): 477-473 (August 8, 1984).

10. Op Cit., Chaisson

11. Friedland, G.H., et al.: Intravenous Drug Abusers and the Acquired Immunodeficienty Syndram: Demographic, Drug Use, and Needle Sharing Patterns. Arch. Interm. Med., 145; 1413-1417 (1985).

12. Study of Risk Behaviors Among IV Drug Users in Washington, D.C.; District of Columbia, Commission of Public Health (1986).

13. Novick, E. et al: Antibodies in New York City, Historical and Ethical Considerations. In: Haris L (ed): Proceedings of the 46th Annual Scientific Meeting, Committee on Problems of Drug Dependence, National Institute on Drug Abuse, Bethesda, MD (in press)

14. Robertson, JR, et al: Epidemic of AIDS Related Virus (HTLV-III/LAV) Infection Among Intravenous Drug Users. Br Med J; 292: 527-529

15. AIDS Weekly Surveillance Report - United States AIDS Program, Center for Infectious Diseases, Centers for Disease Control; March 23, 1987

74-444 0 - 87 - 9

16. Op Cit., AIDS Weekly Surveillance Report

17. Op Cit., AIDS Weekly Surveillance Report

18. Op Cit., AIDS Weekly Surveillance Report

19. Op Cit., Chaisson

20. Weiss, SH, et al: Risk of HTLV-III Exposure and AIDS Among Parenteral Drug Abusers in New Jersey. The International Conference on Acquired Immunodeficiency Syndrome: Abstracts 1985, Philadelphia, American College of Physicians

21. NIDA Notes, December 1986, Vol. 1, No. 4 (National Institute on Drug Abuse)

AIDS

Information/Education Plan to Prevent and Control AIDS in the United States

March 1987

U.S. Department of Health and Human Services
Public Health Service

PREFACE

The most important public health problem facing us today is acquired immunodeficiency syndrome—AIDS.

Nearly 32,000 Americans have developed AIDS, and more than half of them have died. As many as 1.5 million more Americans may already have been infected by the AIDS virus. Even if they currently show no symptoms, they can transmit the virus to others. The Public Health Service estimates that by the end of 1991, total AIDS cases in the United States will have risen to more than 270,000 and more than 179,000 people with AIDS will have died.

The devastating effects of AIDS also are being felt far beyond the boundaries of our own country. Indeed, AIDS already has been reported from at least 90 countries throughout the world. World Health Organization officials estimate that between 5 million and 10 million people worldwide may have been infected by the AIDS virus. By 1990, according to WHO estimates, conceivably as many as 100 million people worldwide may be infected by the virus, and a number of these may have developed AIDS itself.

Clearly, AIDS represents a national and international emergency. For this reason, AIDS is a top priority on my personal agenda and on the agenda of this Administration.

This Department is conducting and supporting intensive research to develop effective treatments for AIDS patients and a safe and effective vaccine that will prevent initial infection with the virus. But no cure for the disease currently exists, and if a successful vaccine can be developed, it will not be generally available for some years to come. Our best hope today for controlling the AIDS epidemic lies in educating the public about the seriousness of the threat, the ways the AIDS virus is transmitted, and the practical steps each person can take to avoid acquiring or spreading it.

A massive, effective campaign to educate the public is in order. The plan presented here is a blueprint for accomplishing it.

This AIDS Information/Education Plan is consistent with the following principles proposed by the Domestic Policy Council and approved by the President:

- Despite intensive research efforts, prevention is the only effective AIDS control strategy at present. Thus, there should be an aggressive Federal effort in AIDS education.
- The scope and content of the school portion of this AIDS education effort should be locally determined, and should be consistent with parental values.
- The Federal role should focus on developing and conveying accurate health information on AIDS to the educators and others, not mandating a specific school curriculum on this subject, and trusting the American people to use this information in a manner appropriate to their community's needs.
- Any health information developed by the Federal Government that will be used for education should encourage responsible sexual behavior—based on fidelity, commitment, and maturity, placing sexuality within the context of marriage.

- Any health information provided by the Federal Government that might be used in schools should teach that children should not engage in sex, and should be used with the consent and involvement of parents.

The Department of Health and Human Services will apply these principles to the fullest extent, working with all other sectors of our society and cooperating with international efforts to defeat this terrible disease. Together, we will press forward on all fronts—research, information, education, and services to those afflicted—and together we will win the battle against AIDS.

Otis R. Bowen, M.D.
Secretary

FOREWORD

The Public Health Service's mission, broadly stated, is to protect and improve the health of the American people. PHS is the component of the Department of Health and Human Services with lea l responsibility fc research and education on AIDS.

Since AIDS cases were first identified in 1981, informing and educating the public about AIDS has been a primary part of our work. These efforts to inform and educate must be greatly intensified, and their effects must be multiplied through the collaboration of many other agencies and organizations in the public and private sectors.

This document presents a comprehensive PHS plan for informing and educating the American people about AIDS. The plan specifies the audiences to be addressed by this effort, the basic elements of AIDS information and education, and the means by which this education will be accomplished (among them, mass media campaigns, health education programs, demonstration programs, a clearinghouse of AIDS information, critical partnerships with other agencies and organizations, and development of special information for use by educators).

The cooperation of State, county, and municipal governments, professional and service organizations, the private sector, and other Federal agencies will be crucial to ultimate success of the Public Health Service's plan. For these varied agencies and organizations, this document provides an overview of the ways in which their efforts contribute to the urgent task of educating Americans about AIDS.

The plan draws upon the knowledge and experience the Public Health Service has gained since AIDS was first recognized, and it incorporates the contributions of many experts in the PHS agencies: the Alcohol, Drug Abuse, and Mental Health Administration, the Centers for Disease Control, the Food and Drug Administration, Health Resources and Services Administration, the National Institutes of Health, and the Office of the Surgeon General. It represents a tremendous amount of work by staff, laboring under many pressures.

I am grateful for the contributions of those who have worked on this plan, and I am proud to be associated with all the dedicated persons in the Public Health Service who have committed so much personal effort to the battle to prevent and control AIDS

Robert E. Windom, M.D.
Assistant Secretary for Health

EXECUTIVE SUMMARY

As of March 2, 1987, deaths in the United States due to acquired immunodeficiency syndrome (AIDS), total almost 18,385. In 1985, AIDS became the 11th leading cause of years of potential life lost, and in 1986 it is expected to be eighth. The report of the Public Health Service (PHS) Coolfont Conference in June 1986 projected that by the end of 1991 the cumulative total of AIDS cases would exceed 270,000, with more than 179,000 deaths. AIDS will remain a serious problem for the nation for some time to come.

At this time, the best hopes for prevention rest on a strategy based on public information and education. Knowledge about AIDS has already proved to be effective in changing behavior among homosexual men.

The 22 Public Health Service (PHS) Guidelines on the prevention of AIDS issued between 1982 and 1986 have provided a foundation for informational and educational efforts to prevent this disease (see Appendices A & B). The Public Health Service Plan for the Prevention and Control of AIDS (1985), the Report of the PHS Coolfont Conference (1986), and the Surgeon General's Report on AIDS (1986) all focus on developing information, education, and risk reduction programs.

Successful implementation of this plan requires action from and cooperation among State, county, and municipal governments, professional and services organizations, the private sector, and the Federal Government. It is expected that funds appropriated by Congress in any given year for information and education will be multiplied manyfold by the efforts and resources of others.

The information/education effort consists of four major components:

1. The Public

Everyone must be aware of behavior that puts them at risk of infection.

2. School and College Aged Populations

Schools and colleges provide an effective channel for appropriately instructing the young people of our nation about AIDS before, and as, they reach the ages that they might engage in behaviors that place them at risk of infection. The Public Health Service will provide national, State, and local educators with up-to-date, factual AIDS information. State and local school boards, along with families, community, and parent groups have the primary responsibility for educating the young.

3. Persons at Increased Risk or Infected

The highest priority for AIDS information and education efforts are those groups at increased risk of acquiring or transmitting the AIDS virus because of certain behaviors or circumstances: gay and bisexual men, IV drug abusers, hemophiliacs, female sex partners of those at risk and who may become pregnant and infect their offspring, and prostitutes and their clients. Persons known to be infected must receive information to prevent their transmission of the virus to others.

4. Health Workers

Members of this group have direct responsibility for patient care, for counseling AIDS patients or persons with laboratory evidence of infection, and for providing leadership in informing and educating the public. By virtue of their occupations, there is some risk, albeit small, of infection.

Following are examples of some of the major projects include in the PHS plan:

The Public.

- Produce a mass media campaign under contract with a leading advertising agency (TV and radio spots, print materials).
- Form a coalition of public and private sector groups to exchange and coordinate AIDS information efforts.
- Set up a clearinghouse on AIDS information to serve State and local AIDS program personnel and the public.
- Support toll-free hotline on AIDS (since 1983).

School and College Aged Populations.

- Convene national school health coalition on AIDS and work with national organizations.
- Stimulate the development of programs for Black and Hispanic youth.
- Help State education departments and colleges of education provide AIDS education.
- Work with State and local areas with highest incidence of AIDS to assist in providing educational programs in schools
- Develop compendium of materials, programs and resources; instruments to measure quality and outcomes of this education.
- Help provide AIDS education to college students, assist especially in areas where AIDS incidence is high, work with other groups to reach youth not in school.

Persons at Increased Risk or Infected.

- Demonstrate effective ways of educating those at increased risk.
- Help States build their own capacity for conducting programs (counseling, health education, minority programs, hotlines, coordination).
- Expand drug abuse treatment services, counseling, and antibody testing and develop new strategies for preventing and treating drug abuse.
- Add educational programs to regional hemophilia centers.
- Provide information on behaviors that reduce perinatal transmission of the AIDS virus.
- Demonstrate effective programs to reduce perinatal transmission.

Health Workers.

- Survey physician counseling practices and develop appropriate materials.

- Train physicians and other health workers through training center programs and outreach programs.
- Provide information and materials to professional organizations.
- Provide training in up-to-date laboratory techniques.
- Educate health professionals to assess women and counsel them, including minority women.

In June 1986, the Public Health Service convened some 85 experts on AIDS to update PHS plans for the prevention and control of the disease in light of new knowledge and of demographic projections through 1991. A major section of the final report from this Coolfont Planning Conference dealt with needed AIDS information and education initiatives. The information/education plan summarized here responds fully to these recommendations.

TABLE OF CONTENTS

I. OVERVIEW

INFORMATION/EDUCATION PLAN TO PREVENT AND CONTROL AIDS IN THE UNITED STATES

I. OVERVIEW

A. INTRODUCTION

Deaths due to acquired immunodeficiency syndrome (AIDS) became the 11th leading cause of years of potential life lost in 1985. In 1986, AIDS was one of the first 10 causes. The report of the Public Health Service (PHS) Coolfont Conference in June 1986 projected that by the end of 1991 the cumulative total of AIDS cases would exceed 270,000, with more than 179,000 deaths. Most of these projected future AIDS cases will be among persons who in 1986 are already infected. Current estimates of infected persons in the United States range from 1 million to 1.5 million. AIDS will remain a serious problem for the nation for some time to come.

The current data indicate that 97% of AIDS patients in the United States can be placed in groups related to possible means of disease acquisition: men with homosexual or bisexual orientation who have histories of using intravenous (IV) drugs (8% of cases); homosexual or bisexual men who are not known IV drug users (65%), heterosexual IV drug users (7%); persons with hemophilia (1%); heterosexual sex partners of persons with AIDS or at risk for AIDS (4%); and recipients of transfused blood or blood components (2%). Insufficient information is available to classify the remaining 3% by the above recognized risk factors for AIDS.

In Africa over 90% of cases have occurred through heterosexual transmission, equally divided among men and women.

The World Health Organization estimates that 50 to 100 million persons worldwide may be infected with the AIDS virus by 1991. Based on current information, 20-30% will progress to AIDS within 5 years of initial infection. This percentage is likely to increase beyond 5 years. Thus, AIDS represents a health disaster of pandemic proportions.

The best hopes at this time for prevention rest on a strategy based on information and education. Knowledge about AIDS has already proved to be effective in changing behavior among gay men. The effectiveness of information/education programs, however, remains to be demonstrated in populations whose members have not been as personally touched by AIDS and who do not perceive themselves to be at risk. The fact that the AIDS virus can be spread by sexual contact with persons who may otherwise appear healthy adds to the complexity of the task.

Key to changing attitudes and behaviors is the provision of factual, consistent, and understandable information about AIDS by persons and organizations in whom the recipient has confidence. Thus, multiple channels must be used, including the Federal, State, and local governments, medical professionals, teachers, parents, religious leaders, voluntary organizations, employee organizations, State and local departments of health and education, businesses, commercial organizations, and public figures held in high esteem.

Information/education efforts will be designed for the general public and for specific groups based on the risks of AIDS, the messages to be provided, and the channels for delivering those messages. The use of multiple channels will reinforce basic messages and increase the opportunities to inform and educate the U.S. population about AIDS.

B. PLANNING

In order to meet its responsibility in controlling the spread of AIDS, the Public Health Service created the Executive Task Force on AIDS in 1984. The Task Force, chaired by the Assistant Secretary for Health, serves as the mechanism by which AIDS related issues are identified and addressed in a coordinated fashion by the PHS constituent agencies: Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), Centers for Disease Control (CDC), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), and the National Institutes of Health (NIH). Within the Task Force, CDC has been designated as the lead agency in the area of AIDS information, education, and risk reduction.

The 22 Public Health Service (PHS) Guidelines on the prevention of AIDS issued between 1982 and 1986 have provided a foundation for informational and educational efforts to prevent this disease (see Appendices A & B). The Public Health Service Plan for the Prevention and Control of AIDS (1985), the Report of the PHS Coolfont Conference (1986) and the Surgeon General's Report on AIDS (1986) all focus on developing information, education, and risk reduction programs.

From 1983 through 1986, the Public Health Service spent $40 million in direct expenditures to inform and educate the public and groups at high risk of acquiring infection. In 1987, PHS will spend $79.5 million for AIDS education; the President's FY 1988 budget requests $103.9 million for this activity. States, local governments, voluntary organizations, and community service organizations have also contributed significantly in information/education efforts.

This plan draws on the knowledge and experience gained since the recognition of the AIDS epidemic in 1981. Each of the PHS member agencies have contributed to the plan. The plan will be reassessed and revised on an annual basis. The revised plan for 1988/89 will be available in November 1987.

C. IMPLEMENTING

PHS has a responsibility to provide clear and accurate information about AIDS to all segments of our society. This plan is designed to ensure that the necessary information about AIDS will be transmitted in an efficient and effective manner. Successful implementation of this plan depends upon action from and cooperation among State, county, and municipal governments, professional and services organizations, the private sector, and the Federal Government. It is expected that funds appropriated by Congress in any given year for information/education will be multiplied manyfold by the efforts and resources of others. Those organizations dealing with specific issues are identified in the sections that follow.

The information/education plan addresses the following:

1. The Public

In order to control transmission of the AIDS virus, everyone must be aware of behavior that puts them at risk of infection. They must learn how the virus is and is not spread.

2. School and College Aged Populations

Schools, colleges, and family institutions provide an effective channel for appropriately instructing the young people of our nation about AIDS before, and as, they reach the ages when they might practice behaviors that place them at risk of infection.

School and college aged populations who do not attend schools or colleges will be informed/educated about AIDS through other agencies that serve youth.

Persons at Increased Risk or Infected

The highest priority for AIDS information and education efforts are those groups at increased risk of acquiring or transmitting the AIDS virus because of certain behaviors or circumstances: gay and bisexual men, IV drug abusers, hemophiliacs, female sex partners of those at risk (because of potential pregnancy), and prostitutes and their clients. Persons known to be infected must receive information to prevent their transmission of the virus to others.

4. Health Workers

Members of this group have direct responsibility for patient care, for counseling persons with laboratory evidence of infection or AIDS patients, and for providing leadership in informing and educating the public. By virtue of their occupations, there is some risk, albeit small, of infection.

D. EVALUATING

Evaluation is an integral part of the planning and implementation process. Both quantitative and qualitative evaluation methods will be used to assess factors such as:

- the effectiveness of the information and education materials and various teaching methods for reaching the target populations
- the extent to which all appropriate organizations and individuals are being made a part of the prevention activities
- changes in the behavior of the target groups toward reducing the risk of infection and transmission
- changes in the rate of virus transmission.

E. TIME TABLE

A beginning date is indicated for each task.

Under this plan, each PHS agency will develop operational plans containing more detailed descriptions of tasks and subtasks, including responsible organizational components, names of collaborating organizations, beginning and ending dates, anticipated outcomes, and methods of evaluation. These operational plans will be available by April 1, 1987.

II. BASIC ELEMENTS OF AIDS INFORMATION

The elements described below will need to be adapted to varying degrees of specificity for different subgroups within the four major groups: the public, the school and college aged, persons at increased risk or infected, and health workers.

Communities and their important institutions, such as churches, families, and voluntary organizations, will need to adapt the presentation of this information to fit within their value systems. Within this framework, individuals will be able to determine responsible behavior, thereby avoiding adverse health consequences to themselves and others.

The specific wording and style of presentation, once developed, should be pretested on representative samples of the intended audiences to ensure effectiveness. Expert advice, consultation, and creative assistance can be provided by public and private health education and communication experts.

A. INDIVIDUALS IN ALL GROUPS NEED TO KNOW:

1. Current information on the seriousness of the disease

2. How the Virus is Spread

- The AIDS virus has been shown to be spread from an infected person to an uninfected person by:

  — sexual contact (penis/vagina, penis/rectum, mouth/rectum, mouth/genital),

  — sharing needles or "works" used in injecting drugs,

  — an infected woman to her fetus or newly born baby, and

  — transfusion or injection of infectious blood or blood fractions.

- An individual can be infected with the virus that causes AIDS without having symptoms of AIDS or appearing ill. Infected individuals without symptoms can transmit the infection to others. Once infected, a person is presumed infected for life, but actual symptoms may not develop for many years.

- A single exposure to the AIDS virus may result in infection.

3. How the Virus is NOT Known To Be Spread

- There is no evidence that the virus is spread through casual social contact (shaking hands, social kissing, coughing, sneezing, sharing swimming pools, bed linens, eating utensils, office equipment, being next to or served by an infected person). There is no reason to avoid an infected person in ordinary social contact.

- It is not spread by the process of *giving* blood; new transfusion equipment is used for each donor.

- It is *not* spread by sexual intercourse between individuals who have maintained a sexuel relationship exclusively with each other assuming that they have not been infected through contaminated blood, blood factors, IV drug abuse, or a previous sexual partner.

4. How to Prevent Infection in Yourself and Others

- Infection through sexual contact can be avoided by practicing abstinence or having a mutually monogamous marriage/relationship with an uninfected person.

- If you suspect you or your sex partner is or may be infected,

  — the only certain way to protect yourself or your partner is to abstain from sexual intercourse with him or her. If it is not possible to practice abstinence until infection status can be determined, always use condoms during sex because use of condoms can reduce the risk of transmission of the AIDS virus.

  — avoid sexual activity that may damage the condom or body tissues. A condom is effective only if it is used properly; it *must* remain intact and in place from start to finish of sexual activity to ensure that semen and blood are not avoidably exchanged. Be aware that condoms sometimes fail. The failure rate may be 10% when used as a contraceptive.

  — seek counseling and AIDS virus antibody testing to be sure of your own infection status. Be aware that weeks to months may elapse from the time of infection to the time that antibodies to the AIDS virus appear in the blood. During this time persons may be infectious but the test may be negative.

  — encourage your partner to obtain counseling and testing.

- Be aware that multiple sex partners increase your risk of acquiring the AIDS virus unless you can be certain that each is uninfected. If you have more than one sex partner or your partner has more than one partner, always use condoms because use of condoms can reduce the risk of transmission of the AIDS virus.

  — Avoid prostitutes; engaging in sexual activity with those who have multiple sex partners increases the risk of contracting the AIDS virus.

- Do not use IV drugs; do not share needles or "works".

5. How To Get More Information About AIDS

- Call an AIDS Hotline number (local number(s) to be provided).

- Call your personal physician, health department, or an AIDS community service organization.

6. Information Which Will Emphasize the Seriousness of the Problem, Yet Reduce Inappropriate Fear

- AIDS is a national emergency requiring attention from all citizens.

- If people change their behaviors, the spread of AIDS virus can be reduced.

- Blood for transfusion in the United States is screened for antibody to the AIDS virus and is now essentially safe, but some risks cannot be eliminated.

- Everyone who engages in high risk behavior is at risk for AIDS, regardless of age, race, or socioeconomic status.

B. ADDITIONAL INFORMATION NEEDED BY THE SCHOOL AND COLLEGE AGED POPULATIONS:

- Saying no to sex and drugs *can* virtually eliminate the risk of AIDS.
- Instructions on how the virus is known to be transmitted and how transmission may be prevented.
- Sexual transmission of the AIDS virus is not a threat to those uninfected individuals who practice responsible sexual behavior, based on fidelity, commitment and maturity, placing human sexuality within the context of marriage and family life.

C. ADDITIONAL INFORMATION NEEDED BY PERSONS AT INCREASED RISK OR INFECTED:

- Know where to get more information and help.
- Where to seek counseling and voluntary testing.
- Do not donate blood, semen, tissues, or organs.
- Know the signs and symptoms of AIDS infection.
- For IV drug users, where to seek treatment for drug abuse.
- Infected women must know that the AIDS virus can be transmitted to unborn babies and to newborns. Female partners of those at increased risk or infected must be aware of the need to be tested to assist in family planning.
- For those infected, inform past and present sexual partners. Avoid sexual contact that may transmit the virus to others. The only certain way to ensure that others will not be infected is to abstain from sex.

D. ADDITIONAL INFORMATION NEEDED BY HEALTH WORKERS (AS APPROPRIATE):

- The basic facts about AIDS (transmission, diagnosis, signs and symptoms, high risk behavior).
- Current public health recommendations.
- How to interpret the test.
- The need to hold test results and diagnosis confidential in accordance with relevant laws.
- How best to cooperate with local public health authorities in surveillance and prevention of AIDS virus infections.
- How to manage AIDS patients clinically.
- How to counsel persons about infection and where to refer high risk individuals and people with AIDS virus infections.

- Current research findings.
- Appropriate infection control measures, including risks of needlestick injuries which present a small but serious risk of virus transmission.
- Which isolation procedures or restrictions of visitors are or are not necessary.
- Where to get additional information for medical professionals, patients and persons caring for the AIDS patients at home.

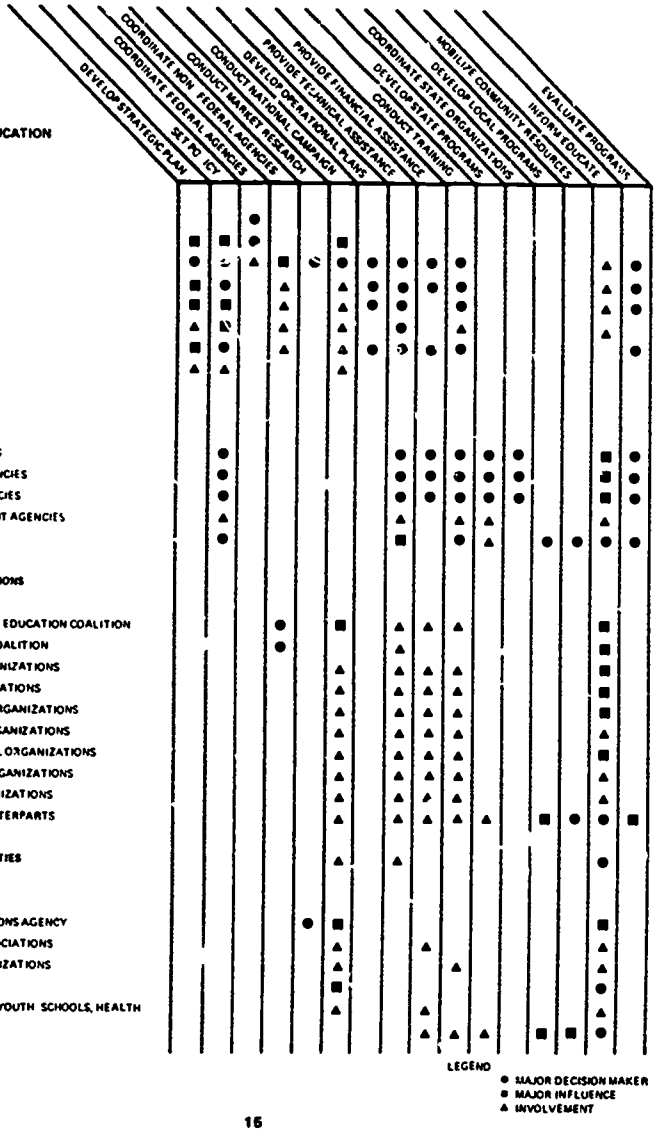
III. COMPONENTS OF THE PLAN

A. ACTION MATRIX

B. ACTION STEPS

A. ACTION MATRIX

AIDS INFORMATION/EDUCATION



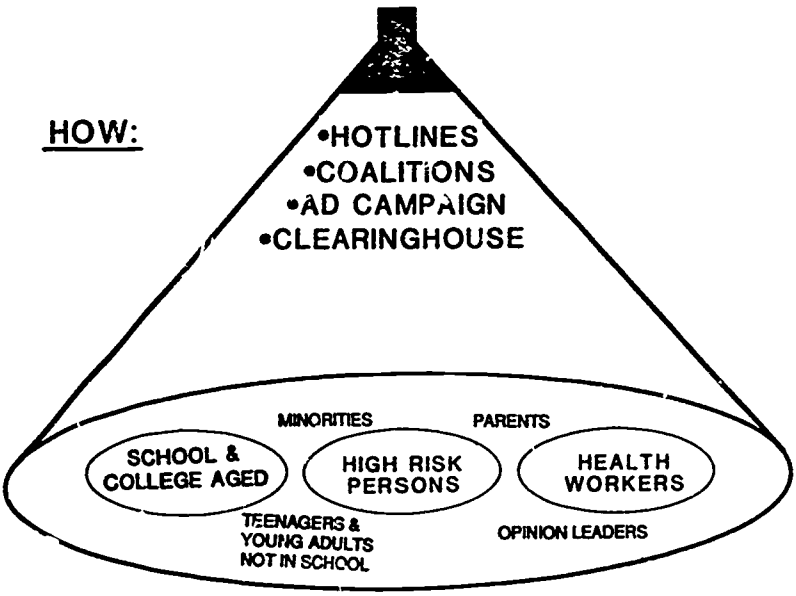
B. ACTION STEPS

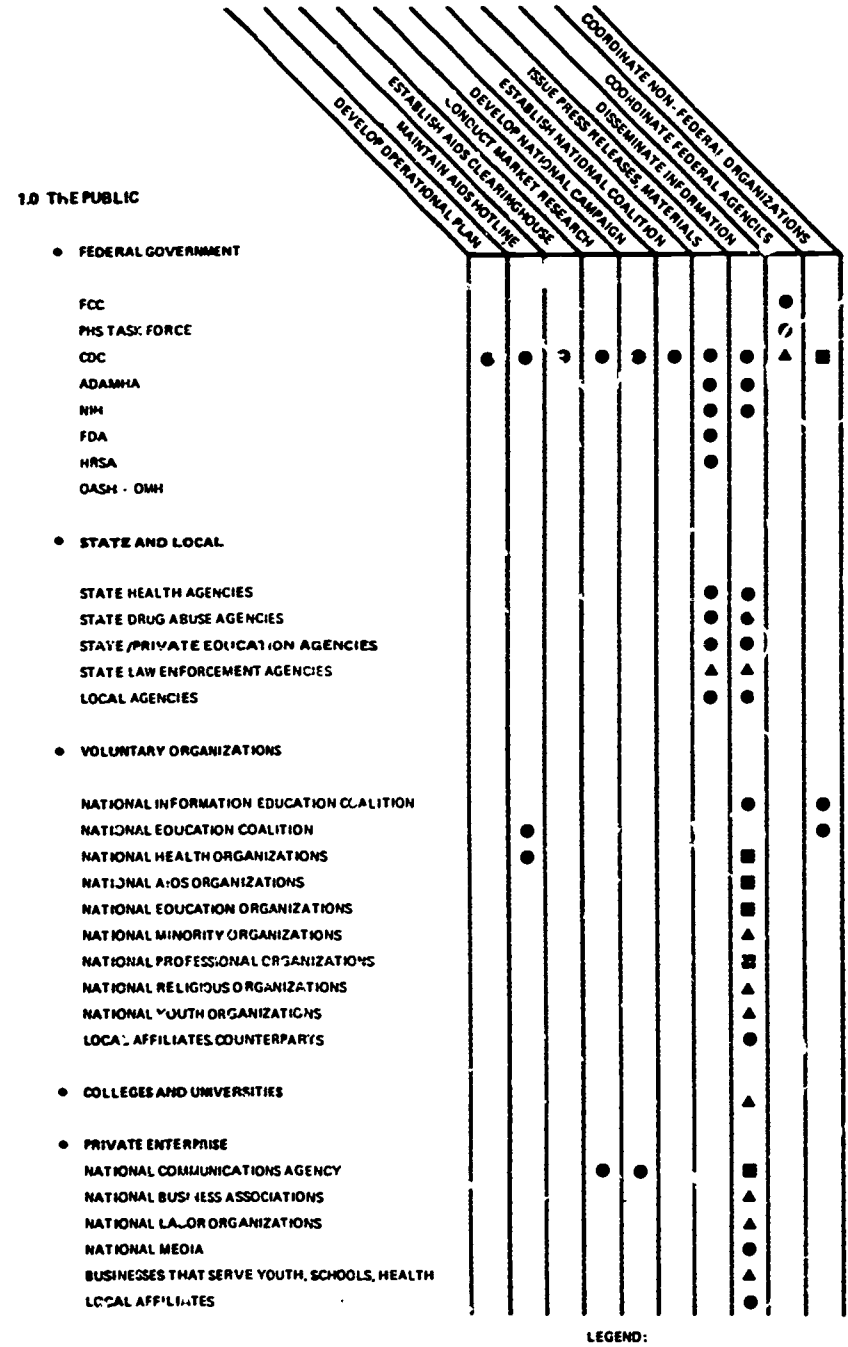
1.0 PUBLIC

An informed public provides the basis upon which other information/education programs operate. Information must be provided through a variety of channels: television, radio, press, posters, leaflets, advertisements, and personal appearances. This effort must be closely coordinated and sustained over a long period of time. Groups specifically spotlighted include teenagers, young adults, parents, minorities, and opinion leaders.

WHAT: Inform and Educate THE PUBLIC

HOW:




DEVELOP OPERATIONAL PLAN
MAINTAIN AIDS HOTLINE
ESTABLISH AIDS CLEARINGHOUSE
CONDUCT MARKET RESEARCH
DEVELOP NATIONAL CAMPAIGN
ESTABLISH NATIONAL COALITION
ISSUE PRESS RELEASES, MATERIALS
DISSEMINATE INFORMATION
COORDINATE FEDERAL AGENCIES
COORDINATE NON-FEDERAL ORGANIZATIONS
1.0 THE PUBLIC
• FEDERAL GOVERNMENT
FCC
PHS TASK FORCE
CDC
ADAMHA
NIH
FDA
HRSA
OASH - OMH
• STATE AND LOCAL
STATE HEALTH AGENCIES
STATE DRUG ABUSE AGENCIES
STATE/PRIVATE EDUCATION AGENCIES
STATE LAW ENFORCEMENT AGENCIES
LOCAL AGENCIES
• VOLUNTARY ORGANIZATIONS
NATIONAL INFORMATION EDUCATION COALITION
NATIONAL EDUCATION COALITION
NATIONAL HEALTH ORGANIZATIONS
NATIONAL AIDS ORGANIZATIONS
NATIONAL EDUCATION ORGANIZATIONS
NATIONAL MINORITY ORGANIZATIONS
NATIONAL PROFESSIONAL ORGANIZATIONS
NATIONAL RELIGIOUS ORGANIZATIONS
NATIONAL YOUTH ORGANIZATIONS
LOCAL AFFILIATES COUNTERPARTS
• COLLEGES AND UNIVERSITIES
• PRIVATE ENTERPRISE
NATIONAL COMMUNICATIONS AGENCY
NATIONAL BUSINESS ASSOCIATIONS
NATIONAL LABOR ORGANIZATIONS
NATIONAL MEDIA
BUSINESSES THAT SERVE YOUTH, SCHOOLS, HEALTH
LOCAL AFFILIATES
LEGEND:
● MAJOR DECISION MAKER
■ MAJOR INFLUENCE
▲ INVOLVEMENT

1.0 PUBLIC

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
1.1.1.	Enter into contract with a major national advertising agency and carry out mass media campaigns (TV & radio spots, posters, print, ads, etc.) at national and local levels	CDC	State & local health departments & private organizations	6/87
1.1.2	Meet with major public and private sector organizations to provide a coalition for information exchange and coordination of information/education programs.	CDC	AIDS organizations, private, professional, & voluntary organizations.	2/87
1.1.3.	Distribute the Surgeon General's Report on AIDS, PHS video tapes as well as publications and public service announcements prepared in collaboration with the Red Cross and other organizations.	CDC	State health departments, & private organizations.	85/86
1.1.4.	Explore the effectiveness of direct mailing as an appropriate method of providing AIDS information to the public.	CDC		2/87
1.1.5.	Provide a clearinghouse to respond to the public's informational needs for the most current & accurate information on AIDS.	CDC	State & local & private	8/87
1.1.6.	Provide a nationally available hot-line.	CDC		85
1.1.7.	Issue press releases & public information materials to provide current information to the public through the news media.	All PHS agencies		83
1.1.8.	Work with national & local print media to assist in accurate reporting on AIDS.	All PHS agencies		83
1.1.9	Complement generic ongoing AIDS information/education programs to stimulate predeposit of blood by elective surgery patients and increased blood donations by healthy donors.	NIH (NHLBI)	National, State, and local organizations representing transfusers, collectors, and donors of blood.	87/88

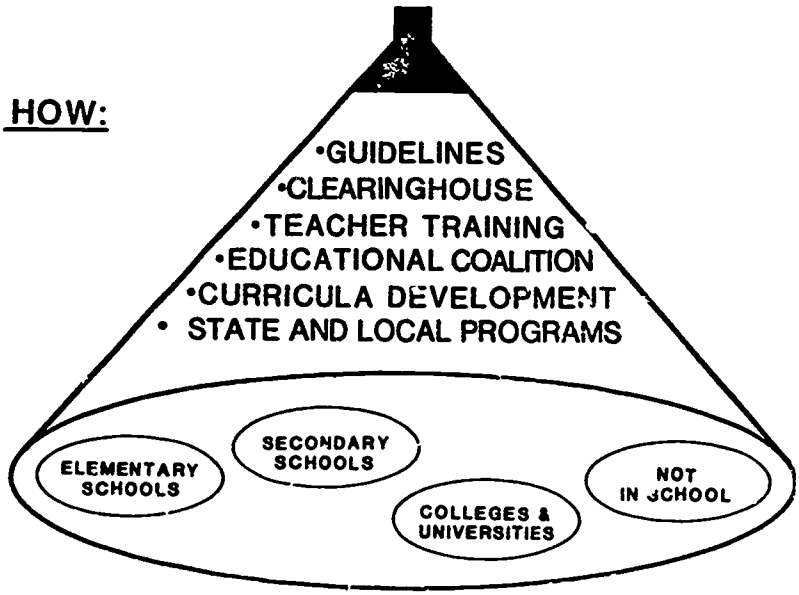
2 - SCHOOL AND COLLEGE AGED POPULATIONS

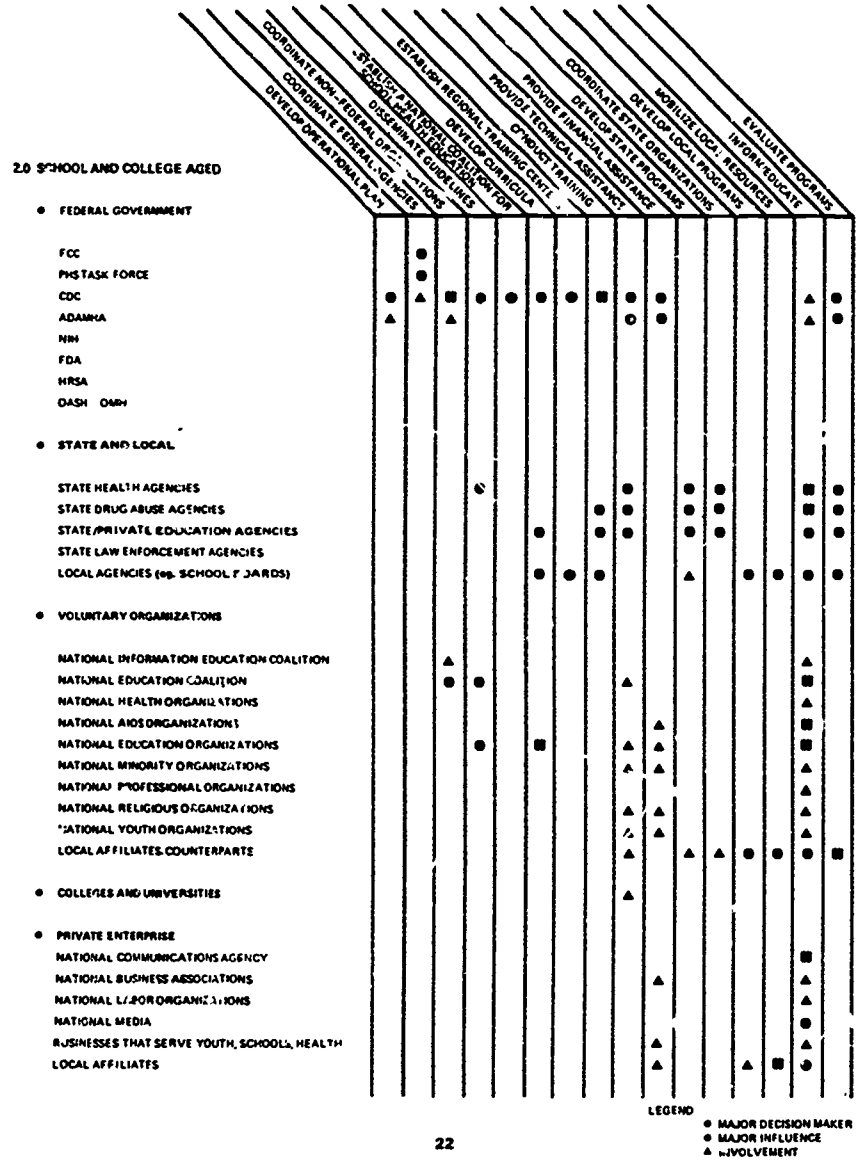
The Public Health Service has a responsibility to provide clear and accurate information about AIDS to all segments of our society. In particular, our youth must understand that sexual activity and IV drug abuse can lead to AIDS. Engaging in sexual activity with multiple partners, both heterosexual and homosexual, increases the probability of contracting AIDS. In the United States, to date, homosexual practices and IV drug abuse have been the main routes for spread of AIDS. Clearly, our youth must have information about the disease, how the AIDS virus is transmitted, and how to prevent infection with this virus.

The Public Health Service will provide national, State, and local educators with up-to-date, factual AIDS information. State and local school boards, along with families, community, and parent groups have the primary responsibility for educating the young. It is for these groups to determine how best to disseminate this information in the most effective fashion, with consideration of their own values and concerns, to achieve the goal of preventing AIDS among our youth.

WHAT: Inform and Educate
SCHOOL & COLLEGE AGED

HOW:




2.0 SCHOOL AND COLLEGE AGED
DEVELOP OPERATIONAL PLANS
COORDINATE FEDERAL AGENCIES
COORDINATE NON-FEDERAL ORGS
DISSEMINATE GUIDELINES
ESTABLISH REGIONAL TRAINING CENTERS
DEVELOP CURRICULA
CONDUCT TRAINING
PROVIDE TECHNICAL ASSISTANCE
DEVELOP FINANCIAL ASSISTANCE
COORDINATE STATE PROGRAMS
DEVELOP STATE ORGANIZATIONS
DEVELOP LOCAL PROGRAMS
MOBILIZE LOCAL RESOURCES
INFORM/EDUCATE
EVALUATE PROGRAMS
FEDERAL GOVERNMENT
FCC
PHS TASK FORCE
CDC
ADAMHA
NIH
FDA
HRSA
OASH OMH
STATE AND LOCAL
STATE HEALTH AGENCIES
STATE DRUG ABUSE AGENCIES
STATE/PRIVATE EDUCATION AGENCIES
STATE LAW ENFORCEMENT AGENCIES
LOCAL AGENCIES (eg. SCHOOL BOARDS)
VOLUNTARY ORGANIZATIONS
NATIONAL INFORMATION EDUCATION COALITION
NATIONAL EDUCATION COALITION
NATIONAL HEALTH ORGANIZATIONS
NATIONAL AIDS ORGANIZATIONS
NATIONAL EDUCATION ORGANIZATIONS
NATIONAL MINORITY ORGANIZATIONS
NATIONAL PROFESSIONAL ORGANIZATIONS
NATIONAL RELIGIOUS ORGANIZATIONS
NATIONAL YOUTH ORGANIZATIONS
LOCAL AFFILIATES/COUNTERPARTS
COLLEGES AND UNIVERSITIES
PRIVATE ENTERPRISE
NATIONAL COMMUNICATIONS AGENCY
NATIONAL BUSINESS ASSOCIATIONS
NATIONAL LABOR ORGANIZATIONS
NATIONAL MEDIA
BUSINESSES THAT SERVE YOUTH, SCHOOLS, HEALTH
LOCAL AFFILIATES
LEGEND
MAJOR DECISION MAKER
MAJOR INFLUENCE
INVOLVEMENT

School Health Education to Pre . AIDS

2.1 Primary and Secondary Schools

TASKS		LEAD PHS / AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
2.1 1.	Develop and disseminate guidelines for effective school health education about AIDS.	CDC	National public, private, professional, & voluntary organizations & State & local departments of education & health	12/86
2.1.2.	Convene a national coalition for school health education about AIDS	CDC	National public, private, professional, & voluntary organizations & State & local departments of education & health.	9/87
2.1.3	Work with relevant national organizations to help schools provide effective health education about AIDS	CDC	National public, private, professional & voluntary organizations & State & local departments of education & health.	8/86
2.1.4.	Work with appropriate national organizations to assure that Black and Hispanic school and youth receive effective education about AIDS.	CDC	National public, private, professional & voluntary organizations & State departments of education & health.	9/87
2.1.5	Work with an appropriate national organization to help colleges of education provide preservice and inservice teacher training about AIDS.	CDC	National public, private, professional, & voluntary organizations, universities,& State & local departments of education & health.	9/87
2.1.6.	Work with an appropriate national organization to help all State departments of education provide effective education about AIDS.	CDC	National public, private, professional, & voluntary organizations & State & local departments of education & health	9/87

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
2.1.7.	Work with the State and local school systems with the highest incidence of AIDS to help schools in these States provide effective education about AIDS.	CDC	National public, private, professional, & voluntary organizations & State departments of education & health.	9/87
2.1.8.	Establish and continuously update an annotated, computerized bibliography of relevant educational materials, programs, research, and resources.	CDC	National public, private, professional & voluntary organizations & State departments of education & health.	4/87
2.1 9.	As requested, provide technical assistance to providers of elementary school health education programs to help elementary school teachers provide effective education about AIDS	CDC	National public, private, professional & voluntary organizations, & State departments of education & health.	9/37
2.1.10	As requested, provide technical assistance to providers of secondary school health materials to help secondary school teachers provide effective education about AIDS.	CDC	National public, private, professional & voluntary organizations, & State departments of education & health.	9/87
2 1.11	Assist relevant public and private-sector organizations to develop and disseminate as requested accurate and effective educational materials that could be used by schools, colleges, and other agencies that serve youth.	CDC	National public private, professional & voluntary organizations, & State departments of education & health.	3/87
2.1.12	Develop and disseminate as requested an annotated compendium of materials, progress, activities, research, and resources.	CDC	National public, private, professional & voluntary organizations, and State departments of education & health.	12/87
2.1.13	Develop, field test, and disseminate as requested instruments that can be used to measure the quality & outcomes of education about AIDS.	CDC	National public, private, professional & voluntary organizations, universities, & State departments of education & health.	9/87
2.1.14	Plan a national survey of secondary school students knowledge about AIDS.	CDC	National public, private, professional & voluntary organizations, universities, & State departments of education & health.	12/87

2.2 Colleges and Universities

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
2.2.1.	Work with an appropriate national organization to help colleges and universities provide effective health education about AIDS for their students.	CDC	National public, private, professional, & voluntary organizations & universities	9/87

2.3 Other Agencies That Serve Youth

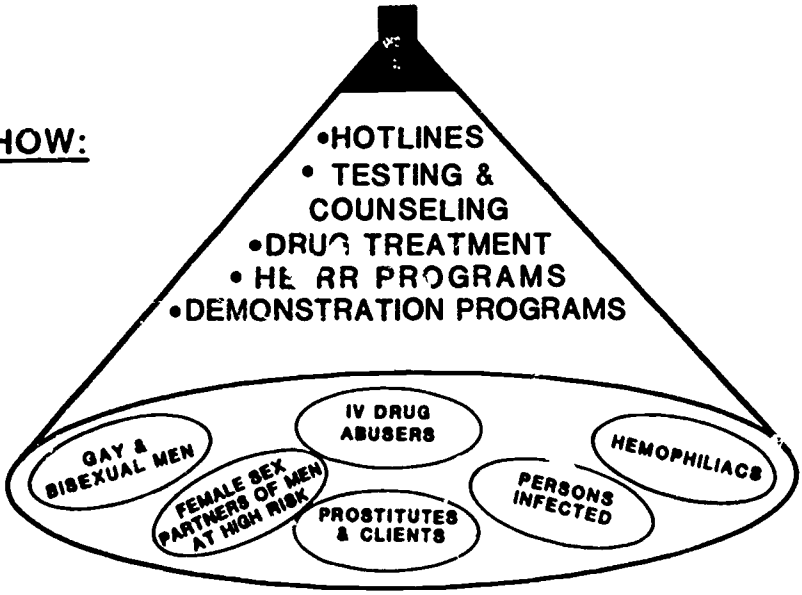
TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
2.3.1	Work with local education departments & other agencies that serve youth in cities with the highest incidence of AIDS to assure that school-age populations who attend, and who do *not* attend, schools or colleges in the area receive effective education about AIDS.	CDC	Local & State education & health departments & other agencies that serve youth in high risk cities.	9/87
2.3.2.	Work with the education departments and other agencies that serve youth in three cities and one State with the highest incidence of AIDS to develop a model system to assure that school-age populations, both those who attend and who do not attend schools or colleges in the area, receive effective education about AIDS and to serve as training and demonstration centers.	CDC	Local & State education & health departments & other agencies that serve youth in high risk cities	9/87
2.3.3.	Support the attendance of at least 300 representatives from local & State education departments to attend the regional training & demonstration centers.	CDC	Local education and health departments and other agencies that serve youth in high risk cities.	9/87

3.0 PERSONS AT INCREASED RISK OR INFECTED

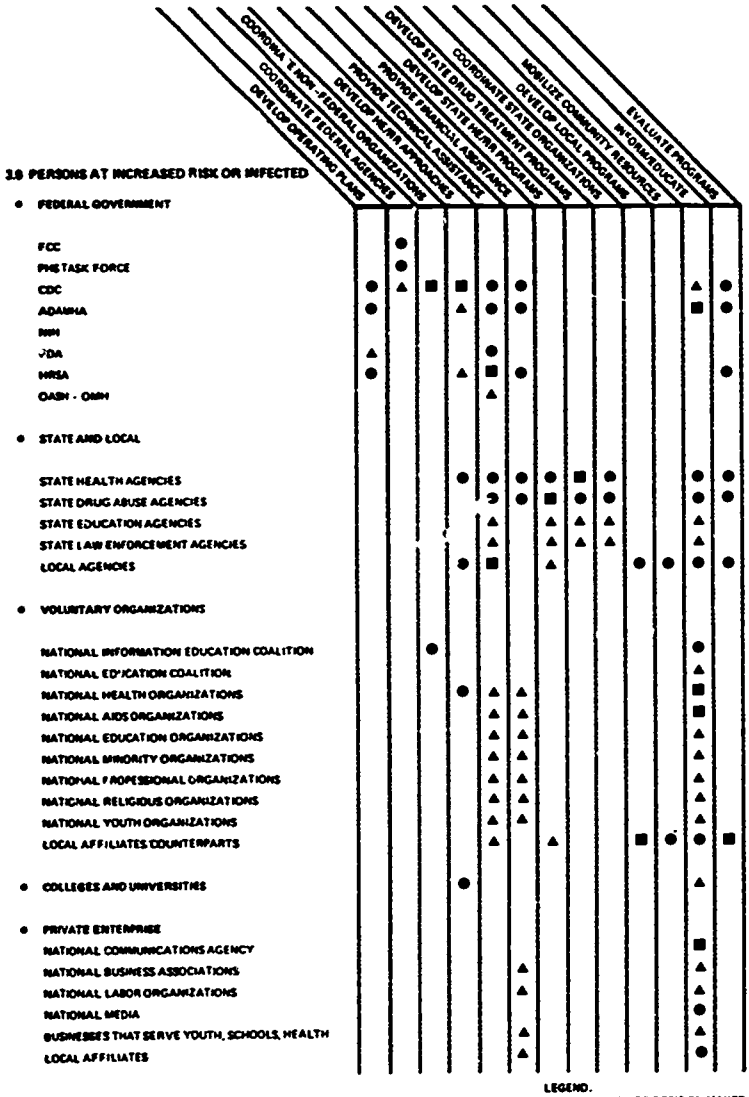
Prevention and control of AIDS will depend upon successfully interrupting the transmission of the virus among those persons whose behaviors or their circumstances put them and others at high risk of infection.

WHAT: Inform and Educate
PERSONS AT INCREASED RISK OR INFECTED

HOW:



28


DEVELOP OPERATING PLANS
COORDINATE FEDERAL AGENCIES
DEVELOP FEDERAL-STATE-LOCAL ORGANIZATIONS
PROVIDE TECHNICAL ASSISTANCE
DEVELOP HEARTH APPROACHES
DEVELOP STATE HEALTH PROGRAMS
DEVELOP STATE DRUG TREATMENT PROGRAMS
COORDINATE STATE ORGANIZATIONS
DEVELOP LOCAL PROGRAMS
MOBILIZE COMMUNITY RESOURCES
INFORM/EDUCATE
EVALUATE PROGRAMS
19 PERSONS AT INCREASED RISK OR INFECTED
FEDERAL GOVERNMENT
FCC
PHS TASK FORCE
CDC
ADAMHA
NIH
VDA
HRSA
OASH - OMH
STATE AND LOCAL
STATE HEALTH AGENCIES
STATE DRUG ABUSE AGENCIES
STATE EDUCATION AGENCIES
STATE LAW ENFORCEMENT AGENCIES
LOCAL AGENCIES
VOLUNTARY ORGANIZATIONS
NATIONAL INFORMATION EDUCATION COALITION
NATIONAL EDUCATION COALITION
NATIONAL HEALTH ORGANIZATIONS
NATIONAL AIDS ORGANIZATIONS
NATIONAL EDUCATION ORGANIZATIONS
NATIONAL MINORITY ORGANIZATIONS
NATIONAL PROFESSIONAL ORGANIZATIONS
NATIONAL RELIGIOUS ORGANIZATIONS
NATIONAL YOUTH ORGANIZATIONS
LOCAL AFFILIATES COUNTERPARTS
COLLEGES AND UNIVERSITIES
PRIVATE ENTERPRISE
NATIONAL COMMUNICATIONS AGENCY
NATIONAL BUSINESS ASSOCIATIONS
NATIONAL LABOR ORGANIZATIONS
NATIONAL MEDIA
BUSINESSES THAT SERVE YOUTH, SCHOOLS, HEALTH
LOCAL AFFILIATES
LEGEND.
MAJOR DECISION MAKER
MAJOR INFLUENCE
INVOLVEMENT

74-444 0 - 87 - 10

3.1 Gay and Bisexual Men

Most of the AIDS cases have been among gay or bisexual men. National and community gay organizations mobilized early to educate their constituents about AIDS. State health agencies have also begun to target educational services to gay and bisexual men. Continued collaboration among these organizations is essential to communicate effectively and reinforce the AIDS risk reduction messages.

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
3.1.1.	Develop through research cooperative agreements innovative ways to change sexual and other behaviors to minimize risk of infection.	CDC	Selected local health depts, academic institutions and community organizations.	12/85
3.1.2.	Determine through demonstration projects in 6 large communities, the effectiveness of comprehensive programs of public information, health education of risk groups, and one-on-one counseling in reducing transmission of the AIDS virus.	CDC	Selected State and local governments.	9/85
3.1.3.	Award 55 cooperative agreement funds to States to build their capacity for health education and risk reduction activities including: • counseling sex partners of persons who are AIDS virus antibody positive • providing pre- and post-test counseling for those considering serologic testing • providing fiscal support for health education performed by community AIDS service groups • providing health education to change sexual practices • determining the needs of minority groups for information regarding avoidance of behaviors conducive to transmission • funding hotlines to give information and education to gay and bisexual men as well as to the general public • coordinate public information, health education of risk groups, and individual counseling efforts at the State level	CDC	State & local governments.	5/86

3.2 IV Drug Abusers

Most of the IV drug abusers who have developed AIDS reside in New York, California, Florida, New Jersey, and Texas. However, infection with the AIDS virus is likely to occur in any locality in which IV drug abusers share needles and syringes and/or are sexually active. Because an infected IV drug abuser can infect his/her sex partner(s), this becomes a major route for introducing the AIDS virus into the heterosexual population. IV drug abusers are difficult to reach because of the covert nature of their IV drug abuse. Enrollment in a treatment program is an important step in providing IV drug abusers with AIDS related risk reduction, prevention, and health education information. Informational and educational programs are needed within drug treatment programs and where IV drug abusers seek health care services, *i.e.*, health department clinics, family planning clinics, hospital outpatient clinics, storefront clinics, private physicians.

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
3.2.1.	Expansion of drug abuse treatment capacity and AIDS virus antibody testing.	ADAMHA	State Health Depts.	7/86
3.2.2.	Development of improved strategies for the prevention and treatment of IV drug abuse.	ADAMHA	State Drug Abuse, Universities.	11/86
3.2.3.	Training drug abuse counselors to provide specialized counseling concerning AIDS virus antibody testing.	ADAMHA CDC		3/86
3.2.4.	Evaluation of educational efforts in decreasing risk-taking behaviors and resulting AIDS virus seropositivity.	CDC ADAMHA	Medical Centers, Universities.	11/86 9/86
3.2.5.	Dissemination of materials on risk factors for AIDS targeted to public health personnel and to high risk groups.	CDC ADAMHA HRSA	State Health Depts, State Drug Abuse.	5/86

3.3 Hemophiliacs

Persons with hemophilia who have been infected with the AIDS virus can infect their sex partners. Hemophiliacs and their sex partners need counseling on how to reduce possible virus transmission and reinforce behavioral changes already adopted. The National Hemophilia Foundation is assisting Comprehensive Hemophilia Treatment Centers (CHTC) in providing health education/risk reduction programs to hemophiliacs in their respective localities.

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
3.3.1.	Award funds to regional hemophilia centers to enable provision of specialized risk reduction counseling related to AIDS, and to provide one-on-one counseling to patients and their spouses about ways to reduce transmission through safer sex practices.	HRSA CDC	National and regional organizations.	9/86

3.4 Persons Known To Be Infected

Persons who learn of their infection with the AIDS virus can reduce the likelihood of further transmission of the virus. These individuals may have been diagnosed with AIDS or learned through antibody testing of their exposure to the virus. State and local health departments offer one-on-one counseling to these individuals. Community organizations, drug abuse treatment programs, and community mental health services offer health education/risk reduction and counseling programs.

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
3.4.1.	Award cooperative agreements to States to provide pre- and post-counseling, serologic testing, and dissemination of information about the availability of such services.	CDC	State & local governments.	5/85
3.4.2.	Provide assistance to community AIDS service groups & drug abuse treatment programs to help patients known to be sero-positive understand and accept their responsibilities to reduce transmission by adopting appro-priate sex practices, eliminate needle sharing, and refrain from donating blood, semen, or organs.	CDC ADAMHA	State & local governments, drug abuse treatment programs.	5/86
3.4.3.	Provide counseling, testing, and where deemed appropriate sex partner referral for the sexual partners of people known to be seropositive.	CDC ADAMHA	State & local governments, drug abuse treatment programs.	5/85
3.4.4.	Support model programs to provide adequate information and support for blood donors found to be infected with the AIDS virus.	NIH (NHLBI)	Blood centers & community organizations.	9/85

3.5 Female Sex Partners of Those at Increased Risk or Infected

The sex partners of those infected with the AIDS virus are at increased risk of infection. These individuals are directly reached through sex and needle-sharing partner referral. Women who are sex partners of those at increased risk of infection are particularly at risk. They may also unknowingly infect their infants during pregnancy or birth. Many women who have developed AIDS belong to minority groups. Women who are at increased risk should receive counseling from facilities that provide them health care service, i.e., family planning centers, health departments, hospital outpatient clinics, and drug abuse centers.

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
3.5.1.	Award cooperative agreement funds to provide one-on-one counseling of females whose sexual partners may be in risk groups, or who are known to be seropositive.	CDC	State & local governments	5/85
3.5.2.	Encourage women who think their sex partners may be at increased risk or infected to use existing counseling and service sites for pre- and post-counseling about serologic testing	CDC ADAMHA	State & local governments, community organizations	5/86 9/87
3.5.3	Develop and disseminate messages about safer sex practices to women who may be sex partners of persons in high risk groups, but who elect not to seek one-on-one counseling	CDC ADAMHA	State & local governments, community organizations	5/86 9/87
3.5.4	Initiate demonstration projects to identify female sexual partners of drug abusers; encourage serologic testing, and reduce risk-taking behavior.	ADAMHA	Community organizations	9/87
3.5.5.	Initiate demonstration projects to reduce perinatal transmission in selected high incidence areas, by intensive outreach and counseling to women who are sex partners of those at increased risk or infected.	CDC ADAMHA	State & local governments, community organizations.	6/87 9/87
3.5.6	Educate health care providers to actively assess the risk status of women, inform them of existing counseling and testing activities, and counsel them about safer sex practices.	CDC HRSA ADAMHA	State & local governments, drug abuse treatment programs	5/85
3.5.7	Determine and address the special needs of minority women for health education materials and counseling to reduce risk	CDC	State & local governments, drug abuse treatment programs.	5/86 9/87

3.6 Prostitutes and Their Clients

Prostitutes are at increased risk of an AIDS virus infection because they have multiple sex partners, and some share needles and syringes while abusing IV drugs. Their clients are also at increased risk

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
3.6.1.	Award cooperative agreements to States to provide general health education and one-on-one counseling to prostitutes and other women with multiple sex partners.	CDC	State & local governments.	5/86
3.6.2.	Encourage prostitutes to utilize existing sites for pre- and post-counseling and serologic testing	CDC	State & local community organizations.	5/86
3.6.3.	Initiate demonstration projects to identify prostitutes who are IV drug abusers or are sexually involved with IV drug abusers, encourage serologic testing, and reduce risk-taking behaviors.	ADAMHA	Community organizations.	9/87
3.6.4.	Provide information to the general public, and targeted health education messages to the users of prostitutes, regarding the risk of female to male transmission.	CDC	State & local governments.	5/86

4.0 HEALTH WORKERS

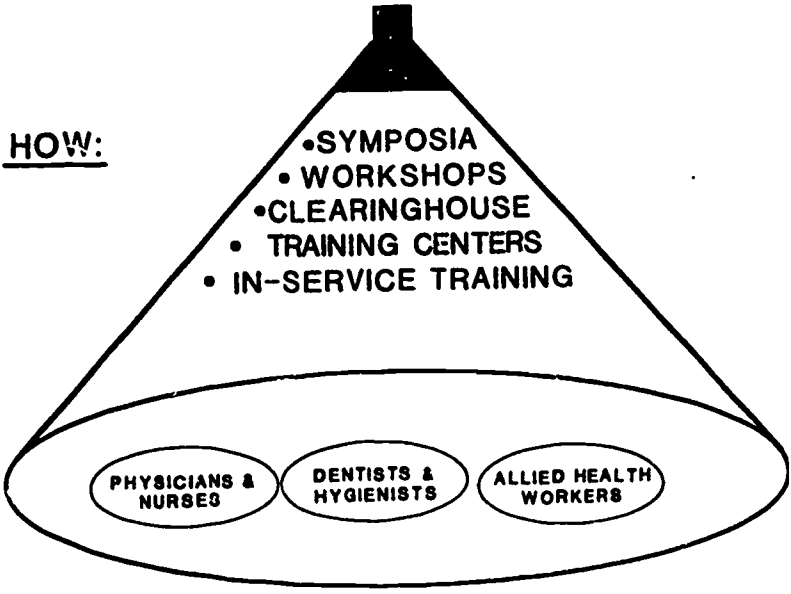
Health workers must be prepared to address infected persons' health needs and to counsel, or refer for counseling, those infected with the AIDS virus to reduce the infected persons' risk of transmitting the virus to others.

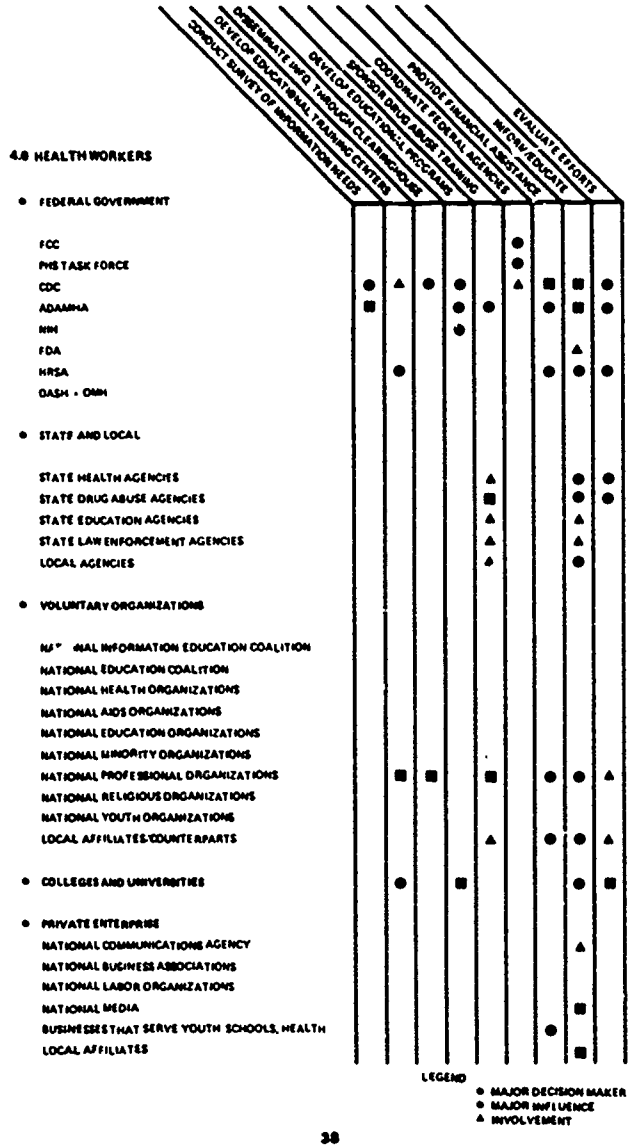
Health workers represent a major channel for providing accurate AIDS information to the patient, sex partners of the patient, friends and family members of the patient, allied health care workers, as well as the public.

Some health care workers by virtue of their occupation need to be informed that there is some risk, albeit small, of infection.

WHAT: Inform and Educate HEALTH WORKERS

HOW:




4.8 HEALTH WORKERS
CONDUCT SURVEY OF INFORMATION NEEDS
DEVELOP EDUCATIONAL TRAINING CENTERS
DISSEMINATE INFO. THROUGH CLEARINGHOUSE
DEVELOP EDUCATIONAL PROGRAMS
SPONSOR DRUG ABUSE TRAINING
COORDINATE FEDERAL AGENCIES
PROVIDE FINANCIAL ASSISTANCE
INFORM/EDUCATE
EVALUATE EFFORTS
• FEDERAL GOVERNMENT
FCC
PHS TASK FORCE
CDC
ADAMHA
NIH
FDA
HRSA
OASH - OMH
• STATE AND LOCAL
STATE HEALTH AGENCIES
STATE DRUG ABUSE AGENCIES
STATE EDUCATION AGENCIES
STATE LAW ENFORCEMENT AGENCIES
LOCAL AGENCIES
• VOLUNTARY ORGANIZATIONS
NATIONAL INFORMATION EDUCATION COALITION
NATIONAL EDUCATION COALITION
NATIONAL HEALTH ORGANIZATIONS
NATIONAL AIDS ORGANIZATIONS
NATIONAL EDUCATION ORGANIZATIONS
NATIONAL MINORITY ORGANIZATIONS
NATIONAL PROFESSIONAL ORGANIZATIONS
NATIONAL RELIGIOUS ORGANIZATIONS
NATIONAL YOUTH ORGANIZATIONS
LOCAL AFFILIATES/COUNTERPARTS
• COLLEGES AND UNIVERSITIES
• PRIVATE ENTERPRISE
NATIONAL COMMUNICATIONS AGENCY
NATIONAL BUSINESS ASSOCIATIONS
NATIONAL LABOR ORGANIZATIONS
NATIONAL MEDIA
BUSINESSES THAT SERVE YOUTH SCHOOLS, HEALTH
LOCAL AFFILIATES
LEGEND
● MAJOR DECISION MAKER
■ MAJOR INFLUENCE
▲ INVOLVEMENT

4.1 Physicians and Nurses

Physicians and nurses make up a primary group of health professionals requiring timely clinical, laboratory, research, and risk reduction information to care for persons infected with AIDS and to serve as a community information resource. They also require appropriate messages for those with positive antibody tests for the AIDS virus and for sex and needle-sharing partners and family members of infected persons. This group will need to be informed of steps they can take to reduce their own risk of infection. Public, private, hospital, and non-hospital personnel are included in this group. Special emphasis will be given to reaching minority health professionals and providers who serve minority patients, particularly minority women.

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
4.1.1.	Plan a survey to determine what pediatricians and OB/GYN general practitioners, internists, and other physicians around the country know about AIDS and identify areas where information efforts should be targeted.	CDC	American Medical Association.	7/87
4.1.2	Plan a survey of physician counseling practices and develop appropriate educational materials.	NIH (NIAID)	Georgetown University.	6/87
4.1.3.	Encourage the efforts of professional organizations that serve minorities and organize symposia.	NIH (NIAID)	Public & private organizations.	6/87
4.1.4.	Develop the Collaborative AIDS Education Training Center Program to train physicians, nurses, and other health care professionals and those who will train others.	HRSA	Public & private organizations.	9/87
4.1.5	Sponsor outreach conference for health care workers.	NIH (NIAID)	Universities, Hospitals.	7/83
4.1.6	Encourage physician and surgeon referral of elective surgery patients for predeposit of blood for autologous transfusion; increase use of other forms of autologous transfusion; and reduction of unnecessary transfusions.	NIH (NHLBI)	National & State professional organizations.	88

4.2 Dentists and Hygienists

Dentists, dental hygienists, and dental technicians are at a small theoretical occupational risk of being infected by the AIDS virus.

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
4.2.1.	Plan a survey to assess the AIDS-related knowledge, attitudes, and infection control practices of dental care providers and use this information to plan an educational program.	NIH (NIDR)	Public and private organizations.	2/88
4.2.2	Develop educational programs on AIDS for dentists and auxiliary personnel designed to meet identified needs.	NIH (NIDR) CDC	Public and private organizations.	3/87

4.3 Allied Health Workers

Allied health workers, such as emergency medical service personnel, hemophilia clinic staff, methadone and othe. drug abuse workers, community health and social service workers, plasma donation center personnel, medical technologists and hospital laboratory staff require accurate information about AIDS and work procedures that decrease unwarranted fear and enhance occupational safety skills.

TASKS		LEAD PHS AGENCIES	COLLABORATING ORGANIZATIONS	BEGINNING DATE
4.3 1.	Provide the latest AIDS information and safety recommendations to professional organizations.	CDC	Public and private organizations.	9/85
4.3.2.	Sponsor a regional training program to train representatives of more than 500 agencies on how to establish, conduct and evaluate outreach to intravenous drug users who are not under treatment to increase awareness of AIDS and high risk behaviors and reinforce adoption of risk reduction measures	ADAMHA	State and local governments, public and private organizations	3/86
4.3.3.	Conduct 30 AIDS regional training workshops for drug abuse counselors and administrators in States that have not yet had many cases of AIDS	ADAMHA	State and local governments.	3/86
4 3 4.	Conduct 19 courses in current AIDS laboratory techniques.	CDC	Public health, hospital & private laboratories & blood banks.	6/83

IV. APPENDICES

APPENDIX A

ACCOMPLISHMENTS

All PHS agencies have participated in AIDS-related public information and education activities. Efforts have aimed at the four groups:

1.0 The Public

2.0 School and College Aged Populations

3.0 Persons at Increased Risk or Infected

4.0 Health Workers

Specific activities aimed at reaching each of these groups are described in the following pages. Frequently one activity mentioned in one section addresses more than one group; however, the activities have not been repeated.

1.D *THE PUBLIC*

A. From 1982, worked with national and local electronics and print media to disseminate information to American public. Planned and arranged press conferences covering heterosexual transmission of AIDS, development of AIDS therapies, PHS guidelines on AIDS and the workplace, PHS recommendations to prevent perinatal transmission, progress in research to develop therapies and a vaccine, PHS recommendations to reduce sexual and drug-abuse-related transmission, the award of contracts for AIDS treatment evaluation units, and the announcement of evidence that azidothymidine (AZT[1]) prolonged survival in some AIDS patients.

B. Released a report from the Surgeon General of the PHS to the general public on the prevention of AIDS (October 1986). The report is being disseminated to the public through many channels. Television public service announcements and news reports advertise availability of report. (OASH)

C. Established and operated a national toll-free AIDS hotline (1983-present) available to the public. As of November 1986, the hotline was contracted to the American Social Health Association, a vendor with related hotline/outreach experience. (CDC)

D. Provided funding for a National Conference on AIDS in the Black Community, (July 1986). Developed and distributed print, television, and radio releases on AIDS nationwide through minority media; produced Morbidity and Mortality Weekly Report (MMWR) article on AIDS in minorities. (PHS)

E. Established AIDS speakers' bureaus in four States—California, Texas, Pennsylvania, and Illinois—through a contract with the AMA. Models will be developed as a result of this pilot project in which local physicians are trained to provide information and risk reduction messages on AIDS to their communities and the local media. The models will be easily and widely adaptable for use in all States. (OASH)

F. Developed a mass media campaign with the American Red Cross, including television public service announcements, a poster promoting the AIDS hotline, and a series of 10 pamphlets for various targeted audiences. (OASH)

G. Wrote and distributed widely across the country AIDS publications—"Facts About AIDS," "AIDS Information Bulletin," and several AIDS booklets. Designed and displayed exhibits at major medical meetings. Developed AIDS videotapes for the general public and occupational groups frightened of AIDS. (DASH)

H. Established Comprehensive Community-Based AIDS Risk Reduction, Health Education and Prevention Demonstration Projects in six cities: Albany (NY), Chicago (IL), Dallas (TX), Denver (CO), Long Beach (CA) and Seattle (WA). Projects will produce prototype, comprehensive community prevention programs for reducing AIDS virus transmission through education/risk reduction efforts. Four projects are into their second year of funding, two were first funded in September 1986 (CDC)

[1] Trade name registered by Burroughs Wellcome, use of trade names does not imply endorsement by the U S Government.

2.0 *SCHOOL AND COLLEGE AGED POPULATIONS*

A. Convened representatives from relevant national organizations to develop guidelines for effective school health education about AIDS. The guidelines will later be distributed through appropriate channels. (CDC)

B. Worked with the Health Insurance Association of America and the American Council of Life Insurance to develop educational materials for adolescents. These materials are to be used for junior and senior high school students. (CDC)

C. Worked with the Indiana Department of Health and Indiana University to develop a manual on AIDS for students and teachers. (CDC)

D. Utilized a computerized system (CHID) for an annotated compendium of materials, programs, activities and resources that could be used by schools, colleges, and other agencies that serve youth to provide effective education about AIDS. (CDC)

30 *PERSONS AT INCREASED RISK OR INFECTED*

A. Awarded information and education program grants to the six largest AIDS morbidity areas (Los Angeles, New Jersey, New York City, Florida, Texas, and San Francisco), beginning in FY 84. Activities include assistance to community organizations in delivering health education and risk reduction messages to groups at risk, support for the creation of hotlines, and dissemination of risk reduction information to groups at risk and to the general population. (CDC)

B. Established AIDS Prevention Augmentation Projects in 18 selected cities and States with a significant AIDS problem. The project areas will use funds to augment ongoing AIDS prevention, risk reduction and health education programs, and evaluate the efficacy of these prevention programs. (CDC)

C. Established Community-based AIDS Prevention/Risk Reduction/Health Education Capacity Building Projects in 37 States, since April 1986. The project areas will obtain baseline data on AIDS virus infection and the AIDS problem in their communities, analyze the community resources related to AIDS, and plan goals, objectives, and activities for an AIDS risk reduction/prevention program. (CDC)

D. Collaborated with the U.S. Conference of Mayors to increase knowledge and influence behaviors associated with transmission of AIDS virus infection, beginning in FY 84. Activities include awarding grants to eight community-based organizations to provide AIDS education for high risk groups; and producing the bimonthly newsletter, "AIDS Information Interchange," which is circulated to cities around the country. (CDC)

E. Funded 55 agencies, via cooperative agreements, to establish "Counseling and Testing" sites beginning in [illegible]85. The purpose of this program is to enable State and local health departments to counsel persons at increased risk for AIDS virus infection, test the antibody status of appropriate people, and counsel those who are AIDS virus antibody positive. (CDC)

F. Funded Innovative AIDS Risk Reduction Projects to evaluate unique and innovative risk reduction, prevention, and/or health education activities for selected high risk groups. Projects have been funded at Sloan-Kettering (NY), University of Pittsburgh (PA), Gay Men's Health Crisis (NY), Ohio Department of Health (OH), AID Atlanta (GA), AIDS Project Los Angeles, Inc. (CA), Narcotic and Drug Research, Inc. (NY), and Beth Israel Medical Center (NY). (CDC)

G. Developed an interagency agreement to provide AIDS risk reduction, health education and prevention programs for the hemophilia populations served by Regional Hemophilia Diagnosis and Treatment Centers. (HRSA, CDC)

H. Provided risk reduction counseling to gay and bisexual men participating in natural history studies being conducted in San Francisco, Los Angeles, Chicago, Baltimore, and Pittsburgh. (NIH)

I. Investigated underlying elements dealing with the psychosocial aspects of persons with AIDS and persons demonstrating high risk behavior for AIDS through a grants program. Among the issues being studied are intervention techniques for risk reduction behavior for AIDS virus seropositive and seronegative persons, ways to encourage drug abusers to enter treatment, factors that influence gay men's compliance or non-compliance with safe sex recommendations, and effects on undergoing AIDS health education sessions upon risk reduction and other behavioral changes among persons in high risk status. (ADAMHA)

J. Funded grants to develop strategies for reaching and modifying behavior of IV drug abusers not in treatment. (ADAMHA)

K. Worked with the blood banks and plasma centers on programs to inform persons at increased risk for AIDS that they should refrain from donation. (FDA).

L. Provided recommendations to blood and plasma collecting centers of steps to take to reduce the risk of transmitting the AIDS virus through the transfusion of blood or plasma. (FDA)

4.0 *HEALTH WORKERS*

A. Participated in hundreds of symposia, workshops, etc., during past 5 years and published hundreds of peer reviewed scientific and other articles on AIDS. (PHS)

B. Sponsored in 10 U.S. cities 18 conferences designed to provide the latest information about AIDS to health care workers (October 1983-October 1986). These conferences addressed the epidemiology, pathogenesis, and immunology of the disease, as well as related psychosocial, economic and social issues. In addition, a number of AIDS workshops have been designed and implemented in conjunction with national professional meetings. (NIH)

C. Conducted 45 comprehensive 2 ½-day Regional Workshops to train over 2,500 drug abuse treatment program counselors and drug abuse treatment program administrators to counsel and manage persons with AIDS virus infection and intravenous drug abusers to prevent transmission; followup technical assistance is being provided to 120 drug abuse treatment agencies. A training guide on education, risk assessment, and treatment planning for counselors and program administrators was developed, pilot tested, and used in these workshops. In collaboration with criminal justice and health care agencies, AIDS training is being delivered to 750 workers who come into contact with IV drug abusers. (ADAMHA)

D. Advised registered blood or plasma establishments on safe procedures for handling blood or plasma collected from donors who are AIDS virus antibody positive. Encouraged educational programs for personnel who screen donors to emphasize the need to reject donors with early signs and symptoms of AIDS. (FDA)

E. Issued a "Dear Doctor" letter to over 500,000 physicians explaining the utility of the AIDS virus antibody test, following its licensure in March 1985. (FDA)

F. Prepared State and local health departments for AIDS virus antibody testing and the establishment of alternate testing sites through training activities (CDC):

- Conducted 44 1-day seminars on AIDS virus antibody testing in 34 cities reaching over 7,500 professionals from health department, blood donation centers, and community organizations concerned with AIDS.
- Conducted 35 2-day courses in 24 States to train personnel staffing alternate testing sites to prepare them to offer sensitive and effective pre- and post-test counseling services. An additional 40 sessions were provided by selected State or local health department personnel using CDC's curriculum.
- Conducted 6 training courses on Western blot serologic tests for 112 students from 42 different States and 3 foreign countries: one course in ELISA test methodology for 19 students representing 10 State health departments; a second course in ELISA test methodology was conducted in Hawaii for 16 students.
- Trained various representatives of government and nongovernment laboratories to culture AIDS virus.

G. Developed and disseminated recommendations and guidelines for the prevention of AIDS and AIDS virus infection. These materials are used to train health-care professionals and others who handle and dispose of materials containing AIDS virus, and who need

to counsel and manage individuals with, or at risk of, infection. The guidelines and recommendations published in the *Morbidity and Mortality Weekly Report* (MMWR) are listed at the end of this appendix. (CDC)

H. Funded 9 comprehensive AIDS-related projects to address the special mental health educational needs of medical students and other health care students and to develop training programs for health care workers who are currently providing health care to AIDS patients. (ADAMHA)

I. Developed and distributed brochures aimed at health care workers, such as "Coping with AIDS;" awarded contracts to continue education efforts through pediatricians, obstetricians/gynecologists, employee assistance program staff, and college health professionals and counselors. (ADAMHA)

J. Supported development of an *AIDS Reference Guide for Health Care Professionals* for the Los Angeles and Washington, D.C. areas, through the Center for Interdisciplinary Research on Immunologic Diseases (CIRID) at UCLA. These guides provide information about the disease and its transmission, as well as about local health care and support services. (NIH)

K. Prepared information packages for patients, physicians, and pharmacists in connection with the program for the distribution of AZT to patients who meet the qualifying criteria for the drug. (NIH)

L. Worked with dental organizations to improve infection control practices in dental offices, with primary focus on preventing hepatitis B virus and AIDS virus infections. Guidelines for dental personnel have been issued. (CDC, NIH)

M. Produced and distributed videotape "What If the Patient Has AIDS?" for use in educating health care workers. (OASH)

N. Wrote and distributed AIDS publications—"Facts About AIDS" (distributed widely, including major supermarket chains across the country), "AIDS Information Bulletin," Channing Bete AIDS booklets, etc.; designed and displayed exhibits at major medical meetings. (OASH)

22 AIDS GUIDELINES/RECOMMENDATIONS PUBLISHED IN MMWR

1. Acquired immune deficiency syndrome (AIDS): Precautions for clinical and laboratory staffs. MMWR 1982 Nov 5;31:577-80.

2. Prevention of acquired immune deficiency syndrome (AIDS): Report of interagency recommendations. MMWR 1983 Mar 4;32:101-03.

3. Acquired immunodeficiency syndrome (AIDS): Precautions for health-care workers and allied professionals. MMWR 1983 Sept 2;32:450-51

4. Prospective evaluation of health-care workers exposed via parenteral or mucous-membrane routes to blood and body fluids of patients with acquired immunodeficiency syndrome. MMWR 1984 Apr 6;33:181-92.

5. Update: Acquired immunodeficiency syndrome (AIDS) in persons with hemophilia. MMWR 1984 Oct 26;33:589-91.

6. Hepatitis B vaccine: Evidence confirming lack of AIDS transmission. MMWR 1984 Dec 14;33:685-87.

7. Provisional public health service interagency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome. MMWR 1985 Jan 11;34:1-5.

8. Update: Prospective evaluation of health-care workers exposed via the parenteral or mucous-membrane route to blood or body fluids from patients with acquired immunodeficiency syndrome—United States. MMWR 1985 Feb 22;34:101-03.

9. World Health Organization workshop: Conclusions and recommendations on acquired immunodeficiency syndrome. MMWR 1985 May 17;34:275-76.

10. Testing donors of organs, tissues, and semen for antibody to human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1985 May 24;34:294.

11. Education and foster care of children infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 1985 Aug 30;34:517-21.

12. Recommendations for preventing possible transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus from tears. MMWR 1985 Aug 30;34:533-34.

13. Update: Revised Public Health Service definition of persons who should refrain from donating blood and plasma — United States. MMWR 1985 Sep 6;34:547-48.

14. Update: Evaluation of human T-lymphotropic virus type III/lymphadenopathy-associated virus infection in health-care personnel — United States. MMWR 1985 Sept 27;34:575-78.

15. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in the workplace. MMWR 1985 Nov 15;34:681-86,691-95.

16. Recommendations for assisting in the prevention of perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus and acquired immunodeficiency syndrome. MMWR 1985 Dec 6;34:721-26,731-32

17. Additional recommendations to reduce sexual and drug abuse-related transmission of human T-lymphadenopathy-associated virus. MMWR 1986 Mar 14;35:152-55.

18. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus during invasive procedures. MMWR 1986 Apr 11;35:221-23.

19. Safety of therapeutic immune globulin preparations with respect to transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus infection. MMWR 1986 Apr 11;35:231-33.

20. Recommended infection-control practices for dentistry. MMWR 1986 Apr 18; 35:237-42.

21. Diagnosis and Management of Mycobacterial Infection and Disease in Persons with Human T-lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Infection. MMWR 1986 July 18;35:448-52.

22. Immunization of Children Infected with Human T-lymphotropic Virus Type III/Lymphadenopathy-Associated Virus. MMWR 1986 Sept 26;35.595-98,603-06.

LIST OF RECOMMENDATIONS/PUBLICATIONS ISSUED BY FDA TO BLOOD/PLASMA COLLECTING ESTABLISHMENTS

-- Recommendations to decrease the risk of transmitting infectious diseases from blood donors, 1983.

-- Recommendations to decrease the risk of transmitting Acquired Immune Deficiency Syndrome (AIDS) from plasma donors, 1984.

-- Source material used to manufacture certain plasma derivatives, 1984.

-- Revised recommendations to decrease the risk of transmitting Acquired Immunodeficiency Syndrome from blood and plasma donors, 1984.

-- Implementation of PHS provisional recommendations concerning testing blood and plasma for antibodies to HTLV-III, 1985.

-- Testing for antibodies to HTLV-III, 1985.

-- Revised definition of high risk groups with respect to Acquired Immunodeficiency Syndrome (AIDS) transmission from blood and plasma donors, 1985.

-- Collection and shipment of HTLV-III antibody-positive blood products, 1985.

-- Letter to medical professionals and blood and plasma collecting establishments from Commissioner Young appending PHS materials concerning the HTLV-III antibody test and its use, 1985.

-- Additional recommendations for reducing further the number of units of blood and plasma donated for transfusion and for further manufacture by persons at increased risk of HTLV-III/LAV infection, 1986.

AIDS information disseminated to medical professionals through the "FDA Drug Bulletin"

-- Research on AIDS -- The FDA Drug Bulletin, December, 1982; 12(3):21-23.

-- AIDS Update -- The FDA Drug Bulletin, August, 1983; 13(2):9-11.

-- Progress on AIDS -- The FDA Drug Bulletin, October, 1985; 15(3):27-32.

AIDS information disseminated to consumers through the "FDA Consumer" magazine.

-- What the Experts Know About AIDS -- FDA Consumer, September, 1983, pp. 15-19.

-- Screening Blood Donations for AIDS -- FDA Consumer, May, 1985, pp. 5-11.

-- AIDS Progress Report -- FDA Consumer, February, 1986, pp. 33-35.

-- The Centuries-Old Struggle Against Infectious Diseases -- FDA Consumer, April, 1986, pp. 18-23.

APPENDIX B

LIST OF MATERIALS AVAILABLE

PUBLIC HEALTH SERVICE PUBLICATIONS, VIDEOTAPES, POSTERS ON AIDS

Publications

Order free (single copies or in quantity) from InterAmerica Research, 1200E North Henry St., Alexandria, VA 22314, Attn: Clint Jones:

- "Surgeon General's Report on Acquired Immune Deficiency Syndrome"—October 1986 report by the Surgeon General of the U.S. Public Health Service to the American people. A clear and comprehensive explanation of what AIDS is, how the AIDS virus is and is not spread, and what practical steps each person can take to avoid infection. Addresses controversial issues and provides projections for the future.*

- "Facts About AIDS"—Leaflet provides timely, accurate information in a question-and-answer format. Updated approximately quarterly. Includes Public Health Service recommendations for the general public, persons at increased risk of infection, and persons with positive AIDS antibody test results.*

- "Coping with AIDS"—Intended for health care workers, this booklet addresses psychological and social considerations in serving people with AIDS and others who have been infected by the AIDS virus.

- Leaflets coproduced by the Public Health Service and the American Red Cross:
  - "AIDS Sex, and You"
  - "Facts About AIDS and Drug Abuse"
  - "AIDS and Your Job—Are There Risks?"
  - "Gay and Bisexual Men and AIDS"
  - "AIDS and Children—Information for Parents of School Age Children"
  - "AIDS and Children—Information for Teachers and School Officials"
  - "Caring for the AIDS Patient at Home"
  - "If Your Test for Antibody to the AIDS Virus Is Positive . . ."

Order up to 25 copies of the following free from the Office of Public Inquiries, Centers for Disease Control, Bldg. 1, Rm. B-63, 1600 Clifton Rd., Atlanta, GA 30333.

Larger quantities are for sale by Channing L. Bete Co., Inc., 100 State Rd., South Deerfield, MA 01373; telephone 413-665-7611. (Price per unit varies, depending on size of order.)

- Scriptographic booklets:
  - "What Everyone Should Know About AIDS" (also available in Spanish)
  - "Why You Should Be Informed About AIDS" (for health-care workers)
  - "What Gay and Bisexual Men Should Know About AIDS"
  - "AIDS and Shooting Drugs" (for intravenous drug users, their family members, and drug treatment counselors)

*Organizations wishing to reprint very large quantities of these two publications can obtain camera-ready copy from the Office of Public Affairs, Public Health Service, 200 Independence Ave., SW, Room 725-H, Washington, DC 20201

Order the following from the National Technical Information Service, 5285 Port Royal Rd., Springfield, VA 22161; telephone 703-487-4650:

- "Recommendations and Guidelines Concerning AIDS Published in the Morbidity and Mortality Weekly Report, November 1982 through April 1986"—Contains all Public Health Service recommendations regarding AIDS during the stated period, including precautions for health care workers and allied professionals, guidelines concerning AIDS and the workplace, recommendations to prevent perinatal transmission of the AIDS virus, and recommendations concerning education and foster care of AIDS-virus-infected children. Order No. PB86-210101. Paper copy, $7.50; microfiche, $5.95. (Add $3 per order for shipping and handling.)

- "Reports on AIDS Published in the Morbidity and Mortality Weekly Report, June 1981 through May 1986"—Also includes all Public Health Service recommendations and guidelines concerning AIDS during the stated period. Order No. PB86-211455. Paper copy, $8.75; microfiche, $5.95. (Add $3 per order for shipping and handling.)

- "Acquired Immunodeficiency Syndrome: Legal and Regulatory Policy," by William Curran, Larry Gostin, and Mary Clark, Department of Health Policy Management, Harvard School of Public Health. Report of a study conducted by the authors under contract with the Public Health Service. Order No. PB86-248291/AS. Paper copy: $30.95; microfiche, $8.50. (Add $3 per order for shipping and handling.)

Videotapes (3/4", BETA 2, VHS)

To purchase tapes ($55 each), contact the National Audiovisual Center, 8700 Edgeworth Dr., Capitol Heights, MD 20743-3701, Attn: Customer Service Section; telephone 301-763-1896.

To obtain tapes on free loan, contact Modern Talking Picture Service, 5000 Park St. North, St. Petersburg, FL 33709, Attn: Film Scheduling; telephone 813-541-5763.

- "AIDS: Fears and Facts"—For the general public. Answers the most frequently asked questions about AIDS: what causes it, who is at risk, how it is transmitted, what is being done to control its spread, and how individuals can reduce their risks of infection. 23 minutes.

- "What If the Patient Has AIDS?"—For health-care workers, including laboratory and hospital personnel. Outlines the risks associated with certain procedures involved in caring for AIDS patients and handling their specimens, and details precautions recommended to minimize these risks. 22 minutes.

- "AIDS and Your Job"—Developed for policemen, firemen, and other emergency personnel. Outlines the precautions that can be taken to reduce the risk of exposure to the AIDS virus on the job. 23 minutes.

Poster

Order free (single copies or in quantities from) InterAmerica Research, 1200E North Henry St., Alexandria, VA 22314, Attn: Clint [illegible]:

- Four-color poster, produced by the Pi[illegible] the American Red Cross, featuring Patti LaBelle. Poster can[illegible] "Do not listen to rumors about AIDS. Get the facts!" and provides t[illegible] number of the Public Health Service's national AIDS hotline (1-800-342-AIDS).

APPENDIX C

GLOSSARY OF ABBREVIATIONS FOR FEDERAL ORGANIZATIONS

ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
CDC	Centers for Disease Control
FCC	Federal Coordinating Committee (AIDS)
FDA	Food & Drug Administration
HRSA	Health Resources and Services Administration
NIAID	National Institute of Allergy and Infectious Diseases
NIDA	National Institute on Drug Abuse
NIDR	National Institute of Dental Research
NIH	National Institutes of Health
OASH-OMH	Office of the Assistant Secretary for Health - Office of Minority Health
PHS	Public Health Service

APPENDIX 2.—MATERIAL SUBMITTED FOR THE RECORD

National Association of State Boards of Education
701 N. Fairfax St., Suite 340
Alexandria, VA 22314
(703) 684-4000

March 4, 1987

Dear State Board Chair:

In January, the National Association of State Boards of Education (NASBE) Board of Directors discussed the issue of the spread of Acquired Immune Deficiency Syndrome (AIDS) among youth. As a result of that discussion, the Board developed a position statement recommending that state boards adopt policies to address the need for educat on about AIDS and its prevention, to assure education and protection of privacy rights for young people who have the disease, and to address the rights and privileges of school personnel with AIDS.

The frightening statistics contained in the position statement underscores the dimensions of the problem. You will also find enclosed with this position statement the American Red Cross brochure, "AIDS and Children." NASBE is collaborating with the Red Cross on an AIDS Education program for use in middle and senior high schools next fall. Included in the program will be a short film, student workbooks, teacher guides and a parent brochure. In addition, Red Cross chapters will be encouraged to make the film available for home video use.

The AIDS crisis, in the opinion of medical experts, is an impending catastrophe. The urgent recommendations contained in the NASBE policy statement will help state boards recognize and meet their obligations to the nation's young people and school personnel.

Sincerely,

Phyllis

Phyllis L. Blaunstein

Phyllis L. Blaunstein
Executive Director

NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION
STATEMENT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME

There is a general agreement among medical experts that Acquired Immune Deficiency Syndrome (AIDS) represents an impending catastrophe. By 1991, there are expected to be 179,000 AIDS related deaths in the United States. Worldwide, conservative estimates put the number of AIDS victims at 100 million by 1990.

Medical experts and scientists assert that the majority of heterosexual victims of AIDS will continue to be young people. The American School Health Association projects some 2.5 million teenagers will contract a sexually transmitted disease this year. It is therefore critical that our youth are educated about the dangers of sexually transmitted diseases and intravenous drug use.

The National Association of State Boards of Education (NASBE) urgently recommends that all state boards of education adopt a policy:

1. To require school districts to provide instruction regarding AIDS that includes a full range of preventive measures youngsters can employ to avoid contracting the disease;

2. To assure that young people infected with AIDS have full access to education, and their rights to privacy are protected; and

3. To address the rights and privileges of all school personnel infected with AIDS.