AIDS PREVENTION

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

JULY 12, 1994

Serial No. 103–154

Printed for the use of the Committee on Energy and Commerce

U.S. GOVERNMENT PRINTING OFFICE

86–462CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046687-3

AIDS PREVENTION

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

JULY 12, 1994

Serial No. 103–154

Printed for the use of the Committee on Energy and Commerce

U.S. GOVERNMENT PRINTING OFFICE
86–462CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046687-3

COMMITTEE ON ENERGY AND COMMERCE

JOHN D. DINGELL, Michigan, *Chairman*

HENRY A. WAXMAN, California
PHILIP R. SHARP, Indiana
EDWARD J. MARKEY, Massachusetts
AL SWIFT, Washington
CARDISS COLLINS, Illinois
MIKE SYNAR, Oklahoma
W.J. "BILLY" TAUZIN, Louisiana
RON WYDEN, Oregon
RALPH M. HALL, Texas
BILL RICHARDSON, New Mexico
JIM SLATTERY, Kansas
JOHN BRYANT, Texas
RICK BOUCHER, Virginia
JIM COOPER, Tennessee
J. ROY ROWLAND, Georgia
THOMAS J. MANTON, New York
EDOLPHUS TOWNS, New York
GERRY E. STUDDS, Massachusetts
RICHARD H. LEHMAN, California
FRANK PALLONE, JR., New Jersey
CRAIG A. WASHINGTON, Texas
LYNN SCHENK, California
SHERROD BROWN, Ohio
MIKE KREIDLER, Washington
MARJORIE MARGOLIES-MEZVINSKY, Pennsylvania
BLANCHE M. LAMBERT, Arkansas

CARLOS J. MOORHEAD, California
THOMAS J. BLILEY, JR., Virginia
JACK FIELDS, Texas
MICHAEL G. OXLEY, Ohio
MICHAEL BILIRAKIS, Florida
DAN SCHAEFER, Colorado
JOE BARTON, Texas
ALEX McMILLAN, North Carolina
J. DENNIS HASTERT, Illinois
FRED UPTON, Michigan
CLIFF STEARNS, Florida
BILL PAXON, New York
PAUL E. GILLMOR, Ohio
SCOTT KLUG, Wisconsin
GARY A. FRANKS, Connecticut
JAMES C. GREENWOOD, Pennsylvania
MICHAEL D. CRAPO, Idaho

ALAN J. ROTH, *Staff Director and Chief Counsel*
DENNIS B. FITZGIBBONS, *Deputy Staff Director*
MARGARET A. DURBIN, *Minority Chief Counsel and Staff Director*

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

HENRY A. WAXMAN, California, *Chairman*

MIKE SYNAR, Oklahoma
RON WYDEN, Oregon
RALPH M. HALL, Texas
BILL RICHARDSON, New Mexico
JOHN BRYANT, Texas
J. ROY ROWLAND, Georgia
EDOLPHUS TOWNS, New York
GERRY E. STUDDS, Massachusetts
JIM SLATTERY, Kansas
JIM COOPER, Tennessee
FRANK PALLONE, JR., New Jersey
CRAIG A. WASHINGTON, Texas
SHERROD BROWN, Ohio
MIKE KREIDLER, Washington
JOHN D. DINGELL, Michigan
(Ex Officio)

THOMAS J. BLILEY, JR., Virginia
MICHAEL BILIRAKIS, Florida
ALEX McMILLAN, North Carolina
J. DENNIS HASTERT, Illinois
FRED UPTON, Michigan
BILL PAXON, New York
SCOTT KLUG, Wisconsin
GARY A. FRANKS, Connecticut
JAMES C. GREENWOOD, Pennsylvania
CARLOS J. MOORHEAD, California
(Ex Officio)

KAREN NELSON, *Staff Director*
TIMOTHY WESTMORELAND, *Counsel*
MELODY HUGHSON, *Research Assistant*
HOWARD COHEN, *Minority Counsel*

CONTENTS

Page

Testimony of:

Agosto, Moises, Treatment Advocate, National Minority AIDS Council 38
Coburn, Jay H.S., Legislative Representative, AIDS Action Council 45
Lee, Philip R., Assistant Secretary for Health, Department of Health and Human Services 11
McAlister, Robert O., Chair, National Alliance of State and Territorial AIDS Directors 52
Morella, Hon. Constance A., a Representative in Congress from the State of Maryland 9
Pelosi, Hon. Nancy, a Representative in Congress from the State of California 4
Rose, Gary, Legislative Director, National Association of People With AIDS 39
Zamora, Pedro, AIDS Action Council 44

AIDS PREVENTION

TUESDAY, JULY 12, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:48 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order. Today's hearing is about reducing and preventing HIV infection. Speaking bluntly, that means that the hearing is about sex and drugs, and about candor and pragmatism. If there were an abstract public health world, its officials would say that it would be better if people just stopped having sex and using drugs, period. But this isn't such a world.

Sex is a strong drive; addiction is a powerful force. So instead of being abstract, we have to be candid and pragmatic. We have to acknowledge that many people will have sex or use drugs. We can tell them not to until we are blue in the face. We can even punish their behavior, but they will continue. And if we ignore HIV, it won't go away. We can at least acknowledge that it is cheaper to mold sex and drug behavior to be safer than it is to pay more hospital bills for acutely ill people.

We have done the easy stuff in AIDS education. Most Americans know the basics, but many Americans have not incorporated these basics into their sex lives or their drug habits. It is not enough just to pass out pamphlets any more, and we can't rely on the cycles of media attention when a sports hero or a movie star gets sick. We need ongoing appropriate and effective local programs.

The AIDS prevention campaign that is right for the gay bars of west Hollywood, is not right for the high schools in Iowa City and vice versa. The efforts needed in crack houses in Newark are not appropriate in family planning clinics in Montana, and vice versa. A pamphlet of genderless stick figures will be ineffective among prostitutes. A film of relentless explicitness will be unacceptable in churches. Community planning that reaches Americans where they live and how they live is the most candid and pragmatic solution.

Secondary prevention, which means preventing AIDS among people who are infected, is a somewhat different issue, but it is also about pragmatism. Counseling and testing can tell someone if they are infected, but after that, our health care system doesn't serve them until they are acutely ill. Referral programs are often miss-

ing. Eligibility for Medicaid and entry into health care are often too late to be true early intervention.

The systems deal with infected people as if they are no longer candidates for preventive health at all, and can only be cared for when they are sick. When there are drugs to prevent TB and pneumonia and other infections, this is a short-sighted and expensive routine.

This subcommittee has held almost three dozen hearings on AIDS over the last 12 years. Story after story has appeared in the press, but the Federal Government has been less than candid and less than pragmatic since the beginning of the epidemic. We can't afford it. Too many lives, too many years of healthy life, and too much money are at stake.

New efforts are underway and we owe a debt to the people who have already begun, but much remains to be done and I hope we can further that goal today. I want to call on Members for opening statements and to, first of all, ask unanimous consent that all Members be permitted to enter a statement in the record. And I want to recognize Mr. Bliley, first.

Mr. BLILEY. Thank you, Mr. Chairman. I want to join you in welcoming our witnesses here today. Dr. Satcher, I believe this is your first time testifying before this subcommittee as the new CDC Director. We often heard from your predecessor, Dr. Roper. I am pleased that you are accompanied by Dr. Lee and am interested in your views.

HIV is truly one of the most devastating diseases of our time. Over the years we have heard very compelling testimony from many of those infected with HIV. And Congress has responded by providing both research and prevention funds. I am concerned, however, that more has not been accomplished. Why is it that with an appropriation of between $400 and $500 million each year for prevention, do we still have approximately 40,000 new HIV infections every year? I am interested in hearing from all our witnesses about the effectiveness of the CDC prevention program.

I am particularly interested in hearing from Dr. Lee and Dr. Satcher about the June 1994 report entitled, "External Review of CDC's HIV Prevention Strategies." My understanding is that this review was initiated in the Bush administration in September of 1992. I hope you will discuss the problem that this—the problems that this report identified and the proposed recommendations to address them. I look forward to the testimony of all our witnesses and thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bliley. Mr. Studds.

Mr. STUDDS. Mr. Chairman, I ask unanimous consent to put a statement in the record. Let me just say that——

Mr. WAXMAN. Without objection, it will be noted.

Mr. STUDDS. The proverbial bottom line here is that we have a disease that is contagious, that is apparently fatal, and that is entirely preventable and that is dramatically increasing. And that is something for which I think we all have to answer.

[The prepared statement of Hon. Gerry Studds follows:]

PREPARED STATEMENT OF HON. GERRY STUDDS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. Chairman, I thank you for holding this important hearing on HIV prevention, and for your tireless leadership on this issue. I would also like to welcome Congresswoman Pelosi and Congresswoman Morella, who have been such committed leaders on this issue in the Congress.

We are here today because of a simple, inescapable fact. Despite the enormous scientific advances we have made in our understanding of HIV, despite the large human and financial resources that have been devoted to the effort to conquer this disease, the epidemic rages on.

AIDS is now the leading cause of death among young men and the fourth leading cause of death among women between the ages of 25 and 44. It is spreading most rapidly today among women and within minority communities, and affects *every* region and *every* community in the land. The gay community, which confronted the epidemic in its initial years and actually succeeded in reducing the rate of new infections, is now seeing a frightening resurgence of the disease among the young.

With hope for a medical solution still many years away, education is the only certain weapon we have. It is tragic and unforgivable that what is now so clearly a preventable disease should continue to ravage our population—let alone the millions infected in countries beyond our shores. Yet for over a decade, HIV prevention efforts were thwarted by the negligence and indifference of successive administrations.

Last year, President Clinton began the process of reversing that trend by requesting significant funding increases for HIV prevention programs at the Centers for Disease Control and Prevention. In FY 1994, the Congress approved a nine percent increase for these programs. This year, thanks to the leadership of Congresswoman Pelosi, whom we have with us today, and other key members of the HHS Appropriations Subcommittee, the HHS Appropriation bill includes a further increase of 12 percent.

These funds are critical if the CDC is to implement its newly-developed community planning process for HIV prevention. That process seeks to enlist state and local health departments in developing regional prevention plans, tailoring programs to local conditions and targeting the needs of all affected populations. These targeted efforts are urgently needed to prevent further spread of the disease.

Community-based prevention is also at the heart of Congresswoman Pelosi's Comprehensive HIV Prevention Act, of which I am proud to be an original cosponsor. The act would expand and improve the effectiveness of federal, state and local HIV prevention efforts. It deserves the support of the Congress and this subcommittee, and I pledge to continue to work for its adoption.

Finally, the community-based approach reflected in the CDC's planning process and the Pelosi bill constitutes a recognition that it is not enough simply to furnish people with the information they need in order to limit their risk. Human behavior is far too complex a phenomenon to yield to purely rational solutions.

For years, the goal of HIV prevention was to ensure that everyone had the information they would need to avoid infection. Indeed, with past administrations doing all they could to prevent the information from reaching those at risk, that goal represented a sufficient challenge. Today, while it remains essential that the information be transmitted, we have learned that information is not enough. Some people refuse to alter behaviors that place them or their sexual partners at risk even after they have the knowledge that can save their lives. The new challenge is to develop prevention strategies that address the cultural and psychological roots of such behaviors if we are to make real strides in arresting the spread of HIV.

I hope today's hearing will give us the opportunity to explore these critical questions, and I look forward to the testimony of our distinguished guests. Thank you.

Mr. WAXMAN. Thank you, Mr. Studds.

Our first witnesses today are two of our colleagues, Congresswoman Nancy Pelosi and Congresswoman Connie Morella. Ms. Pelosi has taken the lead on AIDS prevention efforts in the Congress for some time. She has introduced comprehensive legislation that has been a model for much of the ongoing policy debate, and more recently she has led efforts to increase AIDS prevention appropriations, getting a 12 percent increase in spending in this year's House-passed bill, the first increase of any size in a number of years.

Ms. Morella, has also taken the lead on AIDS activities involving women for some time. She has worked to improve AIDS research on women, AIDS prevention among women, and AIDS treatment for women, and has introduced legislation along these lines. We are pleased to welcome both of you to our hearing today. It is a pleasure to have you with us. Your prepared statements will be in the record in their entirety and we would like to ask you to proceed with your oral presentation to us. There is a button on the base of the mike.

STATEMENT OF HON. NANCY PELOSI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. PELOSI. Thank you very much, Mr. Chairman, Mr. Bliley, and Mr. Studds, for your leadership in calling this hearing and for all of your leadership on the issues of AIDS prevention, research, and care.

Hopefully, your leadership will be followed on this and we will be having the fullest and appropriate focused attention on this issue. Because in my district, we know the price that we pay in human lives, especially young human lives, as Mr. Studds said, for something that is preventable. And we have therefore a moral responsibility to move forward with effective HIV prevention. I think we can stipulate to many things.

You have said them, as well as your colleagues on the committee. It is a serious epidemic, it is spreading, it is costing a great deal of money in addition to the toll that it takes in human lives. We must stop the further spread of HIV infection.

Mr. Chairman, I appreciate your remarks about the appropriations money for this year. This has been a struggle. Three years ago during the appropriations process, I was disappointed to encounter widespread skepticism among my colleagues about whether our Federal HIV prevention efforts were effective. At the same time, national AIDS groups and groups in my district were questioning whether the system was fair and whether the limited funds available were being adequately targeted.

Prevention researchers reported that findings from demonstration research were not being applied to prevention services. For all these reasons, we began to look at legislative ways of improving HIV prevention programs. I want to thank at this point some of the people who helped with this effort.

I am indebted to the Greater Bay Area HIV Prevention Working Group, a group of 76 dedicated people from 11 northern California counties, chaired by Mike Shriver, for their intense work in advising in every step of developing the legislation, and also all of the national groups who have worked closely with my office of the last 2 years. In particular, I want to acknowledge the relentless advocacy of Bill Bailey, who chaired the Coalition for AIDS Education and Prevention.

As you know, we lost Bill to the epidemic in April, but his legacy will live on measured by the thousands and thousands of people who will have long and productive lives because they avoided being infected by HIV. Both the administrative reforms and the legislation are a tribute to Bill and all the others who have joined in this campaign to stop the spread of AIDS.

Before I talk about my legislation, I want to say what also a privilege it is to serve on this panel with our colleague, Congresswoman Connie Morella, who has been absolutely relentless, as you indicated, in her work on issues of HIV and women.

Mr. Chairman, my office findings based on a year of intensive studying are remarkably parallel to the findings from the AIDS Action Foundation, later by the Centers for Disease Control and Prevention External Review Committees. Each group that has looked at the problem has reported remarkably similar findings and makes strikingly similar recommendations.

Last year, I introduced H.R. 1538, the Comprehensive AIDS Prevention Act. I would like to submit for the record H.R. 1538, and a revised discussion draft reflecting suggested amendments, as we have worked them out with the administration.

Mr. WAXMAN. Without objection, that will be received for the record.

Ms. PELOSI. Mr. Chairman, at this point let me commend Doctor Phil Lee, the Assistant Secretary for Health, whose excellent leadership in putting together the PHS HIV Prevention Working Group, which meets with requirements outlined in this legislation. Dr. Lee, as you know, is an inspiration and a valued partner to all in finding ways to reform the HIV prevention system.

The President, Secretary Shalala, and the country, are well-served by having Dr. Lee in his current position. Now, I want to just talk a little bit about the bill. The first section of the bill addresses ways to more clearly define the role of each of the Public Health Service agencies in improving the effectiveness of HIV prevention programs.

Specifically, the legislation gives lead responsibility to the Assistant Secretary for Health to develop a strategic plan for expenditure of appropriations for HIV prevention activities at each of the agencies within PHS. It further establishes a procedure for developing priorities for budget requests through a PHS-wide plan developed in consultation with an advisory panel composed of agency representatives and representatives of State and local health departments, as well as community-based organizations with expertise and commitment to HIV prevention.

The legislation would give clear statutory authority and congressional intent, support external consultation in shaping the PHS-wide budget plan. This legislation would also provide for a plan to be a public document issued by the Assistant Secretary for Health, separate from the internal budget requests that move along to the Secretary and the President in the normal progression of developing the President's budget request. To this extent, the procedure will be similar to the one recently authorized for the strategic budget plan at the NIH Office of AIDS Research.

The second major part of the legislation addresses the reform of HIV prevention programs at the CDC. Here are a number of the themes from all of the groups that have looked at the HIV prevention reform, have been incorporated into a model that promotes community-based HIV prevention programs. You mentioned in your opening remarks, Mr. Chairman, that what works in one part of the country and one particular demographic group may not be effective prevention for another. And the hallmark of this legisla-

tion is that it reflects that—those differences that must be recognized.

Although the scope of the HIV epidemic is national, this model recognizes that preparing an effective response depends on recognizing many local epidemics, which vary greatly depending on the geographical area. Thus, the legislation establishes a community-based prevention program which encourages community level planning and priority-setting with the flexibility to respond to local needs.

Now, I would like at this point to commend Dr. David Satcher, the new CDC Director, and Dr. Jim Curran, the CDC AIDS Office Director, for their leadership in moving CDC in the direction outlined in our legislation.

As you may know, in January the CDC issued extensive guidance to State and local health departments on community planning for HIV prevention. In addition, CDC has contracted for extensive technical assistance to State and local health departments on critical aspects of community planning. These guidelines call upon the State and local health departments to establish planning groups involving health department representatives and representatives of community groups with shared responsibility for setting priorities for HIV prevention programs. These planning groups are required to conduct local needs assessments and recommend priorities for specific intervention targeting specific populations.

For HIV prevention programs to be effective, individuals and groups at risk must be part of finding solutions and setting priorities. Thus, issues of inclusion and representation are extremely important to the success of the planning process. CDC is currently investing resources and focusing attention on issues of representation in the planning process. In my view, these investments will pay off in much more effective HIV prevention programs.

Until late last year, CDC's HIV prevention efforts have been primarily based on good intentions. Some of the comments you made in your opening statement testified to that. The HIV prevention reforms which are currently being implemented depend far more on evaluating specific interventions targeting specific populations. In other words, the expertise from social and behavioral science is being used to more sharply focus HIV prevention programs. In my view, this shift in emphasis will pay off in much more effective programs.

Mr. Chairman, several struggles remain before these reforms can be declared a success. My legislation goes beyond the current CDC reforms in two major ways. First, the legislation would require some States, those that intend to focus all their HIV prevention planning at the State level, to promote more local or regional models for planning. Clearly, for the integrations of HIV prevention into other public health goals, the more local the planning, the more knowledge there will be of local resources and the more direct involvement there will be of local community representatives.

Second, my legislation places additional emphasis on technical services being made available to community-based HIV prevention providers. These organizations tell me that they are in great need of assistance in designing specific interventions and developing efficient ways to evaluate the effectiveness of their programs. The

availability of these technical services can make the difference between programs that work and those that do not.

Mr. Chairman, as you will hear from many witnesses testifying before you today, there is good reason for optimism. In our own community, which has been devastated by the AIDS epidemic, my district alone, over 11,000 people have died of AIDS. That is so staggering that it is almost unfathomable.

On the other hand, we have learned a lot from that that we would like other people to benefit from our experience. And what we have learned is a great deal about prevention which works. So again, I commend you for holding this hearing. The reforms that are in progress or that could be in progress can produce remarkable results. When the book is written on HIV and AIDS prevention, care, and research, you will be the champion, Mr. Chairman. You are a source of hope for us, and as I said to Dr. Satcher and Dr. Lee, the people gathered in this room today are those we have pinned our hopes on and I know that our confidence is well placed. I thank you for the opportunity to testify and for your consideration of my legislation. Thank you, Mr. Chairman.

[The prepared statement of Hon. Nancy Pelosi follows:]

PREPARED STATEMENT OF HON. NANCY PELOSI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Chairman Waxman, thank you for holding this hearing today to focus attention on the reform of our Federal, State and local HIV prevention efforts. As you know, the HIV epidemic continues to spread throughout this country and across the globe at an alarming rate. Clearly, more can—and must be done—to stop the further spread of new HIV infections.

Three years ago, during the appropriations process, I was disappointed to encounter widespread skepticism among my colleagues about whether our Federal HIV prevention efforts were effective. At the same time, national AIDS groups and groups in my district were questioning whether the system was fair and whether the limited funds available were being adequately targeted. Prevention researchers reported that findings from demonstration research were not being applied to prevention services. For all these reasons, I began to look at legislative ways of improving HIV prevention programs.

My office's findings, based on over a year of intensive study, are remarkably parallel to the findings from the AIDS Action Foundation and later by the Centers for Disease Control and Prevention external review committees. Each group that has looked at the problem has reported remarkably similar findings and made strikingly similar recommendations.

In March of last year, I introduced H.R. 1538, the Comprehensive HIV Prevention Act, which now has 90 cosponsors. Through a series of meetings with the administration over the last year, the legislation has been amended to reflect the significant reforms that are currently being implemented by the administration. Mr. Chairman, I would like to submit for the record H.R. 1538, the Comprehensive HIV Prevention Act, and a revised discussion draft reflecting suggested amendments.

Let me explain what the bill does.

The first section of the bill addresses ways to more clearly define the role of each of the PHS agencies in improving the effectiveness of HIV prevention programs. Specifically, the legislation gives lead responsibility to the Assistant Secretary for Health to develop a strategic plan for expenditure of appropriations for HIV prevention activities at each of the agencies within the PHS.

It further establishes a procedure for developing priorities for budget requests through a PHS-wide plan developed in consultation with an advisory panel composed of agency representatives and representatives of State and local health departments as well as community-based organizations with expertise and commitment to HIV prevention.

Mr. Chairman, at this point, let me commend Dr. Phil Lee, the Assistant Secretary for Health, for his leadership in putting together an excellent PHS HIV prevention working group which meets the requirements outlined in this legislation.

Dr. Lee is an inspiration and a valued partner in finding ways to reform the system. The President, Secretary Shalala and the country are well-served by having Dr. Lee in his current position.

This legislation would give clear statutory authority and congressional intent for external consultation in shaping the PHS-wide budget plan. This legislation would also provide for the plan to be a public document, issued by the Assistant Secretary for Health, separate from the internal budget request that moves on to the Secretary and the President in the normal process of developing the President's budget request. To this extent, the procedure would be similar to the one recently authorized for the strategic budget plan at the NIH Office of AIDS Research.

The second major part of my legislation addresses the reform of HIV prevention programs at the Centers for Disease Control and Prevention. Here a number of the themes from all of the groups that have look at HIV prevention reform have been incorporated into a model that promotes community-based HIV prevention programs.

Although the scope of the HIV epidemic is national, this model recognizes that preparing an effective response depends on recognizing many local epidemics, which vary greatly depending on the geographical area. Thus, the legislation establishes a community-based prevention program which encourages community level planning and priority-setting with the flexibility to respond to local needs.

At this point, let me commend Dr. David Batcher, the new CDC Director, and Dr. Jim Curran, the CDC AIDS Office Director, for their leadership in moving CDC in the direction outlined in this legislation. As you may know, in January, the CDC issued extensive guidance to State and local health departments on community planning for HIV prevention. In addition, CDC has contracted for extensive technical assistance to State and local health departments on critical aspects of community planning.

These guidelines call upon the State and local health departments to establish planning groups involving health department representatives and representatives of community groups with shared responsibility for setting priorities for HIV prevention programs. These planning groups are required to conduct local needs assessments and recommend priorities for specific interventions targeting specific populations.

For HIV prevention programs to be effective, individuals and groups at risk must be part of finding solutions and setting priorities. Thus, issues of inclusion and representation are extremely important to the success of the planning efforts. CDC is currently investing resources and focusing attention on issues of representation in the planning process. In my view, these investments will pay off in much more effective HIV prevention programs.

Until the last year, CDC's HIV prevention efforts have been based primarily on good intentions. The HIV prevention reforms which are currently being implemented depend far more on evaluating specific interventions targeting specific populations. In other words, the expertise from social and behavioral science is being used to more sharply focus HIV prevention programs. In my view, this shift in emphasis will pay off in much more effective programs.

Mr. Chairman, several struggles remain before these reform efforts can be declared a success. My legislation goes beyond the current CDC reforms in two major ways. First, the legislation would require some States—those that intend to focus all their HIV prevention planning at a State level—to move to more local or regional models for planning. Clearly, for the integrations of HIV prevention into other public health goals, the more local the planning the more knowledge there will be of local resources and the more direct involvement there will be of local community representatives.

Second, my legislation places additional emphasis on technical services being made available to community-based HIV prevention providers. These organizations tell me that they are in great need of assistance in designing specific interventions and developing efficient ways to evaluate the effectiveness of their programs. The availability of these technical services can make the difference between programs that work and those that do not.

Before closing, let me publicly thank all the many people and organizations that have worked over the last two years to assist in shaping this legislation. In particular, I am indebted to the Greater Bay Area HIV Prevention Working Group, a group of 76 dedicated people from 11 northern California counties chaired by Mike Shriver, for their intense work in advising on every step of developing this legislation. In addition, I must thank all the national groups who have worked closely with my office over the last two years.

In particular, I want to acknowledge the relentless advocacy of Bill Bailey, who chaired the coalition for AIDS education and prevention. As you may know, we lost

Bill to this epidemic in April but his legacy will live on—measured by the thousands and thousands of people who will have long and productive lives because they avoided being infected with HIV. Both the administrative reforms and this legislation are a tribute to Bill and all the others who have joined in this campaign to stop the spread of AIDS.

Mr. Chairman, as you will hear from many of the witnesses testifying before you today, there is good reason for optimism the reforms that are in progress are nothing short of remarkable. Again, I commend you for holding this hearing and look forward to working with you to enact comprehensive HIV prevention legislation.

Mr. WAXMAN. Thank you very much, Ms. Pelosi. Thank you for your kind words.

Ms. Morella.

STATEMENT OF HON. CONSTANCE A. MORELLA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Ms. MORELLA. Thank you, Mr. Chairman. I want to thank you also for giving me the opportunity to make some comments as you begin this critical hearing. I want to also acknowledge your continuing leadership on HIV/AIDS issues. Indeed, there is just no doubt you have been a leader on these issues since the very earliest days of the epidemic.

I also want to particularly commend my colleague, Congresswoman Pelosi, as well, for her tireless work to reform the CDC prevention programs, and to develop the new prevention community planning process. This new community planning process will result in a shift of funding to community-based prevention. There can be no question that prevention programs are most effective if they are developed and implemented by community-based organizations and the peers of those being targeted.

In my work, as you mentioned, focusing on the needs of women in the HIV epidemic, this fact has been demonstrated time and time again. For women, prevention activities related to sexual activity, abstinence, or condom use, require the cooperation in all instances of their sexual partner. It is the men who actually wear condoms, and in many communities, it is the men who decide when sexual intercourse will occur.

Prevention activities for women must take these realities into account. To assert dominance in a sexual relationship may be uncomfortable and dangerous for many women, and the fear of jeopardizing a relationship which provides material and emotional support may be greater than the fear of HIV infection.

Providers with a history of community-based service to women's communities understand this basic concept and how to best teach women condom use negotiation skills. Prevention strategies designed to reach women most at risk of HIV must build upon all that we have learned about combating the victimization of women.

With the implementation of the new community planning process, I want to recognize CDC for its initial efforts to conduct a public outreach process to ensure that planning bodies are truly representative. CDC has also worked with minority organizations in awarding grants for technical assistance. However, this effort must be an ongoing process, subject to careful monitoring, to ensure that underrepresented communities, such as women and people of color, are included and empowered to be full participants.

I will continue to work with Congresswoman Pelosi, with Congressman Studds, and others to ensure that adequate funding is provided for prevention in the fiscal year 1995 appropriations bill. The $63 million increase in prevention funding in the House bill, while below what we know is needed, is still nothing short of a miracle in this very difficult year. I know that many of the members of this panel will be working with us to prevent any reduction in this funding in the final bill, and hopefully, to increase it further.

Finally, I also want to make mention of the critical need for increased funding for prevention research. We must expand the prevention options available. It is essential that women have a method of prevention that they can control, with or without their partner's knowledge or consent.

The development of a microbicide, a chemical method of protection against HIV and sexually transmitted disease infection, must become a top priority for this country's prevention and research agendas.

And again, I want to thank this panel, Congresswoman Pelosi, members of the Appropriations Committee, for their support of this effort as well. The National Institutes of Health has increased its commitment to microbicide research, but far more funding is needed.

Mr. Chairman, HIV prevention has not been a high enough priority. The HIV epidemic is leaving no population untouched, and it is spreading particularly rapidly among our young people, women, and people of color. Indeed, prevention is all we have, since a cure and a vaccine are unlikely to be developed in the very near future. We have already squandered countless prevention opportunities. We must make a meaningful and substantial commitment to community-based, targeted prevention now. It is critical that we provide adequate funding for AIDS prevention, research, and care; these three elements must work together in a cohesive way if we are to act effectively to stem this epidemic.

I look forward to continuing to work with Secretary Shalala, Dr. Phil Lee, Dr. Satcher, and Dr. Curran, and I commend them for their efforts to reform our HIV prevention effort. I urge them to move forward aggressively and I offer my full assistance in their efforts. And again, Mr. Chairman, thank you for your steadfast leadership in this area, and I thank Mr. Studds as well. Thank you.

Mr. WAXMAN. Thank you. I want to thank you both for your determination not to let this issue be pushed aside, and for your consistent support for all the efforts that need to be made to deal with the tragic epidemic, the care, the research, the prevention. Today, we are addressing the preventive aspects of what policies we ought to sponsor at the Federal level and encourage at the local level, and both of you have introduced very important bills that I think give us a good guide as to where we ought to go.

We really don't have anything else that we can say about this epidemic at this moment, except that prevention can stop this disease from being spread further. And we hope we can announce a cure. Someday we will be able to. We would love to have a vaccine, but there is none now, and what we have got to do is try to figure

out ways to change behavior. And that is not easy, when we are talking about sex and drugs.

It is particularly not easy if we are burdened by fear of the radical right or others who are unwilling to be honest about drugs and sex, which are the two main ways this disease is spread. So I thank you very much for your leadership. I don't have any questions particularly of you. Ms. Pelosi.

Ms. PELOSI. Mr. Chairman, in addition to thanking you and Mr. Studds for your leadership on this, I wish to express my gratitude to you for the work of Tim Westmoreland of your staff on every aspect of AIDS. I am also proud of Dr. Steve Morin on my staff. We have gotten so much guidance and judgment and energy and encouragement from Tim Westmoreland. I want to publicly thank you for the role that he has played in all this as well.

Ms. MORELLA. And I associate myself with the sentiment just expressed.

Mr. WAXMAN. Yes, thank you both.

Mr. Studds.

Mr. STUDDS. Mr. Chairman, at the risk of expending our entire morning commending one another, let me just say that seated at the table are two of the most compelling reasons for hope in a very dark time that I know, and I salute them both. Thank you.

Mr. WAXMAN. Thank you very much. Our second panel today is made up of witnesses from the United States Public Health Service. Dr. Phil Lee is Assistant Secretary for Health and an expert on AIDS prevention in his own right. At the University of California, Dr. Lee led many of the pioneering evaluations of effective AIDS prevention and now at the Public Health Service he leads the Federal efforts in this area.

Dr. Lee is accompanied by Dr. David Satcher, the Director of the Centers for Disease Control, and a long-time spokesman on issues of public health; and Dr. James Curran, a familiar witness to this subcommittee on issues of AIDS and HIV; and Dr. Helene Gayle, the new head of CDC's Washington office, and an AIDS expert as well.

We are pleased to welcome all of you to our hearing today, and your prepared statements will be in the record in full. We would like to recognize you for your oral presentation, Dr. Lee. There is a button on the base of the mike, just push it forward.

STATEMENT OF PHILIP R. LEE, ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DAVID SATCHER, DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION AND JAMES W. CURRAN AND HELENE D. GAYLE, ASSOCIATE DIRECTORS

Mr. LEE. Thank you very much, Mr. Chairman. I am honored actually to have this opportunity to report on the HIV/AIDS prevention efforts of both primary prevention and secondary prevention from the perspective of the U.S. Public Health Service and to be joined by Dr. Satcher, Dr. Curran, and Dr. Gayle from the Centers for Disease Control and Prevention.

At the outset, Mr. Chairman, let me also express our deep personal sadness at the loss of lives to this epidemic. Congresswoman Pelosi, who happens to be my Congresswoman, has I think ex-

pressed it eloquently. That is the impact in only one community, and it has occurred in many, many communities across this country. It is a great tragedy. It is also a great challenge for all of us to achieve the prevention objectives that we all share.

Let me also add my words of thanks to you, Mr. Chairman, Members of this committee, for great leadership over many years during a very difficult period. And we hope to work in very close partnership with you, both evaluating our programs critically, sharing information, whatever information you desire, and to work with you and Members of this committee to achieve our common goals. The focus of this hearing, prevention of HIV infection among gay men, bisexuals, lesbians and heterosexuals at risk, could not be more timely or more important.

While some progress has been made in slowing the progression of the HIV/AIDS epidemic in the gay community in some cities, and Congresswoman Pelosi spoke about the progress in San Francisco, that, thanks largely to the leadership of both the gay community in San Francisco and the Public Health Department working in close partnership, I think both gives us a model and also illustrates what is the challenge ahead. We have made progress, but we have not made nearly enough progress.

In the testimony submitted for the record, I review the status of the epidemic; the need for prevention; CDC's prevention activities, including HIV prevention and community planning, prevention marketing, evaluation of HIV prevention efforts, epidemiological and behavioral research; and other PHS prevention activities, particularly those at NIH, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, and the Food and Drug Administration. And finally in the testimony, Mr. Chairman, I review the strategic planning efforts that the Secretary has initiated in the Department and the HIV/AIDS Coordination Group which I chair.

I think there are just a very few points that I want to highlight, because you have all had an opportunity to review the testimony and I will not go into that in detail. First of all, I think we need to appreciate the magnitude of the epidemic. More than 350—more than 360,000 cases of AIDS have been reported through December 31, 1993. And in 1993, more than 100,000 AIDS cases were reported, reflecting both the expanded AIDS definition, the surveillance definition of CDC, but also the trends in the epidemic.

There is no doubt about the need for prevention. It has been stressed at this hearing. The CDC Advisory Committee on the Prevention of HIV Infection stressed it very eloquently. We are certainly committed to that. Over the past decade, we have learned some valuable lessons with respect to prevention.

First, the importance of a sound, scientific basis, both in terms of biomedical, epidemiological and behavioral sciences. Second, the need for participation of populations and communities at risk in the planning and implementation of prevention interventions. Third, the need for targeted, linguistically specific, developmentally appropriate and culturally competent messages in interventions aimed at impacting behavior. And, the importance of a multidisciplinary team, of a multifaceted approach, and of broad partnerships in HIV/AIDS control, including the public and private sector,

the scientific and community groups, political and advocacy groups, business and the media—all of us must be in this together. We describe in the testimony in some detail the CDC prevention activities and the review by the advisory committee.

The committee reviewed the following areas: monitoring of the HIV/AIDS epidemic; promoting knowledge of serostatus; developing partnerships for HIV prevention; preventing risk behaviors among school-aged youth; and improving public understanding of the epidemic. Concurrent with the external review of its programs and in response to the Secretary's direction, CDC has begun two new initiatives which, again, are described in detail in the testimony: HIV prevention community planning, and the Prevention Marketing Initiative, which are designed to target prevention efforts better and to more closely involve its prevention partners and particularly communities affected by the epidemic.

In December, as Congresswoman Pelosi noted, CDC issued an HIV prevention community planning guidance, which outlines a process whereby the identification of high priority prevention needs is shared between the health department administering the funds and representatives of the community for whom the services are intended. And Dr. Satcher and Dr. Curran can comment on this in more detail as we go forward.

The second major activity is the Prevention Marketing Initiative, and this has basically four distinct integrated components (1) a national health communications program, (2) a national prevention collaboration, and transfer of technology and service, (3) local demonstration sites, and (4) applications of prevention marketing principles with the HIV prevention community planning.

With respect to the messages, the public service announcements which have been developed to really deliver the messages: Abstaining from sexual activity is the most effective HIV prevention strategy, and individuals who are sexually active can significantly reduce their risks by using latex condoms consistently and correctly. And the CDC research has demonstrated overwhelmingly the preventive benefits of effective and appropriate condom use. And I can't stress that point enough.

The second component focuses on the establishment of a national prevention collaboration among governmental and nongovernmental partners to facilitate the interchange of technical assistance and promote and facilitate support for the objectives of the overall program. The third component is CDC assisting five communities in taking the lead to plan and implement innovative data-driven prevention marketing programs to prevent the sexual transmission of HIV and other STD's among young people. The fourth will be CDC working with the communities in partnership with the new prevention strategy.

With respect to evaluation, several things have been learned. First, a basis, programs must be based on real, specific needs and community planning. They must be culturally competent, and include clearly defined audiences, objectives and interventions. They must have a basis in behavioral and social science theory and research. Quality monitoring, adherence to plans must be part of the process; use of evaluation findings and mid-course corrections and sufficient resources—those are the essentials.

86-462 O - 95 - 2

The evaluations indicate that community-level interventions are particularly promising for changing risky behaviors. Community-level interventions are those which are targeted—which target the community, which may be defined by gender, geography, high-risk behaviors, race, ethnicity or sexual orientation, rather than a specific individual. I can't stress that enough.

Second, involve community members in the actual kind and delivery of the interventions and attempt to change community norms about high-risk behaviors as well as to modify those behaviors. CDC conducts extensive epidemiological and behavioral research which undergirds these policies.

And, finally, with respect to the other Public Health Service programs, the NIH, as you know, is supporting broad-based research, and just one comment on that, and that is the results of the NIH-sponsored clinical trial on AZT, which has demonstrated that AZT administered to an HIV-infected woman during pregnancy and labor and to the infant after birth can significantly reduce by as much as two-thirds the risk of perinatal transmission.

In view of the significance of these findings in this clinical trial, the Secretary has established an HHS task force to make recommendations regarding the implementation of this study with respect to the clinical use of AZT in pregnant women and counseling and testing for those women. The other activities detailed in the testimony include the other NIH research on vaccine development, on microbicides, the work of the Substance Abuse and Mental Health Services Administration, the work of the Food and Drug Administration, and the work of the Health Resources and Services Administration, particularly through the Ryan White Program.

Let me just say a final word, Mr. Chairman, about the strategic planning process the Secretary has initiated. Because of the importance of HIV and AIDS, the Secretary has established an HHS Coordinating Group on HIV/AIDS, which I chair. We have four working groups, three already up and operating, one on research, a second on prevention, a third is on care services, and a fourth will be developed with respect to disseminating HIV and AIDS information. We have identified emerging opportunities to significantly improve the availability of treatment information to care providers and to the public. We are now preparing plans to consolidate several separate systems and 1–800 access points in a single point 1–800 voice access.

Additionally, we will streamline several processes to increase the speed with which we move information from research findings to concise and usable treatment information. This we hope to get off the ground in the very near future. Mr. Chairman, the challenge of preventing further spread of HIV infection during the rest of this decade will require our greatest efforts. And we commit ourselves to doing everything we can to meet that challenge. We appreciate the opportunity to testify before this subcommittee. Thank you.

[The prepared statement of Dr. Philip Lee follows:]

PREPARED STATEMENT OF PHILIP LEE

Mr. Chairman, members of the Subcommittee, I am Dr. Philip Lee, Director of the U.S. Public Health Service (PHS) and Assistant Secretary for Health at the Department of Health and Human Services (HHS). I am honored to have the oppor-

tunity to comment on HIV/AIDS prevention efforts from the perspective of the nation's public health agencies.

In my testimony today, I will discuss some of the key Federal efforts in preventing HIV infection and AIDS, as well as some of the important lessons we have learned from these and other activities. These efforts are in large measure the result of Congressional leadership, especially by this Subcommittee.

I would like to begin by giving the Subcommittee some perspective on the scope of the HIV/AIDS epidemic in the United States. HIV infection and AIDS continues to be a leading cause of death among young Americans. In 1992, HIV/AIDS became the number one cause of death among men ages 25-44 years, and the fourth leading cause of death among women in this age group. It is also the sixth leading cause of death among young people ages 15-24. During 1992, HIV/AIDS became the eighth leading cause of death overall, up from ninth in 1991.

Thirteen years of AIDS case surveillance has documented increasing diversity among people infected with HIV. From 1982, when the vast majority of AIDS cases were in a few communities among men who have sex with men, the epidemic has evolved into a composite of multiple epidemics in different regions and among different population subgroups. Cumulatively, more than 360,000 AIDS cases had been reported through December 31, 1993. In 1993, more than 100,000 AIDS cases were reported, reflecting both the expansion of the AIDS surveillance case definition and overall trends in the epidemic. Also during 1993, for the first time, cases reported among homosexual/bisexual men did not represent the majority of cases reported in a calendar year. From 1985 through 1993, the proportion of persons with AIDS who reported heterosexual contact with a partner at risk for or with documented HIV infection increased from 1.9 percent to 9 percent. In 1993, the rate of increase in case reporting was greatest for women, racial/ethnic minorities, adolescents, injecting drug users, and persons infected through heterosexual contact. Although the pediatric AIDS case definition remained unchanged in 1993, the number of children reported with AIDS increased and paralleled the increase in AIDS among young women.

Among persons with heterosexually acquired AIDS, adolescents and young adults, women, blacks, and Hispanics have been disproportionately affected. Persons at highest risk for heterosexual HIV transmission are those who have multiple sex partners, sex with a high-risk partner, or sexually transmitted diseases (STDs). The highest proportion of cases associated with heterosexual contact during 1993 was reported in the South (42 percent) and Northeast (31 percent).

It is important to note the close relationship between the prevalence and incidence of HIV infection and other-STDs, particularly gonorrhea, syphilis, and chlamydia. Because sexual behaviors that can facilitate STD transmission are the same as those for HIV infection, and because some STDs can facilitate the transmission of HIV, a high incidence of STDs in an area or among a particular population can serve as a sentinel warning system for increased HIV infections. For example, the rates of many STDs are highest among sexually active adolescents, indicating many young people are potentially at risk for HIV infection from engaging in sex without condoms; data from States that report HIV infections indicate the ratio of cases of HIV infection to AIDS cases is higher for adolescents than for other age groups. In some studies, persons with STDs have as much as a three- to fivefold increased risk of acquiring HIV infection.

It is clear from our surveillance data that the HIV/AIDS epidemic is a formidable public health challenge in today's world. As has been recently noted by the CDC Advisory Committee on the Prevention of HIV Infection, "With neither a cure nor a vaccine on the immediate horizon—and with a huge national reservoir of infection—the only promising barrier against the virus is widespread adoption and maintenance of personal behaviors that eliminate or minimize the chances of exposure and infection;" that is, prevention.

The Public Health Service (PHS), within HHS, has primary responsibility for Federal HIV prevention programs. In fiscal year 1994, total HHS funding for HIV/AIDS will total about $5.4 billion, including $2.6 billion for PHS HIV/AIDS programs; about 17 percent of these PHS funds is dedicated to direct HIV prevention efforts. Although most of the PHS agencies have HIV prevention activities, the bulk of these programs are carried out by the Centers for Disease Control and Prevention (CDC). Today I will focus my remarks on key prevention activities by CDC, but will also highlight important prevention efforts of the National Institutes of Health, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and the Food and Drug Administration.

Over the past decade, we have learned a number of valuable lessons about HIV prevention: (1) the importance of a sound scientific base; (2) the need for participation of populations and communities at risk in planning and implementing HIV pre-

vention interventions for them; (3) the need for targeted, linguistically specific, developmentally appropriate, and culturally competent messages and interventions aimed at impacting behavior; (4) the importance of a multi-disciplinary scientific team, including public health practitioners, epidemiologists, social and behavioral scientists, laboratory specialists, clinicians (including primary care and infectious disease), and management and health systems specialists; (5) the importance of coordinating efforts to prevent STDs, tuberculosis, and substance abuse and to promote reproductive health with HIV/AIDS prevention activities; (6) the need for multifaceted approaches and strategies aimed at changing behavior; and (7) the need for broad partnerships in HIV/AIDS control, including the public and private sector, scientific and community groups, political and advocacy groups, and business and the media.

Federal HIV prevention programs were developed relatively rapidly during the 1980s to respond to the emerging HIV/AIDS epidemic. CDC's programs have evolved to include financial and technical support for State and local health department programs (the largest component of CDC's HIV prevention efforts); direct funding for community-based organizations; funding for national and regional minority organizations; a national public information and education program; funding and technical support for education programs in the nation's schools; and the more traditional epidemiologic, behavioral, and laboratory studies.

Recognizing the changing patterns of the HIV/AIDS epidemic, and the necessity to evaluate what has, and what has not, been effective in prevention efforts to date, in February 1993, CDC requested that its Advisory Committee on the Prevention of HIV Infection (ACPHI) convene subcommittees of outside experts to review five of CDC's key HIV program areas: Monitoring the HIV/AIDS Epidemic; Promoting Knowledge of Serostatus; Developing Partnerships for HIV Prevention; Preventing Risk Behaviors Among School-Aged Youth; and Improving Public Understanding of the HIV Epidemic.

From April through October 1993, the subcommittees, composed of approximately 60 members, held more than 30 public meetings in 18 cities to visit program sites, meet with governmental and nongovernmental representatives, and discuss program strategies and activities. Following these meetings, each subcommittee produced a report for consideration by the full ACPHI. The reports addressed specific concerns and provided recommendations to ensure CDC's future success in preventing the spread of HIV infection. The ACPHI has subsequently reviewed each of the subcommittee reports and developed a final executive summary report and formal list of recommendations for CDC. The Director of CDC and I have carefully reviewed this report, which I am providing this Subcommittee.

The ACPHI, in its general findings, acknowledged that HIV prevention is necessary and urgent, that prevention efforts should be guided by science, and that partnerships and collaboration are key to the success of prevention programs. The Committee also advised that "prevention interventions must strike a balance between targeted efforts and efforts to change general community norms." All Americans are potentially at risk, but it is important to maximize limited resources and minimize new infections by targeting those whose behaviors place them at highest risk.

Concurrent with the external review of its programs and in response to the Secretary's direction, CDC had begun two new initiatives—HIV Prevention Community Planning and the Prevention Marketing Initiative—which are designed to target prevention efforts better and to more closely involve its prevention partners and, particularly, communities affected by the epidemic.

HIV Prevention Community Planning represents a significant step forward in the planning of culturally competent and scientifically sound HIV prevention services—programs to address unique community needs.

In December 1993, CDC issued an HIV Prevention Community Planning Guidance, which outlines a process whereby the identification of high-priority prevention needs is shared between the health department administering the funds and the representatives of the communities for whom the services are intended. In addition to including representatives of affected populations, the HIV Prevention Community Planning process embraces the notion that the behavioral and social sciences must play a critical role in the development, implementation, and evaluation of HIV prevention programs within a given community. The guidance will be implemented in fiscal year (FY) 1994 and applies to all of CDC's 65 State, territorial, and local health department grantees.

According to the CDC guidance, community planning groups should be established and reflect in their composition the characteristics of the current and projected epidemic in that community. To date, 224 community planning groups have been formed to address HIV prevention needs in their respective communities. The guid-

ance also outlines the essential components of a comprehensive HIV program, the necessary elements of a comprehensive HIV prevention plan, and principles that all HIV community planning efforts must address.

The guidance was developed through collaboration with both governmental and nongovernmental organizations, with particular assistance from the Association of State and Territorial Health officials and the National Alliance of State and Territorial AIDS Directors.

CDC is also providing technical assistance and training to health departments and community planning groups in the following areas: Parity, inclusion, and representation; Surveillance and the uses of epidemiologic data; Community planning processes and models; Evaluation of effective and cost-effective HIV prevention efforts; Access to behavioral and social science expertise; and, Conflict of interest and dispute resolution.

This technical assistance is being delivered through a network of governmental, nongovernmental, and private providers, including the National Association of People with AIDS, the National Alliance of State and Territorial AIDS Directors, the National Council of La Raza, the National Minority AIDS Council, the National Native American AIDS Prevention Center, the National Organization of Black County Officials, Inc., the United States-Mexico Border Health Association, the Council of State and Territorial Epidemiologists, and the Academy for Educational Development.

The community planning guidance calls for a careful use of the scientific-effectiveness and cost-effectiveness literature when prioritizing HIV prevention interventions. This rapidly growing body of literature contains important information related to HIV prevention efforts. HIV prevention community planning involves community groups and members, but it also requires using the best available scientific information. By using this information, successful interventions can hopefully be translated for use in other geographic areas and demographic groups.

Although CDC's HIV prevention efforts have traditionally focused on the use of health communications to convey important messages to the general public, CDC's health communication efforts have now shifted toward more targeted efforts using consumer-oriented health communications technologies and marketing approaches. In January 1994, CDC formally announced the Prevention Marketing Initiative, or PMI.

This initiative represents a large-scale effort to influence behaviors which contribute to the sexual transmission of HIV and other STDs among young people 18-25 years of age. PMI uses proven social marketing principles to shift from previous mass media health communications programs, aimed at increasing general awareness of HIV infection and AIDS, to activities designed to influence behavior changes among persons at high risk of HIV infection or transmission.

PMI is designed to encourage: Young people who are not currently engaging in any form of sexual activity to maintain this behavior; Sexually active young people who use condoms consistently and correctly or are in a mutually faithful relationship with an uninfected partner to maintain these behaviors; and, Sexually active young people who are not in a mutually faithful relationship with an uninfected partner to refrain from sexual activity, choose nonpenetrative sex, or use condoms consistently and correctly.

The PMI is composed of four distinct yet integrated components: (1) a national health communications program, (2) a national prevention collaboration and transfer of technology and information, (3) local demonstration sites, and (4) application of prevention marketing principles within the HIV Prevention Community Planning process.

The PMI National Health Communications effort represents the strategic use of disciplines such as social advertising, media relations, media advocacy, and community mobilization to inform, remind, and motivate people at increased risk for HIV infection about the critical role that their behaviors play in the prevention of HIV infection. The effective and integrated use of these disciplines is critical to ensure that highly credible information is appropriately positioned to impact on the intended audiences. Specific messages will focus on condoms efficacy and encourage young people to adopt safer behaviors. The most visible aspect of the national program thus far has been a series of public service announcements (PSAs) providing these messages that have been produced and distributed to major networks and their local affiliates. The PSAs deliver two main HIV prevention messages: (1) abstaining from sexual activity is the most effective HIV prevention strategy; and (2) individuals who are sexually active can significantly reduce their risk by using latex condoms consistently and correctly.

The second component focuses on the establishment of a national prevention collaborative among governmental and nongovernmental partners to facilitate the

interchange of technical assistance and promote and facilitate support for the objectives of PMI at the local level. In early March, 150 representatives of national, State, and local public- and private-sector organizations met in Washington, D.C., to review strategies in this area. The meeting also included 25 young adults. With the assistance of this prevention collaborative, CDC will continue to develop and distribute materials, planning guides, data gathered for the national program, case studies, and other materials to State and local communities.

In the third component, CDC is assisting five communities in taking the lead to plan and implement innovative, data-driven prevention marketing programs to prevent the sexual transmission of HIV and other STDs among young people. CDC will monitor each of these sites in tracking the skills and resources needed to effectively engage communities in planning and implementation of their interventions. Both long-term and short-term process and behavioral outcome evaluations will be applied to interventions in each site. Lessons learned from these demonstration sites will be distributed through the Prevention Collaborative Partners and will impact the National Health Communication Component.

In the fourth PMI component, CDC will specifically work to facilitate the application of prevention marketing principles in CDC-funded HIV prevention community planning efforts by promoting guidelines and providing technical assistance for incorporation of these principles at the local level.

PMI is an important example of how we base prevention efforts on increasing scientific knowledge. Although we have known for some time that condoms were effective in reducing transmission of HIV and other STDs, recent studies have provided compelling evidence that latex condoms are highly effective in protecting against HIV infection when used properly for every act of intercourse. In a study of discordant couples (in which one member is infected with HIV and the other is not) in Europe, among 123 couples who reported *consistent* condom use, *none* of the uninfected partners became infected. In contrast, among the 122 couples who failed to use condoms *consistently*, 12 of the uninfected partners became infected.

Although there have been demonstrations that HIV prevention efforts reduce high-risk behaviors, it is still important to ask the following question: What mix of HIV prevention interventions work "best," for whom, under which circumstances, for how long, and quantitatively by how much? Because of the extent of the epidemic and the urgent need for prevention efforts, we have made careful and timely evaluations a high priority. This information about program effectiveness and efficiency is critical for decision-making about future HIV prevention priorities, at the Federal level and in the community planning process.

A review of data from program evaluations does indicate that behaviorally-based HIV prevention programs have a positive impact on behavioral outcomes in specific populations, particularly when these programs have sufficient resources, intensity, and cultural competency. In addition, economic evaluations to date indicate that HIV prevention efforts appear to be cost-effective (and some programs are even cost-saving). Thus, we believe in a continued commitment of public funds for behaviorally-based HIV prevention programs.

In 1994, HIV prevention programs are being particularly scrutinized, not only because of their increasingly important role in light of health care reform, but also because of the needs of community planning groups who will share in the decision-making about HIV prevention efforts. Community planners will need to use HIV/AIDS epidemiologic surveillance and other data, ongoing program experience, program evaluations to date, and a comprehensive, objective needs assessment process to develop appropriate program strategies.

CDC scientists recently looked at studies evaluating "what works" in HIV prevention. The results of their review are in press; I would like to summarize some of their findings.

In reviewing the general characteristics of reported successful, behaviorally-based HIV prevention programs, the CDC scientists noted that common elements of such programs are: A basis in real, specific needs and community planning; Cultural competency; Clearly defined audiences, objectives, and interventions; A basis in behavioral and social science theory and research; Quality monitoring and adherence to plans; Use of evaluation findings and mid-course corrections; and, Sufficient resources.

The CDC researchers looked at programs directed to persons at relatively low risk of HIV infection, those at potential risk of infection (such as adolescents), and persons at high risk or who were already infected. Following are a few examples of successful prevention programs.

Analysis of several studies indicated that publicly funded information programs have led to an overall increase in basic HIV knowledge in the general population. In particular, data from the National Health Interview Survey showed that basic

knowledge about how HIV is transmitted has increased greatly over the last several years.

In addition, findings indicate that HIV education in the context of comprehensive school-based health education has significantly increased knowledge among school- and college-aged youth, and that HIV prevention programs in educational settings can delay the onset of or reduce the practice of high-risk behaviors. Effective adolescent HIV prevention programs were generally found to be those that are based on social learning theories; focus on reducing sexual risk behaviors; provide accurate information on risks of and methods for avoiding unprotected sex (i.e., without a condom); address social influences on sexual behaviors; support values that discourage unprotected sex; and provide communication and negotiation skills.

Programs for high-risk or already infected persons have received the most extensive study. According to the CDC analysis, evaluations of counseling and testing programs indicate that such programs tend to reduce HIV-related risk behaviors in specific populations—especially among heterosexual couples in which one partner is HIV infected and the other is not, and among gay men testing HIV seropositive. However, there seems to be little evidence that counseling and testing leads to favorable behavior change among persons who are engaging in risky behavior but receive *negative* test results. These findings would indicate a need to strengthen the length, intensity, and quality of the counseling and other preventive services for selected high-risk persons who test negative and to evaluate these improved efforts. Several studies of individual or small group risk-reduction counseling interventions completely unlinked to testing indicate that such interventions increase knowledge about HIV and AIDS and decrease high-risk drug- or sex-related activities among different specific high-risk populations, at least in the short term.

Evaluations indicate that community-level interventions are particularly promising for changing risky behaviors. Community level interventions are those which (a) target the community (which may be defined by gender, geography, high-risk behaviors race/ethnicity, or sexual orientation) rather than a specific individual, (b) involve community members in the actual design and delivery of the intervention, and (c) attempt to change community norms about high-risk behaviors as well as modify individual behaviors.

One example of community-level interventions is the CDC funded AIDS Community Demonstration projects, which has operated in five cities and targeted five priority populations: (1) men who have sex with men but do not self-identify as gay, (2) out-of-treatment injecting drug users (IDUs), (3) female sex partners of men at risk of HIV infection, (4) prostitutes, and (5) youth in high-risk situations. The projects used actual success stories of behavior change by community members, translated these stories into HIV prevention messages, and trained community members to deliver these prevention messages. The AIDS Community Demonstration Projects used a behavior change model combined with the behavior change stories to design messages specifically for persons at particular stages of behavior change. Among the lessons learned from the these projects are (1) the timing, content, and delivery of instruction messages must be tailored to the stage of behavior change of the client or population; (2) social norms play an important role in the initiation and maintenance of behavior change; and (3) confidence in the ability to use condoms, perceptions of condoms as pleasurable, and perceived risk are significantly associated with condom use among hard-to-reach populations.

Several outreach programs have been found to be successful, particularly those focusing on IDUs and their sex partners. Outreach programs can refer persons to HIV prevention programs offered in other settings (such as drug treatment facilities) or provide services in street or other nontraditional settings. Through information, education, and counseling sessions, HIV prevention programs have attempted to change drug- and sex-related HIV-risk behaviors of IDUs. Such programs encourage IDUs to (1) stop using drugs; (2) if using, stop injecting; (3) if injecting, stop "sharing" needles and syringes and use only new (sterile) equipment; and (4) stop high-risk sexual behaviors. In general, the programs reduced high-risk (particularly injecting related) behaviors of IDUs. Specifically, the National AIDS Demonstration Research Project, in a study of 13,475 IDUs and 1,637 sex partners of IDUs, in 28 project sites, found that after street outreach interventions, participants reported significant decreases in injected-drug use as well as decreases in borrowing or sharing of needles and syringes. Participants also reported increased attempts to use new rather than used needles, and to use bleach to clean injection equipment between uses when new needles were unavailable. Although participants reported greater use of condoms, there was less reported evidence that the interventions caused IDUs to modify risky sexual behaviors such as having sex with multiple partners or exchanging sex for drugs or money.

In addition to its prevention programs, CDC performs epidemiologic and behavioral research that provide a basis for HIV prevention activities. Effective prevention programs must be guided by effective surveillance and epidemiologic studies of HIV infection and AIDS. Data provided by CDC's surveillance systems have been the basis for planning, implementation, and allocation of resources for the vast majority of Federal and non-Federal prevention programs. CDC's HIV/AIDS surveillance and epidemiology activities include determining the numbers of persons who have developed AIDS; determining the prevalence of HIV infection in different population groups and estimating the overall prevalence of HIV in the United States; studying HIV- associated morbidity and mortality; helping States to standardize HIV infection reporting and evaluate other monitoring systems; studying the natural history of and risk factors for HIV infection; and examining the nature and frequency of occupationally related exposures to HIV infection. In addition, CDC has surveillance systems to monitor knowledge, attitudes, beliefs, and behaviors related to HIV transmission.

CDC has also enhanced its tuberculosis (TB) surveillance systems to identify TB patients co-infected with HIV and ensure their appropriate therapy and case management; monitor trends in TB cases among persons with underlying HIV infection; describe the epidemiologic characteristics of persons with TB disease and HIV infection; and determine the prevalence of substance abuse among TB patients.

Many of CDC's applied behavioral research activities are related to the evaluation of HIV prevention programs. Several such examples were described earlier. For instance, CDC's AIDS Community Demonstration Projects are important evaluation *and* research activities. Additionally, CDC does research, and closely monitors the literature, on determinants of high-risk behaviors. CDC is also actively involved in transferring behavioral science findings to its grantees and the HIV prevention community planning groups.

In addition to CDC's efforts, several other PHS agencies have important prevention functions. The National Institutes of Health (NIH) biomedical research studies provide crucial insight for the prevention, treatment, and control of HIV infection and its sequelae through the development of potential therapeutic agents and vaccine candidates. For example, NIH is investigating critical issues associated with prevention of maternal-fetal transmission. Results from a recent NIH-sponsored clinical trial (ACTG 076) have demonstrated that AZT administered to an HIV infected woman during pregnancy and labor and to the infant after birth can significantly reduce (by as much as two-thirds, or 67 percent) the risk of perinatal HIV transmission. In view of the significance of these findings, the Secretary has established an HHS Task Force to make recommendations regarding the implementation of this study with respect to the clinical use of AZT in pregnant women and to counseling and testing. This analysis will be completed by August 11 and will be reported back to the Subcommittee. Later this month the FDA Antiviral Drugs Advisory Committee will discuss the zidovudine application for use as a prophylaxis against maternal to fetal transmission of HIV infection.

The development of safe and effective vaccines for preventing HIV infection in exposed individuals is a major public health priority in the national and international effort to combat this pandemic. NIH is investigating various strategies to stimulate a protective immune response against HIV. in addition, vaccines may serve as immunomodulators to improve immune function and prevent disease progression in HIV-infected individuals and may serve to prevent transmission from mother to fetus.

An important prevention research priority is the development of virucides, microbicides and physical barriers, including the development of condoms from new polyurethane materials, that can be used by women to prevent HIV transmission. NIH research also seeks to determine whether vaginal irritation and lesions produced by spermicides in some women increase the rate of HIV transmission. In addition, research is supported to identify the determinants and mediators of HIV-related risk behaviors that can be addressed in community-level interventions. NIH also plans to initiate a research program, in coordination with other appropriate PHS agencies, to investigate various models and strategies linking drug abuse treatment with medical care. Other studies identify and explain associations between alcohol use and unprotected sexual intercourse, and evaluate innovative strategies targeted at sexual behavior and HIV exposure of drug users.

Prevention of HIV infection through behavioral change is also a priority. NIH-funded research is aimed at enhancing the effectiveness of existing prevention and intervention strategies and the development of new behavioral strategies. Improving the effectiveness of culturally sensitive educational interventions in different populations continues as an important research focus. NIH is funding studies that examine how knowledge, attitudes, and beliefs about AIDS and other sexually transmit-

ted diseases affect risk behaviors. NIH studies also address the social, cultural, economic, and psychological factors associated with HIV risk behaviors. The NIH, in collaboration with other Federal agencies, has initiated a multi-site, multi-population prevention trial to identify theory-based interventions that can be readily adopted by public and private agencies. Such interventions can be used effectively to reach persons who continue to engage in at-risk behaviors.

Another PHS agency, the Substance Abuse and Mental Health Services Administration (SAMHSA), targets its HIV prevention efforts to substance abusers. Substance abuse plays a key role in the current phase of the AIDS epidemic, especially for drug addicts.

A new and promising medication for opiate addiction, LAAM (1-alpha-acetylmethadol) has just been introduced, largely as a result of the National Institute on Drug Abuse, Medications Development Program efforts. LAAM is an orally active medication that is converted to more active substances. This metabolic conversion produces a slow onset, a lesser peak effect than methadone, and a longer duration of action. LAAM can be administered on an every other day basis or three times a week. It is perceived by many in treatment to allow themselves to "feel normal" without feeling any drug effect. Some patients prefer LAAM to methadone.

LAAM is a pharmaceutical that has been shown to be effective as an alternative to methadone. LAAM has effects similar to those of methadone in terms of treatment retention and reduction of illicit opiate use. Thus, we anticipate that all the known benefits associated with methadone maintenance will also occur during LAAM therapy. LAAM is intended to provide the treatment community with more options and improved treatment matching for patients.

While the approval of LAAM represents a major new treatment for opiate dependence, cocaine and "crack" cocaine dependencies have proven to be refractory to pharmacotherapeutic intervention. NIDA has initiated a program that has preclinical and clinical components with the purpose of discovering and developing new medications that can be used in the treatment of crack/cocaine abuse.

The sexual transmission of HIV is more likely when the parties are under the influence of drugs and/or alcohol. Alcohol has also been determined to be a key determinant of unsafe sexual practices in the gay community. Thus, whether one looks at injection drug use, trading sex for drugs, or unsafe sexual practices under the influence of alcohol, the reduction of substance use and abuse is essential to help curb the HIV/AIDS epidemic. Special consideration is being given to HIV prevention for youth. Youth, in particular, may be most vulnerable to unsafe sexual practices under the influence of alcohol or other drugs. Public information campaigns, experiential training for youth, and peer counseling are some of the ways in which HIV/AIDS prevention education is evolving.

The mentally ill are also at risk for the spread of HIV/AIDS, especially when institutionalized. The development of specialized AIDS prevention education materials and the appropriate training of mental health providers is a high priority. The recognition of neuropsychiatric consequences of AIDS, the counseling of individuals with HIV/AIDS, and the support of families and significant individuals in the lives of AIDS patients is a high priority for those programs supported by the PHS through SAMHSA.

The Health Resources and Services Administration (HRSA) administers several HIV/AIDS programs, including those authorized by the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. These program activities have strong prevention elements, which contribute to the overall HIV prevention strategy of PHS. These care programs will play a major role in implementation of the PHS recommendations, which I mentioned earlier, on prevention of maternal/infant transmission of HIV through administration of AZT to mother and baby during and after pregnancy. In addition:

Titles I and II of the Ryan White Act authorize grants to metropolitan areas and States for outpatient health and support services to persons with HIV infection, including services aimed at preventing the further spread of the disease. These services include treatment and referral for substance abuse, safe sex counseling for people with HIV and their spouses or sex partners, and support groups where people with HIV can help each other live safely with HIV.

The Pediatric AIDS Demonstration program, administered by HRSA's Maternal and Child Health Bureau, requires grantees to demonstrate effective ways to prevent HIV infection in addition to developing systems of care for women and children who have the disease.

HRSA's Bureau of Health Professions supports 17 regional AIDS Education and Training Centers. One of the purposes is to train community primary care providers to incorporate strategies for HIV prevention into their clinical care of people with HIV/AIDS.

Title III of the Ryan White Act authorizes a program, administered by the Bureau of Primary Health Care, of "early intervention." This includes medical, educational, and psychosocial services designed to prevent the further spread of HIV.

Identification of safe and effective products to prevent transmission of HIV and other STDs has become a high priority public health concern. The Food and Drug Administration (FDA) continues to encourage development of products for STD prophylaxis through inter-center and inter-agency working groups, participation in workshops, and focused regulatory research.

Through its regulatory activities, the FDA helps ensure the safety and effectiveness of AIDS-related medical devices, including devices that prevent transmission of HIV. This includes sampling and testing of medical gloves and latex condoms, and premarket evaluation of new barrier products.

The FDA is also involved in secondary prevention efforts in its responsibilities for the approval of safe and effective drugs and biologics used in the treatment of HIV infection, AIDS, and AIDS-associated opportunistic diseases and for regulating the investigation of new drugs. The agency places special emphasis on ensuring the most timely and efficient premarketing review possible of products that offer promise for diagnosing, treating, or preventing HIV and HIV-related illnesses. FDA has approved 19 applications for products to treat HIV/AIDS. Four drugs are to treat HIV infection and 15 are to treat HIV/AIDS-related illnesses.

In addition to treatment activities, the FDA conducts a variety of regulatory, testing, and research activities to approve for marketing satisfactory test methodologies for detection of HIV. Currently, there are 15 kits licensed for the detection of antibody to HIV-1, one kit licensed for detection of HIV-1 antigen, one kit licensed for detection of antibody to HIV-2 and two test kits licensed for the detection of antibodies to both HIV-1 and HIV-2.

The FDA continues its efforts to help ensure the safety of the nation's blood supply. The agency is working with the American Red Cross and the other major blood organizations to prevent the release of contaminated units of blood and blood products.

To ensure that all aspects of HHS' HIV-related activities address the multiple challenges posed by the HIV epidemic in prevention, research, drug development and approval, health care services, and financing in a coordinated manner, HHS Secretary Donna Shalala recently convened the HHS Coordinating Group on HIV/AIDS. I chair this group. Among the initiatives the Group has established to date are development of a research plan, a care services strategy, and a prevention plan.

As part of our strategic review of our efforts in disseminating HIV and AIDS information, we have identified emerging opportunities to significantly improve the availability of treatment information to care providers and to the public. We are now preparing plans to consolidate several separate systems and "1-800" access points into a single point of "1-800" voice access. Additionally, we will streamline several processes to increase the speed with which we move information from research findings into concise and usable treatment information. This re-engineered approach will make more information available, more easily, to more people, more efficiently.

Creation of an HIV Prevention Work Group in June 1994 reflects the compelling need to ensure that HHS' prevention programs are addressing the prevention needs of those at risk for HIV. This new Work Group is designed to build on the prior effort of the agencies—in particular, the recently completed external review of CDC programs and the new plan developed by the Office of AIDS Research at NIH. The Work Group will also take into consideration earlier recommendations of such groups as the National Commission on AIDS and the National Academy of Sciences.

The HIV/AIDS Coordinating Group has asked the HIV Prevention Work Group to assist HHS in setting clear priorities for its prevention efforts. In an era of growing budgetary constraints, it is important to base decisions about the allocation of resources on explicit priority setting criteria. It will be critical to review what information is available—and what information is needed—to assist the Work Group and HHS in making informed decisions about investments in HIV prevention.

Specifically, the mission of the HIV Prevention Work Group is to help HHS establish priorities for investment in HIV/AIDS prevention. In addition, the Work Group will develop an agenda for working over the next year that will result in a more comprehensive plan for HIV prevention activities across HHS agencies. These activities include primary and secondary HIV prevention programs; program evaluation; research; training; technical assistance and other prevention capacity-building activities; and financing of prevention activities.

The Work Group will recommend to the Office of the Assistant Secretary for Health and Secretary Shalala priority areas for action and investment of Federal dollars that will support long-term efforts aimed at promoting and preserving health

and reducing the number of HIV infections in the United States as close to zero as possible. The Work Group will also suggest an ongoing process for developing a comprehensive HIV/AIDS prevention plan.

The Work Group will look critically at the current status of major governmental and nongovernmental prevention efforts and will plan future efforts. It is made up of senior HIV/AIDS agency staff from the PHS agencies (CDC, HRSA, NIH, SAMHSA, FDA, the Agency for Health Care Policy and Research) and the Health Care Financing Administration. Input to the Work Group from outside government includes HIV-infected persons and persons from populations affected by HIV and at risk for infection with expertise in HIV prevention, persons representing community-based and national HIV prevention service and advocacy organizations, researchers, epidemiologists, health providers, substance abuse specialists, educators, and communications and social marketing specialists.

The challenge of preventing further spread of HIV infection during the rest of this decade will require our greatest efforts. We must continue to direct our prevention programs toward people infected with the virus (to help them avoid the behaviors that transmit the virus), those who are at highest risk of becoming infected, those who have not yet adopted the behaviors that put them at risk for infection (such as adolescents), and others who have an occupational risk for infection.

We must consider the special challenges presented by the multi-cultural and multiracial nature of our society, and we must consider communities' needs, characteristics of the epidemic, and resources in determining appropriate prevention programs. To meet these challenges, we must work closely not only with communities, but also with our State, national, and international partners, in supporting programs found to be most effective and in implementing new strategies to prevent the spread of HIV infection.

Our HIV prevention strategy has evolved into one that recognizes the complexity of human behavior change, the diversity of partners needed to combat this common enemy, and the importance of integrating HIV prevention efforts into other prevention, medical, and social services. We will continue to work closely with Congress to evaluate our activities carefully, build upon those that are most effective, and develop new strategies where needed to make the best use of our resources and achieve the important goal of HIV prevention.

Mr. Chairman, this concludes my testimony. I will be glad to answer any questions that you or any other members of the Subcommittee may have. Thank you.

Mr. WAXMAN. Thank you very much, Dr. Lee. I appreciate all of your colleagues being here to answer questions that we have about the AIDS prevention activities. Much of the government's prevention programs is about education, just getting the facts out. But recently there have been a number of reports about people, especially young people, who know the facts about AIDS, but they take these risks anyway, almost recklessly. What works to change such behavior? And I direct this to any of you.

Mr. LEE. Let me comment, then let me ask Dr. Satcher and Dr. Curran and Dr. Gayle to comment as they wish. I think first, information we know is not sufficient to change behavior. The information has to be targeted to both the individual and to the community in which that individual lives. As you pointed out in your opening statement, Billings, Montana, is different than the South Bronx, or San Francisco is different than Newark, New Jersey. So that the messages must be specific for the groups within those communities. They must involve the communities and there must be a community-wide effort.

I think this was one of the lessons of San Francisco, is that it is possible with the participation of the affected communities to change the norms in those communities, which is the critically important thing. And then provide sustained social support for the changes in behavior and sustaining those behavior changes. I think those are the critically important elements, and then making accessible and available condoms, for example. I mean that—the latex condom is an effective approach when used appropriately. If they

are not available, all the information in the world isn't going to help, so that there has to be the availability of effective methods of prevention as well.

Dr. Satcher.

Mr. SATCHER. I really can't add to what Dr. Lee has said. I would like to say, this whole thrust of trying to deal with community norms and behavior is behind CDC's strategy of developing community partnerships. A major, major component of our strategy is to really get involved with communities—with people at the community levels and groups in communities to have them help us develop strategy for changing behavior. I think the issue of changing behavior is one of our most difficult challenges. It is not easy, we don't have any great answers yet, but I think we are moving toward answers because we are involving communities as communities.

One of the most encouraging things to me has to do with our experience with school health programs, where we deal with teenagers, and we know now, for example, that when teenagers are exposed to information as a group about tobacco use, for example, in the 7th grade, there is a 40 percent reduction in the risk of their becoming smokers by the time they are in 11th or 12th grade. Same thing with high-risk sexual behavior.

We have been able to demonstrate that exposure of teenagers as a group in school to information about sex education, decrease the onset of sexual activity and significantly decreases high risk sexual behavior. So our strategy is based on this whole idea that Dr. Lee described, is that we have to intervene at the community level and try to change community norms of behavior.

Mr. LEE. Mr. Chairman, also, Dr. Satcher, as you can hear, is one of the most eloquent spokesmen on this community partnership idea, which he actually brought to CDC from Meharry, where he demonstrated the effectiveness of this approach. And we are now thinking of expanding this much more broadly, beyond HIV and AIDS prevention, to many of the other CDC programs.

As he has mentioned, cigarette smoking, violence prevention, there are a number of other areas where the principle, and his efforts already in this regard and Dr. Elders' also, have been very important in moving us very significantly as a Public Health Service in the direction of what I call a new paradigm, which is community participation in public health.

Mr. WAXMAN. I guess what bothers me about some of what you are saying is that if we only have a limited number of funds and we are spreading it out to educate the community overall, and we are working with people who are involved in community activities, we are missing, it seems to me, the people we need to reach the most, and those are the high risk kids, high-risk individuals, who are not part of any community activity, who don't just need to get some statement of information, but who can't incorporate this into his or her life. What can we do to not just tell people go use condoms, but direct it specifically to gay men? Should we be working in the gay bars, should we be doing something more?

When we hear about these kids coming along now who just don't have a sense of what AIDS is all about, the way maybe a previous

generation of gay men did, who have seen so many of their numbers die. Any of you want to respond to that?

Mr. LEE. I think several of us, and I would just like to say that in—when we are talking about new partnerships and community, we recognize this adolescent group is the most difficult one to reach in terms of changing norms and changing behaviors. Adolescents typically are involved in multiple high-risk behaviors. But they would be part of this effort to develop new partnerships within the communities. It isn't just with the community generically. It is specifically within neighborhoods and you are mentioning gay bars, there are a variety of other efforts that would be absolutely necessary, different in one community from another.

In one community it may be heterosexual spread among partners of IV drug users. The approach to that group is quite different than it would be for the gays in a more integrated, if you would, community, where there is more communication among members of that gay community, let's say in the Castro district in San Francisco or in neighborhoods in New York, where you can reach a community and that community can help you reach this adolescent at-risk group.

Mr. SATCHER. Let me just say, I am going to ask Dr. Curran to give some specific examples, but targeting is a major part of our strategy. We are really targeting some of the most difficult-to-reach groups. I was in a meeting with some of them yesterday, and they said we shouldn't say they are hard to reach, we just haven't had the courage to reach them, because they are not hiding. I think what we are trying to say is that we realize that certain groups, African-American gay men groups for example, with whom we met recently, and several other examples of groups that have been difficult to reach in terms of this broad-based strategy, because they are not that active with the broad-based community. So we are targeting and I would like Dr. Curran to give some specific examples of this targeting strategy.

Mr. CURRAN. Well, I think the whole idea of community planning is not to simply overlay prevention programs on existing community groups, but to make sure the community planning group reflects the epidemic in the community, both the current epidemic and the future epidemic. And that means a group which deals with organizations and individuals and is comprised of individuals who are at the highest risk in a given community, whatever that is.

As the father of two teenagers who were actually born during the AIDS epidemic, I am beginning to personally realize how hard it is to be a teenager. When you overlay on that trying to determine and deal with sexual orientation on top of dealing with being a teenager in an adult world, you realize how difficult the problem really is in HIV prevention for that particular group of people. But I think that the other thing that we have to keep thinking about with young people is not to give up. Because every year there are new teenagers. This is not something that we solve once and for all and say, well, they should have learned this 10 years ago or 5 years ago, because they were 6 then or they were 12 then or they were 14 then.

We have to set in place systems that give young people, as they emerge in society, as gay adults, as straight adults, as women, as

men, the skills and the knowledge that they need to live in the society they are going to live in. Not the society we want them to live in or not the society we grew up in. We think community planning is the beginning of that process of integrating them into making decisions about their community and influencing their community norms, but it is by no means the guarantee of commitment, nor the guarantee of effective programs.

Mr. WAXMAN. Well, are you evaluating these programs to know what is effective? Can you tell what really will reach not a teenager from a middle class home that you would provide, but a teenager who is an outcast and on his or her own, not part of a community of any sort, marginalized by society, not particularly involved in what is happening with those who participate in seeking the grants or trying to spread messages? What evaluations have you done, what do you know what is succeeding or not? Do you have to be very targeted and specific? Does that work? Do you know whether you are reaching these people?

Mr. CURRAN. I guess there are maybe four parts to the question, four parts to the answer. So there is a need for a lot more prevention research and evaluation in reaching high-risk people, not only with efforts that are effective in the short run, but efforts that will persist in keeping them safe throughout their lifetime or throughout a prolonged period of time.

Second, as Dr. Satcher pointed out, many high-risk youth are not really hard to reach. They just haven't been reached out to. Third——

Mr. WAXMAN. I think they are hard to reach. You maybe haven't done enough to reach them, but I think it is awfully hard to figure out what is going to be effective.

Mr. CURRAN. They are not hard to find. They may be hard to engage or they may be difficult to deal with in part because we haven't dealt with them in the context of their needs. They don't want to get AIDS. They have a lot of other things going on, but they don't want to get AIDS. And we often approach them and say, you know, use condoms or don't get AIDS or don't have sex or don't use drugs, instead of trying to get inside and say what are the needs that you have right now. And I am not saying that this is easy.

As I said, I am struggling with raising two teenagers who have more benefits than many people we want to reach. The third and fourth thing I wanted to say is that we can't make assumptions about the middle-classness or nonmiddle-classness of people. Of course, hundreds of thousands of middle-class and upper-class people have died of AIDS already, who were raised in homes where their parents thought that they were privileged and would not be at risk. And, of course, they were wrong, because they made, I guess, heterosexist assumptions or nonrisk-behaving assumptions about their own young people.

The last thing is that the evaluation effort I think is the real key effort as we look to the future. And that is that we really do have to replicate programs that work based upon empirical evidence that they work, and not be afraid to use them if they work. I mean we have a lot of barriers to prevention programs, in addition to wheth-

er or not they work. It is whether or not they are politically acceptable in a given community and a lot of other things.

Mr. SATCHER. Congressman, we are evaluating all of these programs, and it takes time to evaluate them, so we don't have all of the answers yet that we would hope to have within a few years, but I can assure you one thing, that with all of the investments that we are making in these communities, we require evaluations.

I wanted to just say briefly a word about the overall strategy of the CDC, because Congresswoman Pelosi mentioned some things that I think are really important. Part of our strategy at CDC relates to making sure that the work force at CDC itself reflects the diversity of the communities that we are trying to serve. Just an example of that, we were talking about the impact on women. Up until the end of last year there had not been a woman director of a center at CDC. We have seven centers and four institutes. We now have a Deputy Director at CDC, who is an outstanding woman scientist and physician. We have a Director of the National Institution of Occupational Safety and Health, who is one of the outstanding people in that field in this country, Dr. Linda Rosenstock, and we have a Director of the Washington office, who has really led USAID's efforts in AIDS internationally, Dr. Helene Gayle, over the last few years. And so I think we are trying to make sure that we have people on board who have backgrounds and experiences that make them comfortable relating to communities at risk.

The other thing that we are trying to make sure of is that our strategy includes reaching out to communities and developing partnerships, and when we say communities, we are including what we are calling hard-to-reach communities. We are making a real effort at that.

Health communication you mentioned, and that is another area, we are developing the Office of Health Communications at CDC, and social marketing, because we believe that we need to have the expertise there to help communities, to provide technical assistance, in how to develop messages that can be most effective. So the issue of prevention effectiveness and making sure we evaluate that is a major part of our agenda.

I just wanted to assure you that we at CDC are dealing with some of the most difficult issues in our society today and we have a special appreciation for the intelligent and courageous leadership that you provided in dealing with some of these very difficult issues, because we deal with them and appreciate your leadership.

Mr. WAXMAN. Thank you very much.

Mr. LEE. Mr. Chairman, let me just say——

Mr. WAXMAN. I want to recognize Mr. Studds to give him an opportunity to ask some questions. Go ahead.

Mr. STUDDS. Thank you, Mr. Chairman.

Mr. WAXMAN. I will come back to you on another round.

Mr. STUDDS. Thanks. First of all, let me preface my questions I might ask by assuring you that I understand that at the table are the good guys. I understand that. And you may hear a certain degree of frustration among other emotions behind what I have to ask.

Dr. Lee, what is our current best guesstimate of the number of HIV-infected people in this country?

Mr. LEE. Jim, can you give us the latest figures?

Mr. CURRAN. Well, the latest official estimate remains at approximately 1 million Americans.

Mr. STUDDS. The interesting thing to me is that I first asked you the same question 10 years ago and got the same answer. How can that be?

Mr. CURRAN. Well, the reason for that is that the first estimate I think the Public Health Service made was approximately 1986. In 1986, based upon relatively little information on the natural history of the disease and very shortly after the licensing of the antibody test, in the absence of essentially no surveys, the consensus estimate made at the Public Health Service Conference in Virginia was 1 million to 1.5 million. The range was to reflect uncertainty and there was a great deal of uncertainty.

In the end of 1989, there were a lot more scientists involved and literally the results of hundreds of millions of tests and dozens of surveys. It was then recognized that back in 1986 there were probably no more than 750,000 people infected, and the estimate was revised downward to a range of 800,000 to 1.2 million, which we rounded off at about 1 million. We stated at the end of 1989 that between 40,000 and 80,000 Americans were becoming infected each year. Since 1989, nearly 100,000 of those Americans have died of HIV infection, hence, were subtracted from the million.

Mr. STUDDS. So the number ought to be growing, not staying the same.

Mr. CURRAN. And the number then was looked at once again by scientists this year and the estimate that they make from surveys now is probably slightly less than 1 million. The consensus estimate will be in the range of 800,000, I would think, when the estimates come in.

Mr. STUDDS. Well——

Mr. SATCHER. Mr. Studds, let me say, I understand your concern with the numbers. I happen to believe that the fact that the numbers are not going up suggests that we probably are making some progress with our prevention effort.

Mr. STUDDS. Excuse me, sir, but do you really believe that? Every number I have ever seen in every community that we are concerned about is increasing.

Mr. SATCHER. No, in the adult gay community, for example——

Mr. STUDDS. I believe we had a dip, especially in urban centers like San Francisco. But among young gay people it is increasing again, is it not?

Mr. SATCHER. Yes, but I think that is a very important community that you just mentioned, and we have made some progress in that community. We don't take anything for granted. We are intensifying all of our programs. We happen to believe that we are headed in the right direction.

Tim Westmoreland was with us in Morocco for the AIDS—International AIDS Conference in the African Continent. There were people there from various countries. But I think you are right in the sense that what we are seeing throughout the world is an increase in these figures. The survey that Dr. Curran mentioned that was done recently, in fact, suggests that the numbers are fairly sta-

ble in this country, and I think that does reflect some effectiveness, but we take nothing for granted.

Mr. STUDDS. I did not intend to get for any length of time into a discussion of numbers. I just want to reflect as a layman listening to what you all just said, I would reach the conclusion we don't have a clue, basically. We can't speak with any precision about this. It clearly, as I understand everything I have seen, is increasing amongst people of color in the inner city. It appears to be increasing amongst young gay people again, the two principal groups in which it is focused at the moment. Where the hell is it decreasing?

Mr. LEE. Well, the area where it has decreased, would be in the older adults in the gay community. But we would agree with you, and I think the problem, it goes back to the availability of data with respect to the numbers.

These are, as Dr. Curran indicated, consensus figures, and it is really a best guess. And we would all prefer if we had surveillance data that was broadly representative and could provide the kind of information that we would all like.

Mr. STUDDS. Believe me, I didn't mean to extend that argument, and it really is an unknowable figure. Because we don't have any way of knowing who is infected. They don't know themselves for the most part. How we can pretend to measure who they are just elludes me.

Again, remember my initial preface, that I know you are the good guys. Dr. Lee, you have almost 20 pages of single-spaced testimony here, and quite frankly it is eye glazing. I mean it could be written by any agency of government. It is in that special language in which government agencies write things. And I know your heart and soul and professional expertise is all behind it, but my God, it is hard to put it into simple English.

There is going to come later, I am not going to spoil his testimony by reading from it, a young man I hope you will stay to hear, who says, with all due respect, at least as much in a page and a half, about the real world, which is what we are all trying to deal with here. And I think that we need this—I don't mean to lecture you, you are the experts here, but if you think about communities which the disease appears to be primarily focused statistically, such as people of color in the inner city, how does one reach—how does one talk to a young African-American in an inner city about the dangers of AIDS when he doesn't expect—doesn't see any future for himself anyway?

It seems to me those are the kinds of questions. Maybe we need philosophers and other kinds of folks as well as public health professionals here. But the bottom line is we are talking about kids who don't think they have any future at all, so what do they care about a disease that might or might not kill them in 10 or 12 years? That is a challenge, to reach that young person, it seems to me, to persuade him or her they have to give a damn about something that might or might not happen a decade from now, when very few of them think about tomorrow, never mind a decade from now. Just something else also, and then I am throwing it to you.

I heard you say several times these people aren't hiding. Well, with respect to the other community in which this disease is con-

centrated, the gay community, you bet your life they are hiding. Ninety some percent of them are in deep hiding. We don't know who they are. Many of them don't know who they are. But we certainly don't know who they are. They are in fact literally hiding because of the society in which they live. You are going to hear, if you are able to stay, some pretty eloquent, very brief words from a young man, who happens to be a man of color, who grew up struggling with his own sexual identity as a high school student.

Now, can you name me any high schools, maybe one or two in New York or San Francisco, but beyond that in this whole country where a young person can freely and openly seek counsel with regard to confusion in sexual orientation? I can't. Not one. Who are we kidding, they are not hiding? Who are we kidding when we put out a 20-page statement about how we are going to reach them with polysyllabic words? I am just not at all confident either with regard to that young gay person or that young Afro-American that we are being very real here. That is my frustration. I throw it to you.

Mr. LEE. Let me just make a comment, then I would ask Dr. Satcher also. Clearly, the adolescent, whether gay or heterosexual or engaging in risky behaviors with respect to drugs, are very hard to reach. Congressman Waxman mentioned what some people would call runaways or some people would say throw-away kids. In the very, very difficult—I mean kids with very serious emotional problems, with drug abuse problems, these are not easy problems to solve.

The fact is that we have not been as direct and as frank as we need to be. The fact is that we have not targeted our efforts in a way that we are now attempting to do with this new approach through CDC. But I would say we share your deep concern and our capacity at the local level, because that is where the rubber hits the road. It is in San Francisco. It is in Newark. It is in the South Bronx. It is in neighborhoods in Houston or Los Angeles or Miami, some rural areas, many urban areas, and it is a neighborhood effort that we have to mobilize. And the communities have to become concerned about these kids.

It isn't just the exposure to HIV, the exposure to drugs. There are many other problems that confront these kids moving into adolescence. And we don't have easy answers. We have tried at the policy level and now at the program level at CDC to move it forward, but we would welcome any advice about how best to do this.

Mr. SATCHER. I just wanted to say that we share your frustrations. I sort of grew up in this kind of community, but started my career in Watts, then came to a medical center that developed several programs in that kind of community and in the last 12 years at Meharry.

It is interesting, you said you are talking about the future. In 1985, we started a program in the housing projects in Nashville to try to deal with teenage pregnancy. And when we ended up sending clinical psychologists and social workers out to try to find out what we needed to do; they came back and said that teenage pregnancy was not the problem any more than violence or tobacco use or school dropout. The problem was the kids didn't feel they had a future. So we named the program, I Have a Future, and tried to

deal comprehensively with the attitudes of teenagers in that community toward the future. And I think made some progress. And I hope you understand that we share your frustration, we don't take for granted the difficulty of this problem, but we are not hopeless. And the reason that we are not hopeless is that we do believe that there are some things that can make a difference.

But I think you are right, I think you have to deal comprehensively with the problems of these teenagers, and not just one issue at a time. That is one of the problems with our programs. We have got to stop going out to communities one issue at a time.

Mr. STUDDS. Thanks. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Studds. You had an external review, a Blue Ribbon Panel, that looked at the work for the Centers for Disease Control, not just at the AIDS/HIV area. But they said that HIV prevention services are not integrated into programs across agencies and this, "results in uncoordinated approaches to prevention and increased difficulty in getting access to comprehensive services." The report goes on to say that grantees who try to integrate their services face numerous fiscal and programmatic obstacles.

What are you doing, Dr. Satcher, to address these problems?

Mr. SATCHER. The first assignment that we have given Dr. Broome, the Deputy Director, is to look at the AIDS programs, and they are in 10 different centers and institutes at CDC. There is a problem in terms of coordination and integration. She has put together a committee and that committee will be coming forth with a recommendation, then bringing in an external group of people to review the recommendations, and hopefully within the next 2 to 3 months we will be able to make the kind of changes in the organization of the AIDS program at CDC that will especially help with the coordination and integration, so that our grantees can see a more comprehensive program at CDC and be in a better position to develop comprehensive programs.

Mr. WAXMAN. So you think over the next couple months you will be——

Mr. SATCHER. Hopefully, within the next 2 or 3 months we will be able to have the recommendations to respond to in terms of the kind of—it is not going to be easy. I want to make that clear. We have two competing things going on here. One is the need for coordination, and the other one is the need to make sure that we have the science base for all of our prevention programs. And in a sense, you know, the way things are organized now is to make sure that the National Center for Infectious Diseases, that has the expertise and laboratory diagnosis, et cetera, is in charge of that part of the AIDS program, to make sure the National Center for Prevention Services is in charge of that part of the program that deals with prevention services. And that involves tuberculosis and AIDS and things like that. So the challenge we face is to maintain the scientific integrity of the program, and yet at the same time to integrate the programs across CDC. It is not going to be easy, but I think we can make significant progress.

Mr. WAXMAN. One of the comments by the External Review Committee was that CDC's organizational structure actually hindered

prevention programs and that programs are spread among 10 centers that compete for resources.

The review went on to say that the efforts lack a clear line of authority for policy, programming and budgeting. What are you doing to respond to that?

Mr. SATCHER. We agree. That is what we hope to change. I won't try to tell you today exactly the changes we are going to make but I think we are approaching it in such a way that the outcome would be improved communication, coordination and integration, internally and externally.

Mr. WAXMAN. The External Review concluded that counseling and testing was of questionable use as a prevention tool and raised many questions about the management and effectiveness of the program. Some have argued that people with negative test results change no behavior and that many don't even come back for their results. Others have pointed out that counseling is inadequate. What is the current balance between counseling and testing and other prevention efforts that might focus more on behavior and what are you doing to improve the quality of the program?

Mr. SATCHER. I will ask Dr. Curran to respond because we have invested a lot in counseling and testing programs in the past, and we do need to respond to that.

Mr. CURRAN. The external review certainly clarified our thinking about the variable role of counseling and testing referral on partner notification and prevention efforts. I believe that the major role for counseling and testing in general is as a diagnostic test for people who want to know and need to know their status. There is a continued need for available counseling and testing for people regardless of whether they can afford it and regardless of whether they feel comfortable going to their own doctor. So there is a continued need for anonymous testing and counseling. The system quickly became very overwhelmed, and in addition we had a congressional mandate that said there had to be so much of our money spent on counseling and testing. Thanks to the appropriations process this year that mandate was taken away and all communities planning groups throughout the country and health departments understand now that they needn't be burdened by having a congressional mandate as they have in the past. So we expect that there will be much more targeting of counseling and testing. We expect that anonymous counseling and testing will still be available in every State throughout the country. We want it to be and we also expect that there will probably be considerably less Federal funds spent over time, Federal prevention funds spent over time for counseling and testing. The need for it however to assist diagnosis, to assist in perinatal HIV prevention, and to assist people in knowing their own status will continue.

Mr. LEE. Mr. Chairman, at the departmental level we took the CDC Advisory Committee's recommendations very seriously and looked across all the agencies of the Public Health Service. We have the same problem that CDC has, multiple centers. We have multiple agencies with multiple programs. The Secretary did establish this broad committee. The example of AZT and pregnant women is a good example of how that process is now at work to review those clinical findings, to look at the counseling and testing

at CDC. FDA will be looking at an application from Burroughs Wellcome with respect to the indications for AZT. Indian Health Service—each of our agencies will be involved in a broad effort to disseminate the findings to physicians and to the public and it is an illustration that you cannot, without very close collaboration across agencies, solve this problem, and I think we have at least set in motion a system that will move us forward. It doesn't solve the problem, but certainly will move us forward, I think, in a constructive direction.

Mr. WAXMAN. Dr. Curran, on the issue of counseling and testing, is it your conclusion that as a prevention tool the counseling following testing is of little value and the testing and counseling is much more needed for diagnosis and then trying to deal with the early treatment or intervention for the disease itself?

Mr. CURRAN. I would say generally, yes. The counseling and testing programs and efforts are as dissimilar and disparate as the populations they serve. The overall evaluations of these programs would say that in general for people who seek counseling and testing who are found to be HIV positive in that process, that they are associated with positive behavior change. For other selected situations such as in discordant couples, whether gay or heterosexual, there also seems to be a substantial benefit. I would anticipate as we follow the perinatal AIDS prevention issues of those we will find the same type of benefit. In general in counseling and testing as a tool for HIV negative populations there also has been benefit found. But the targeting issue and the recognition of the specific needs of the individuals for longer-term intervention efforts is the important thing. It is really, I think, naive for any of us to think that telling somebody they have a negative test and go live the rest of your life is going to be a effective intervention. The positive test is often followed by much more follow-up, and I think that is the key.

Mr. WAXMAN. For that group where you do have a positive test and counseling then proceeds, how effective is that counseling to create a behavior change?

Mr. CURRAN. It is intuitive and empirically good for people who are positive to know their status for their own health benefit and for their own ability to prevent transmission to others. The key is availability of long-term follow-up, including additional prevention counseling if needed and high quality prevention counseling if needed. That is more or less available, often through community organizations throughout the country. We are hoping to integrate our prevention efforts with the Ryan White efforts and with other community efforts for medical services for people who are infected and social services for people who are infected.

Mr. SATCHER. I think there is a role that is being played in this country by people who know that they are positive that we shouldn't underestimate, not only in changing their own behavior but also in working in prevention programs. There is a program in Atlanta that I wish that you could visit sometime called Outreach Atlanta, and it is run by Sandra MacDonald. I spent an afternoon in that program and virtually all people working in that program are positive for HIV. They were drug users or prostitutes or whatever. To listen to them tell their stories and what they are doing

going into the communities during the day and during the night and talking to people about AIDS, I think they are making a significant contribution. So the people with AIDS who have been diagnosed and who have now modified their own behaviors but also who are going out and talking to people about what they wish they had known before they became positive is a major force in this movement that I hope we don't discount.

Mr. WAXMAN. As Dr. Curran said, the counseling and testing programs are very much important, maybe even more so than prevention techniques, in the area of trying to get people aware of their situations so they can get early treatment, especially for tuberculosis or other opportunistic infections. Does CDC have programs to encourage people to be tested because they can get better care, sort of like we have with mammography messages to encourage women to catch breast cancer early?

Mr. CURRAN. Yes. One of the problems the counseling and testing program ran into in the past 2 years is the ability to pay for good quality counseling and testing didn't meet the demand on the public systems. The same amount of money was being used for counseling and testing with Federal dollars for 2.7 million people in 1992 that was used for 1.7 million people in 1991. So the ability to push the system was being forced with a lot of "worried well" and a lot of people who perhaps didn't need counseling and testing quite as much. This is an ongoing issue and problem, I think, that is directly related to the availability of medical care, social services, and substance abuse treatment services for people who are either found to be positive or who are high-risk negatives as well. It is always the ongoing debate with community organizations and local health departments and others who will testify later about how much you want to push the front end of the system. I believe that people ought to have the whole array of services available when they get counseling and testing, but it is, as you know, difficult.

Mr. WAXMAN. I would like to ask you to give us for the record a fuller description of programs to encourage testing to get early care, what kind of outreach there is to get people to participate in those programs. I want to know what percent of the people who test positive at these CDC clinics are referred for further testing and care, and what education programs you have to encourage infected people to get effective care.

The following was submitted for the record.]

Through the HIV prevention cooperative agreement program, CDC funds 65 State, local, and territorial health departments with $170 million to provide HIV prevention activities in their jurisdictions. The purpose of this program is to assist State and local health departments to prevent the transmission of HIV and reduce associated morbidity and mortality of HIV-infected persons by increasing access to early medical intervention to delay the onset of symptoms and to prevent and treat complications of HIV infection. All activities funded under the HIV prevention cooperative agreement, including street and community outreach, risk reduction counseling, prevention case management, and community-level interventions, are directed to support these goals.

To further emphasize the importance of linking HIV-positive persons with early intervention services, the counseling, testing, referral, and partner notification (CTRPN) section of the HIV prevention cooperative agreement program announcement states that:

"...clients who are infected with HIV are often in need of many services such as STD screening and treatment, substance abuse counseling and treatment, tuberculosis testing and treatment, family planning, further HIV prevention counseling,

evaluation of immune system function, and HIV early medical intervention. These services should be provided at the testing site. If they are unavailable at the testing site, individuals must be referred to another service provider. States should have a system in place to link counseling and testing sites with other health, medical, and psychosocial service providers through referral.

"...HIV-infected persons should be counseled about the benefits of early medical treatment and be provided opportunities, either on-site or through referral, to receive appropriate medical therapies."

There is currently no database in place to track the number of persons testing positive who are referred for further testing and care. However, the referral component of the CTRPN program is a required activity of all 65 recipients of HIV prevention cooperative agreement funds.

In addition to funding CTRPN activities under the cooperative agreement program, CDC has participated in several other efforts to promote testing and follow-up care. From April 1991 to April 1994, CDC collaborated with the Health Resources and Services Administration to develop and implement HIV early intervention networks in seven cities (Chicago, Houston, Los Angeles, New York City, Philadelphia, Washington, D.C., and San Francisco). The purpose of the project was to develop "networks" that would improve referral and case management systems so that persons diagnosed with HIV infection in publicly funded HIV counseling and testing sites would be provided preventive, diagnostic, clinical, and therapeutic services. The central goal was to provide local health departments with the opportunity to experiment with different strategies for strengthening the linkages between counseling and testing services and medical care to increase the number of HIV-positive persons who access medical and social services at an early stage of infection. The collaborative project period has recently concluded; however, CDC continues to support some of these projects and hopes that some will continue to be supported through the HIV prevention community planning process.

Under a cooperative agreement with CDC, Columbia University documented and assessed the activities of the seven projects during year 1 and year 2 of implementation. These reports, including recommendations learned from the demonstration projects, have been shared with CDC's HIV prevention grantees and presented in meetings and workshops.

In addition, CDC staff served on the American Medical Association's Advisory Group on HIV Early Intervention and assisted in writing their *Physician's Guidelines for HIV Early Intervention*. The Guidelines were distributed to 192,000 primary care physicians to assist them in ensuring that HIV-positive patients receive early intervention services.

CDC has worked with the Agency for Health Care Policy and Research to write and produce *Clinical Practice Guidelines on Evaluation and Management of Barly HIV Infection* as well as two consumer guides on the importance of early treatment for HIV infection. These have been promoted through the media and distributed widely.

CDC staff wrote an article entitled "Preventive Services Guidelines for Primary Care Clinicians Caring for Adults and Adolescents Infected with the Human Immunodeficiency Virus" that appeared in the September 1993 *Archives of Family Medicine*. The article outlines how primary care physicians can assess the prevention needs of HIV-positive persons and ensure that needed prevention services are received.

CDC also has a cooperative agreement with the National Association of People with AIDS which supports, among other things, the provision of referrals and medical information to persons with HIV/AIDS and to service providers, community-based organizations, the public, and the media.

Mr. SATCHER. You mentioned tuberculosis, and I would like to ask Dr. Helene Gayle to comment briefly. She was involved in early international studies of the relationship between TB and AIDS.

Ms. GAYLE. Briefly, I think a lot of comments made earlier can be highlighted in the area of TB and HIV. I think it is clear that this is one area where the integration of services as well as prevention are shown in our efforts. A lot of the research we did internationally also has helped substantially to increase our knowledge about what we need to do for TB prevention control in this country and it is an issue that we have talked about; while our focus here is on domestic prevention there are a lot of opportunities to look

at the interface between what we have learned in the international setting, particularly as it relates to outreach to communities and integration of services, that we can learn for our situation domestically as well.

Mr. WAXMAN. Thank you. Let me ask you this last question. We understand that the Centers for Disease Control recently completed a comprehensive evaluation of current knowledge about the role of needle exchange programs and a comprehensive AIDS prevention program. What did the CDC conclude regarding the effect of these kinds of programs on the incidence of intravenous drug abuse?

Mr. CURRAN. The University of California, San Francisco, and the University of California, Berkeley, submitted a report, under contract with CDC, of their evaluation of 33 programs throughout the United States. They concluded that it would be difficult if not impossible to actually prove that these programs could actually decrease HIV infection in a community, but that the evidence, the preponderance of the evidence, was consistent with a decrease in needle-sharing, a decrease in—an increase in referrals to substance abuse treatment programs, and that there was no evidence of any increase in HIV infection or any increase in substance abuse in any of these programs.

Mr. WAXMAN. So at least with regard to whether there was an increase in intravenous drug use, there was no evidence to conclude that there was an increase?

Mr. CURRAN. That is right. And their recommendations were that these be—that Federal funding be allowed for these programs.

Mr. WAXMAN. I would like you to provide the subcommittee with a copy of the CDC's analysis for inclusion in the hearing record.

Mr. LEE. We would be glad to do that, Mr. Chairman. The CDC has forwarded that report to me. We are currently reviewing it in my office, and when we complete that analysis we will certainly make that available as well.

Mr. WAXMAN. I thank you for your participation at this hearing. I know it is not easy to do the job that we are expecting from you, and when you get critical reports, I know it is not easy to turn things around in a rapid sort of way. If we do seem frustrated, it is because we are frustrated, as I know you are as well. There is a lot to do.

One question, Dr. Lee. How much of what the people working with you think needs to be done is not done for fear that right-wing politicians are just going to attack because you tell gay men how to have sex without transmitting the disease or you tell drug users that they can use drugs, but they can do it in a way that won't transmit the disease as well?

Mr. LEE. Speaking from my point of view as the Assistant Secretary, and having, as you know, served as Chairman of the Health Commission in San Francisco, as President of the Health Commission during 4 years of the epidemic, I don't really personally view that as affecting our decisions. Now, clearly we have to look at the whole range of views of the body that we respond to, which is the Congress, in terms of our policies. In some areas, we have been given fairly specific instructions about what we can and we can't do and we follow those instructions. But I would say that as I review this, and as people in my office review these issues, that is

not a primary concern. Our principal concern is I think is to achieve these objectives with respect to prevention, to find the best ways possible to do that, and communicate as openly and as directly as we can with you, with the committee, with the Appropriations Committees, about what we think is the best way to proceed. Sometimes we take longer than I would like to make some of those decisions because we do engage a lot of people in the process, but I think that represents where I think my office comes from with respect to what influences the decisions we make with respect to say explicit information or other controversial, and there are some very controversial policy areas.

Mr. WAXMAN. Well, I understand that you have come before this subcommittee and you have Mr. Studds and myself asking, why aren't you doing more and how much more can you do, can't you reach the targeted groups, can't you be more effective; but then there are other committees of the Congress where you are before politicians who are going to say, what? You are going to talk about a needle exchange program and maybe use Federal dollars for such a program. I say parenthetically that a report on that from CDC seems to have been held up for some period of time. I don't know if that weighs upon you, but I think that we have got to put aside the fear of right-wing politicians and those who want us to be naive about this disease and completely respond to the fact that we have to do everything we can to stop the spread of this disease. I know you share that view, and I want you to know that this committee of Congress expects you to act in the way that I know you think is appropriate.

Mr. LEE. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Studds, do you have further questions?

If not, we will look forward to working with you. We may ask for additional information for the record as Members request it. We would like you to respond.

Our third panel is made up of people who advocate for and work on the prevention of HIV infection and the prevention of AIDS. Moises Agosto is a treatment advocate testifying on behalf of the National Minority AIDS Council, accompanied by Helen Fox, the Council's Director of Public Policy; Gary Rose is Legislative Director of the National Association of People with AIDS. Pedro Zamora has been a spokesman for AIDS for some time and was a witness before this subcommittee on AIDS and health reform. Jay Coburn is a Legislative Representative of the AIDS Action Council; and Robert McAlister is the Chair of the National Alliance of State and Territorial AIDS Directors.

We want to welcome you to our hearing today. Your statements will be in the record in full.

Mr. Agosto, let's start with you.

STATEMENTS OF MOISES AGOSTO, TREATMENT ADVOCATE, NATIONAL MINORITY AIDS COUNCIL, ACCOMPANIED BY HELEN FOX, DIRECTOR OF PUBLIC POLICY; GARY R. ROSE, LEGISLATIVE DIRECTOR, NATIONAL ASSOCIATION OF PEOPLE WITH AIDS; PEDRO ZAMORA, AIDS ACTION COUNCIL; JAY H.S. COBURN, LEGISLATIVE REPRESENTATIVE, AIDS ACTION COUNCIL; AND ROBERT O. McALISTER, CHAIR, NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS

Mr. AGOSTO. Mr. Chairman and Members of the subcommittee, I am Moises Agosto, the Research and Treatment Advocacy Manager for the National Minority AIDS Council, and also I am a person living with AIDS.

I would like to introduce you to Helen Fox, the Director of Public Policy and Education and an expert on primary prevention and community planning.

On behalf of the National Minority AIDS Council, I want to thank you and the subcommittee for giving us the opportunity to testify in this important hearing. The National Minority AIDS Council represents more than 500 frontline AIDS service organizations serving people of color with HIV and AIDS around the country. We provide technical assistance and we advocate at the national level for communities of color impacted by this epidemic.

HIV disease has continued to have a profoundly disproportionate impact on African American and Hispanic/Latinos since the onset of the AIDS epidemic. African Americans and Hispanic/Latinos account for 49 percent of U.S. AIDS cases so far, and death rates from HIV related causes have been the highest for African Americans and Hispanic/Latinos. During 1990, the number of reported deaths per 100,000 population was 29.3 for African Americans and 22.2 for Hispanic/Latinos as compared with 8.7 for whites.

Funding is necessary to support effective prevention efforts in communities of color, as well as community input in the design of the new prevention community planning process. More behavioral research needs to be funded to better understand behavioral patterns in communities of color and in the subgroups that belong to those communities, like women, youth, injection drug users and gay men of color.

But the main issue that I would like to address through this testimony is what advocates, including myself, call AIDS secondary prevention. That is the utilization of low-cost, effective preventive measures against AIDS-related diseases, so individuals living with HIV disease can prevent the development of opportunistic infections, improve their quality of life and live longer.

At the early years of this epidemic, the life expectancy of people with AIDS was 6 months after diagnosis. Now people with AIDS live longer, thanks to the availability of preventive measures against opportunistic infections. We have the scientific proof that AIDS-related pneumocystis carinii pneumonia is a preventable and treatable opportunistic infection itself. Although those can be prevented, mycobacterium avium-intracellulare complex, what they call MAI infection, and fungal infections, and there is some data that suggests that toxoplasmosis could be also prevented with the same drug that prevents PCP. The use of preventive measures

against AIDS-related diseases in conjunction with HIV early intervention strategies has proven to be the most critical prevention measure for those infected by HIV.

Grassroots initiatives have been aimed at developing AIDS secondary prevention measures that make accessible for some people with AIDS what we define as life saving information, or what I will call now AIDS secondary prevention information. There is a crucial need to institutionalize the concept of AIDS secondary prevention.

The Federal Government has a public health responsibility regarding access to AIDS secondary prevention information. There is an urgent need to create public policy that provides an infrastructure where people living with AIDS, care givers, case managers and primary providers can access AIDS secondary prevention information and have an infrastructure that supports implementation of a comprehensive AIDS secondary prevention education.

AIDS treatment activists and community leaders have been loud and clear about this issue. However, the Federal Government has not taken any responsibility addressing this matter. There is not a single, centralized well-coordinated program supported by the Federal Government that provides comprehensive AIDS secondary prevention education to people living with AIDS, their caregivers and case managers. More depressing is the fact that none of the major Federal agencies under PHS want to take responsibility over this identified need. Therefore, even though we know AIDS-related pneumonia can be prevented, we still have AIDS-related pneumonia defined as the main killer of people with AIDS. Action needs to be taken around this issue and a more aggressive strategy needs to come from the leadership of the Federal Government.

People with AIDS are unnecessarily dying of diseases that can be prevented. Not taking action on that situation has overlooked the most critical prevention measure for those of us living with this disease.

At the end of the testimony you will find copies of articles, reports and publications related to the matter. Thank you for your future action with regard to this issue.

Mr. WAXMAN. Mr. Rose.

STATEMENT OF GARY R. ROSE

Mr. ROSE. I am Gary Rose, and I am a gay man who has lived with HIV for almost 10 years. We are grateful for the opportunity to testify. We sort of realize that we are speaking to the converted and repeating things that I am sure everybody behind that table knows all too well.

Our sense is that we are losing ground in the fight against HIV. Every year, more and more men who have sex with men, more women, more drug users and more young people become infected with the virus. No community in the world has been left untouched by the epidemic. In purely logical terms, this explosion of new cases precisely defines the level of our failure in coping with the moral, sexual, epidemiological and economic underpinnings of this terrible pandemic.

We are not powerless in this fight. We know a lot about what strategies work and how to implement these strategies. We assume, for example, that prevention of any disease requires long-

term interventions. We also presume that successful efforts to prevent diseases of public health significance must originate at the community level.

Without accurate assessment of prevention programs, assessments that have not been conducted to date, however, we tend to be flying half blind. We know that large, nationwide campaigns have never been terribly successful at reaching people at risk for HIV. Programs like "America Responds to AIDS," Surgeon General Koop's nationwide mailing on HIV, and even the CDC's Prevention Marketing Campaign are inefficient because they never deliver targeted prevention messages to those communities that are at greatest risk for infection. After all, any message about prevention that internalizes explicitly our society's phobias about "faggots," "junkies" and welfare queens is doomed from the outset. If we can't get clean needles, and if we can't get information about and access to the services we need to prevent infection—services perhaps like peer counseling, street outreach and truly informative school prevention programs—what is the point of these incredibly expensive exercises?

The CDC's new HIV Prevention Community Planning process is giving us a lot of hope. It puts the prevention effort back where it belongs, in communities at risk for infection. It places resources into the hands of those who know our local epidemic so well, resources that may make it possible for us to prevent our peers, our friends and our families from continuing to fall prey to the ignorance, prejudice and fear that are the real root causes of this epidemic. Even these efforts will be doomed, however, unless America is willing to come to terms with some of its most intractable prejudices, prejudices that are literally killing our citizens.

Homophobia: This country has a real problem with men who have sex with men and women who have sex with women, yet it appears that every community of men who have sex with men is experiencing rapid rises in new HIV infections. Even gay white males, the community that we have so often cited as an example of the success of prevention efforts, are seeing rising rates of new infections in many places. In communities of color, messages developed for gay white males have had tragically little impact.

What can we do?

First, currently circulated messages about "safer sex" and about condom use seldom deliver the kind of accurate information that we can use to protect ourselves and our partners. It is the softness of these messages that keeps them from penetrating our exhaustion and our denial, feelings that are normal after 14 years of living in a war zone. These messages are all about being "good," or about which sex acts may be "approved." Then, if we don't follow the rules, we are accused of having "relapsed" into unsafe sex practices. We haven't relapsed. We are merely returning to ordinary, human sex. Stating that these are ordinary behaviors may constitute the first step in gaining the trust we need to make our prevention programs for these communities really successful.

This is a special problem for young men who are being told to say no while their bodies are insisting on saying yes. Many researchers now expect one-third of gay or bisexual 20-year-olds to be infected or dead by the time they are 30. And yet we aren't even

permitted to talk to young men and women about "anything that might promote a homosexual lifestyle." In this case, homophobia truly equals murder.

Second, we have to develop programs that will reach gay men of color more effectively. These programs, if they are to be successful, must be specifically tailored to the community being targeted and must be developed by peers within the community.

Third, we have to be more specific in the development of messages being given to the gay community. We can no longer afford to insist on sex acts that carry with them no risk. So-called "gay sex" is normal sex and gay sex acts are normal sex acts. That is the starting point. We have seen how far telling people that mutual masturbation is the only truly safe activity has gotten us. No wonder people can't keep from "relapsing." We have to concentrate our efforts on stopping the one activity that we know causes most cases of gay transmission, anal sex without condoms, and stop wasting our breath and our credibility on activities—oral sex especially—that have minuscule impact and that very few people pay attention to.

Fourth, we must make sure that wherever we have sex, there will be fresh condoms, water soluble lubricant and clear and graphic prevention messages available.

Women——

Mr. WAXMAN. Mr. Rose, the whole statement will be in the record. I want to limit the testimony to 5 minutes. Thank you very much.

[The prepared statement of Gary R. Rose follows:]

STATEMENT OF THE NATIONAL ASSOCIATION OF PEOPLE WITH AIDS

Good morning. My name is Gary R. Rose. I am testifying today on behalf of the National Association of People with AIDS where I am the Associate Director for Legislative and Regulatory Affairs. We are grateful for the opportunity to testify on the state of our nation's HIV prevention efforts, a subject of increasingly vital importance to all Americans.

The sad fact is that we are losing ground in our fight against HIV. Every year, more and more men who have sex with men, more women, more drug users and more young people become infected with the virus. No community in the world has been left untouched by the epidemic. In purely logical terms, this explosion of new cases precisely defines the level of our failure in coping with the moral, sexual, epidemiological and economic underpinnings of this terrible pandemic.

The responsibility for this failure runs so deep and wide that casting blame has become an increasingly empty exercise. We all have to own this epidemic, to see it for what it is (and for what it isn't) and to take whatever responsibility we can for doing whatever we can to end it. Our first job is to admit our failures and to explore the reasons behind those failures so that our immediate efforts will have some chance of successfully preventing new HIV infections.

We are not powerless in this fight. We know a lot about what strategies work and about how to implement those strategies. We know, for example, that prevention of any disease requires long term interventions. We also know that successful efforts to prevent diseases of public health significance must originate at the community level.

For more than 10 years, people living with and affected by HIV, prevention experts and medical care providers have fought to get the government to allow us to conduct the fight against HIV in the only way that will work, within our own communities. We know that large nationwide campaigns have never been terribly successful. Programs like "America Responds to AIDS," Surgeon General Koop's nationwide mailing on HIV and, even, the CDC's Prevention Marketing Campaign fail because they never deliver targeted prevention messages to those communities that are at greatest risk for infection. After all, any message about prevention that internalizes our society's phobias about "faggots," "junkies" and "welfare queens" is

doomed from the outset. If we can't talk publicly and graphically about anal intercourse, if we can't get clean needles, and if we can't get information about and access to the services we need to prevent infection—services like peer counselling, street outreach and truly informative school prevention programs—what's the point of these incredibly expensive and obscenely misguided exercises?

The CDC's new HIV Prevention Community Planning process puts the prevention effort back where it belongs—in communities at risk for infection. It places resources into the hands of those who know our local epidemics so well, resources that may make it possible for us to prevent our peers—our friends and our families—from continuing to fall prey to the ignorance, prejudice and fear that are the real root causes of this epidemic. Even this effort will be doomed, however, unless America is willing to come to terms with some of its most intractable prejudices, prejudices that are literally killing our citizens.

This country has a real problem with men who have sex with men and women who have sex with women. And yet, every community of men who have sex with men is experiencing rapid rises in new HIV infections. Even white gay males, the community that we used as an example of the success of prevention efforts, are seeing rising rates of new infections. And in communities of color, messages developed for gay white males have had tragically little impact. Complicating the issue is the reluctance of men of color who have sex with men but are not gay identified to access services that they perceive as being intended for gay men only.

What can we do?

First, currently circulated messages about "safer sex" and about condom use almost never give us accurate information that we can use to protect ourselves and our partners. It is the softness of these messages that keeps them from penetrating our exhaustion and our denial, feelings that are normal after 14 years of living in a war zone. These messages are all about being "good," or about which sex acts may be "approved." Then, if we don't follow the rules, we are accused of having "relapsed" into unsafe sex practices. We haven't relapsed. We are merely returning to ordinary, human sex. Stating that these are ordinary behaviors may constitute the first step in gaining the trust we need to make our prevention programs for these communities really successful.

This is a special problem for young men who are being told to say no while their bodies are insisting on saying yes. We now expect one-third of gay or bisexual 20 year olds to be infected or dead by the time they are 30! And yet we aren't even permitted to talk to young men and women about "anything that might promote a homosexual lifestyle." In this case, homophobia equals murder and silence truly does equal death.

Second, we have to develop programs that will reach gay men of color more effectively. These programs will have to be constructed in the language of this community, by members of the community that is being specifically targeted. Then, the messages will have to be delivered by peers within the community, and these programs will have to be adequately supported. As things stand now, the message received by men of color is that they are a disposable population both on the grounds of their sexuality and their race. This message is being actualized by the number of men of color who are dying of HIV disease.

Third, we must be more specific in the development of the messages being given to the gay community. We can *no longer afford* to insist on sex acts that carry with them *no* risk. So called *gay* sex is normal sex and gay sex acts are normal sex acts. That's the starting point. We've seen how far telling people that mutual masturbation is the only truly safe activity has gotten us. No wonder people can't keep from "relapsing." We have to concentrate our efforts on stopping the one activity that we know causes most cases of gay transmission (anal sex without condoms as either the active or passive partner) and stop wasting our breath—and our credibility—on activities (oral sex, especially) that have minuscule impact and that very few people pay attention to. This approach undermines *all* prevention efforts.

Fourth, we must also stop blaming the location of the sexual interchange (bedroom vs. sex club, outdoors vs. indoors) and the state of mind of gay men and lesbians (drunk vs. sober, safe vs. relapsed) for their rising infection rates. Instead, we have to make sure that wherever and with however many people we have sex, there will be fresh condoms, water soluble lubricant and clear and graphic prevention messages available.

Fifth, we must take the responsibility for getting clear prevention messages to people in their teens. If we are prevented by those who are disinclined to acknowledge young people as sexual beings, we have to find ways to get around any restrictions that may be applied. Our only job is to get accurate information to young people and to give them a safe and convenient place to go for more help. Young men and women usually begin to come to terms with their sexuality while they are in

high school. For gay and lesbian high schoolers, high suicide rates and other self-destructive behaviors have become the price these young people have paid for our society's homophobia. Now, HIV has raised the stakes and being forced to hide your sexuality will substantially increase the likelihood that you will die of HIV disease.

From very early in the epidemic, the women whose lives were destroyed by HIV disease, most of whom were from poor communities of color, have been ignored. I can still remember the days when women with AIDS were described only as "sexual partners of intravenous drug users." Women are still being relegated to second class status in the fight against HIV, denigrated as either the mothers of children at risk or as vectors for disease transmission. We've kept them out of studies, we've refused them benefits because their infections didn't fit into our preconceived notions of HIV disease, and, because so many of these women were poor and disempowered, we've kept them in ignorance, unable to adequately care for themselves or their loved ones.

Women *are not* a homogenous group. There are many different communities of women at risk for HIV infection and if we're going to end the ravages of this epidemic among women we have to give them real information *and* provide them with the support that will allow them to take control of their sexual lives. This requires us to develop messages that are clear and complete and to deliver those messages in settings appropriate to women who may be at risk. If we do not take some radical steps in this direction, women will continue to find out about HIV when either they or their children enter the hospital with their first opportunistic infection. While we have made some progress in beginning to implement programs that address these problems, much work remains to be done.

Central recommendations for improving HIV prevention programs for women must include: The provision of services to women as whole individuals and as the bearers of primary familial responsibilities. Since women usually have primary responsibility for children and sick partners, if we don't provide for day care, transportation and a flexible schedule for the provision of social and medical care, women will never be able to access the services that will allow them to protect themselves from becoming HIV-infected, or, if infected, to receive treatments that will prevent the worst ravages of HIV disease; A crash program to develop effective microbicides so that women can protect themselves regardless of the proclivities of their partners; and, The development of clear and informative materials that can target the many, many communities of and the many non-community identified women who are at risk for HIV infection.

Once again, we fail at preventing new infections among injection drug users because we aren't willing to admit why people use drugs in the first place. Keep the following three rules in mind when you think about HIV prevention: Rule number one: People don't shoot drugs because drugs feel bad. Rule number two: People don't shoot drugs because they're bad people. Rule number three: Some people will never stop shooting drugs.

Some people *will* stop shooting drugs, however, *if* they're offered a better alternative. Things like fast access to a sympathetic and skilled drug program will help. Also, we could make sure that people keep their benefits—especially health, nutrition and housing related benefits—while they're doing the hard work of kicking their habits. Even then, some people won't stop doing their drugs.

So, what do we do? Do we give them and their partners and their children up for dead because they can't/won't stop doing drugs? No! That would be illogical on at least two levels. First, treatment for the multitude of opportunistic infections to which poor, physically debilitated people fall prey—OIs like drug resistant tuberculosis—are incredibly expensive to treat. So prevention in this community is cost effective. Second, I have often been told—sometimes by members of this Congress—that programs for drug users are ineffective. That may be so. It is just as likely, however, that truly effective drug treatment programs in this country are few and far between. But as the three rules stated above suggest, I admit that some users will never want to stop using. That doesn't mean that they want to die! (Call that rule #4). For both communities of users, however, there is method available by which we can stop most new cases among drug users and their families. We simply offer them a dependable supply of clean needles.

I realize that this suggestion suggests genocide to many who have worked long and hard on America's drug problems. I agree with these people when they say that we must concentrate on building trust through sensitive and compassionate drug treatment programs. Until these programs are a reality, however, my primary concern is to prevent the huge increases in the number of new HIV infections that are ravaging our inner cities.

All of us who are working towards ending the ravages of this epidemic hold high hopes for the success of the community planning process. We hope that by allowing

people at the local level to create appropriate interventions for their own communities, we will circumvent many of the problems described above that have proven fatal to the HIV prevention efforts until now. Congress has the capacity to either assist in this process or to create legislative roadblocks that will inevitably cripple this promising new paradigm. Congress can help by:

Funding the Community Planning Initiative at the level necessary to ensure its success; and

Enacting rational legislation that will put Congress back at the forefront of establishing civil liberties and effective health care and social support programs for the real untouchables in our society, poor people of color, women, drug users and men, especially young men and men of color, who have sex with other men.

If you do not do these things, then in 2001, my predecessor will be here delivering this same message to your predecessors because a million Americans will have died of HIV disease. Thank you.

Mr. WAXMAN. Mr. Zamora.

STATEMENT OF PEDRO ZAMORA

Mr. ZAMORA. Thank you for the opportunity to appear once again before you. I am a member of the Board of Directors involved in a number of local organizations in my home of Miami, Florida. For the past 6 months, I have been living in San Francisco filming MTV's The Real World. You can catch me on Thursdays at 10 p.m. to learn my adventures living with six other young adults under the constant glare of TV cameras. MTV invited me to be on their show because I am a young, gay man living with HIV. I was infected with HIV when I was a freshman in high school. MTV, in a rare example of entertainment industry leadership on the issue of AIDS, thought that my story, a young person living with AIDS, could send a powerful message to teenagers in this country that AIDS is real and could happen to everybody, including young people just like us.

As a young gay man growing up in the Miami, Florida school system, education about HIV/AIDS was almost nonexistent. Unfortunately, I am not talking about way back in 1980 in the earliest years of the epidemic. I graduated from high school in 1990. The little information I got was not information I could make part of my life or translate to make it part of my life.

I was dealing with my mother's death from cancer and the fact that I was gay. It should be no surprise that my mother's death had a tremendous effect on me. My mother treated me as the most wonderful and special person in the world. As a 14-year-old, the way I dealt with her death was to become a straight-A student and a track star but the only way I could replace her love and support was through sex, with men who would pick me up in bars and rarely practice safe sex.

Sure, I could have used a condom and protected myself from HIV. But I ask you to think about the reality of an adolescent who has never learned about condoms from a health teacher or other trained professional and who has heard nothing but shameful messages about being attracted to other men. I just didn't have the strength and self-esteem to challenge a partner 10 years older to wear a condom.

I needed positive messages about my sexuality. I needed to know about condoms, how to use them correctly and where to buy them. I needed to know that you can be sexual without having intercourse. I needed skills to negotiate relationships. I needed to know

how to say that I don't want to have intercourse, I just want to be held.

None of the things I needed were provided by the 50-year-old doctor who lectured my seventh grades class about this terrible thing called AIDS. Now, I have nothing against 50-year-old doctors, but what me and my classmates needed to know was more than "just don't do anything."

I also needed prevention messages that met other needs. There are many issues in my life that are just as important as AIDS. As a young boy and an adolescent, I was sexually abused. Those abusive experiences have scarred how I feel about myself and made it hard for me to say no. It was easier to make people happy even if that meant having unprotected sex.

The reason many prevention programs fail is because they are not grounded in the reality of my life and the lives of my peers. They don't include the people they serve in every level of the program and the organization. If an organization is going to serve youth, they must be present everywhere from the board of directors to peer educators.

I am also frustrated with programs that are more concerned with offending people in the general public than with saving lives. If you want to reach me as a young, gay man, especially a young gay man of color, then you need to give me information in a language and vocabulary I can understand and relate to. I will be much more likely to hear the message if it comes from someone I can relate to.

My family and I fled Cuba to escape Castro's repressive regime. We traveled for 24 hours over rough seas on an unsafe boat to come to this country full of hope and opportunity. I am proud to be an American and to live in a land where I can say who I am and what I want without fear of punishment from my government. My dream was to go to college become a doctor or lawyer, live the American dream and, who knows, maybe be elected a Member of Congress. But because I live with AIDS. My dreams may not be possible.

Mr. Chairman, we need your leadership to change HIV prevention. We need your help to make prevention grounded in the reality of real lives like mine and the millions of young people who are at risk for HIV. We can prevent HIV infection and the loss of millions of Americans. What we need is the collective will to care about young people, about people with different backgrounds and to make sure that 1 day people grow up in a world without AIDS.

Thank you.

Mr. WAXMAN. Mr. Coburn.

STATEMENT OF JAY H.S. COBURN

Mr. COBURN. Thank you for the opportunity to address this committee on the issue of HIV prevention. Your leadership is very much appreciated by people living with AIDS and the 1,000 community-based organizations we at AIDS Action Council represent.

Our Nation's prevention efforts have largely failed. HIV is the leading cause of death among men and the fourth leading cause of death for women between 25 and 44. With a vaccine years away, a redoubling of our prevention efforts is urgently needed.

We are pleased with CDC's new, yet long overdue, requirement that health departments work in partnership with communities to set HIV prevention priorities through community planning. My written testimony speaks to community planning and raises concerns about CDC's ability to implement this new initiative.

This morning I want to focus my remarks on AIDS Action's vision of further prevention reforms that are needed to make HIV prevention client centered. While community planning is a welcome change, the Federal Government must not abdicate its role in providing leadership in HIV prevention. The leadership of Secretary Shalala, Dr. Lee, Dr. Elders, Dr. Satcher and others is very much welcome. However, greater leadership is needed from the President, business leaders and celebrities. Most Americans still believe that AIDS won't happen in their neighborhood or family. Frank leadership is critical to galvanize the Nation to take action against AIDS and to provide an integrated vision of what prevention should be.

Prevention must be centered on the needs of the client, not the needs of public health officials, and be firmly rooted in the real-life experiences of people at risk. Prevention must acknowledge the interrelated behaviors of alcohol and other drug use and unprotected sex. Now, prevention programs rarely address sexual behavior and drug use together. Partners of injection drug users are often unaware of their partners' drug use. Crack cocaine heightens sexual drive and addicts exchange sex for drugs. Adolescent sexual activity often occurs after drinking or drug use.

Implementing separate HIV and drug prevention programs just doesn't make sense. Unfortunately, the very structure of Federal prevention programs perpetuates this lack of integration. Separate initiatives at the CDC and the Center for Substance Abuse Prevention force community agencies to combine multiple funding streams to build comprehensive programs.

Prevention must meet the real and immediate needs of people who are at risk. It is naive to think that addicts can readily change risky sexual behaviors. Drug treatment on demand is primary HIV prevention, and it is appalling that individuals must wait months for treatment programs. Even with treatment on demand, some drug users aren't ready for treatment.

The Federal Government must support needle exchange to prevent HIV. CDC's comprehensive study of needle exchange found that exchange programs reduce needle-sharing. The study found no evidence that needle exchange increases drug use by exchange program clients or changes community levels of drug use. In fact, providing needles can be the first link to treatment and the long journey to recovery.

This committee should remove restrictions on Federal needle exchange programs contained in the substance abuse block grant. Client center prevention must address adolescent sexuality, the existence of gay adolescents and the failure of abstinence-only HIV prevention. By age 21, 82 percent of young people have had sexual intercourse and 42 percent have had 4 or more sexual partners. Nearly half of all 14-to-17-olds have had sexual intercourse. We need comprehensive, school-based sexuality and HIV education beginning in the preadolescent years, behavior changes when edu-

cation emerges from an individual's community and is supported by the individual's environment. Community planning groups must include youth and young people, must have seats at any table at which policies are made that affect their lives. Youth programs must be comprehensive, including information about abstinence and contraception. Evaluation of abstinence-only curricula show that these programs are ineffective in delaying or reducing sexual activity and contain medical inaccuracies.

Abstinence-only curricula often spread disinformation about the effectiveness of condoms. The CDC/FDA/NIH have stated definitively that latex condoms, when used consistently and correctly, prevent the spread of HIV. While most teens are at risk male-to-male sexual contact remains the primary route of adolescent HIV transmission. HIV prevention for youth must include gay and lesbian teenagers, and the Federal Government must support the efforts of families, schools, churches and even 4–H clubs to provide HIV prevention that responds to the needs of gay teens.

Prevention must also acknowledge the mental health needs of individuals at risk and the impact that oppression and abuse have on behavior. A study found that men with histories of sexual abuse were twice as likely to have HIV compared to unabused men. Men and women who reported childhood sexual abuse were four times more likely to engage in prostitution. For people who lack self-worth and community support, sex helps them feel connected and valued. Drugs can be an escape from the reality of their beleaguered lives. Prevention programs that are client must be responsive to these real life experiences.

Mr. WAXMAN. Mr. Coburn, we will have to move on. That whole statement will be in the record. Thank you very much.

[The prepared statement of Jay H.S. Coburn follows:]

STATEMENT OF AIDS ACTION COUNCIL

Thank you Mr. Chairman for the opportunity to address you and members of the Committee on the critical issues of HIV prevention. Mr. Chairman, since the beginning of the epidemic, you have been one of the strongest supporters of a compassionate federal response to this public health crisis. Your leadership is very much appreciated by the people we represent—people living with AIDS and their families. As you know, AIDS Action Council, the Washington voice of America's 1,000 community-based AIDS education and service providers, has been an important advocate for more aggressive and community centered prevention efforts. For nearly a decade, we have spoken on behalf of communities at risk for HIV infection and pressed for greater federal leadership to halt the spread of this epidemic. It is an honor for us to appear before this committee once again to talk about HIV prevention.

This hearing could not be more timely. Our nation's past efforts to prevent AIDS have largely been a failure. HIV infection is now the number one health emergency facing our country—the leading cause of death among men between the ages of 25 and 44 and the fourth leading cause of death for women in this age group. It is spreading most rapidly among adolescents, young gay men, women and within both the straight and gay communities of color. Once a disease centered in large urban areas, HIV/AIDS now affects every state and every community across the country.

In the coming year, 40,000 to 80,000 individuals will become infected with HIV, the virus that causes AIDS. With a vaccine years away, a redoubling of our prevention efforts is urgently needed. We are pleased with the Centers for Disease Control and Prevention's (CDC) new, yet long overdue, requirement that state and local health departments work in partnership with communities most at risk for HIV to set priorities for HIV prevention through a process known as community planning. Community planning is an important first step in reforming our nation's prevention programs. Much more, however, remains to be done.

This morning, I would like to share with you AIDS Action's analysis of the important reforms at CDC, our view of CDC's progress in implementing community planning, and our vision of further reforms that are needed in federal prevention efforts.

HIV infection has struck communities that are historically disconnected from traditional public health and social service systems. From the beginning of the epidemic, the needs, behaviors and characteristics of gay men, and IV drug users and their sexual partners were a mystery to most public health officials. The cause of AIDS was an unknown in the early 80's. The epidemic first appeared in marginalized populations that many of the nation's leaders viewed as "different from us." HIV was found to be transmitted by behaviors that were at best characterized as bizarre and at worst as criminal, immoral or wrong. Tragically our national reluctance to learn and respond to the life experiences of these groups of Americans has contributed to countless preventable infections and to this epidemic, which a decade later, continues to rage out of control.

From the beginning, it was clear to us at AIDS Action that community-based, peer to peer prevention programs were key. The community-based agencies we represent demonstrated this by implementing innovative and effective prevention campaigns, largely with private funds. CDC was baffled as to how to deal with this emerging public health crisis in a time of significant budget cuts and under very conservative administrations. Rather than institutionalizing community participation in all of its prevention initiatives, CDC funded a small grants program at the U.S. Conference of Mayors. While the Conference of Mayors was able to fund several innovative and effective programs, this was one of the first of many examples of CDC's backing away from its mandate to be a science-based protector of the public's health.

Rather than provide leadership and force change, CDC funded controversial, yet effective programs through the back door, while continuing to allow many state and local health departments to conduct business as usual and avoid working with those "different" populations. Even though CDC encouraged departments of health to work with affected communities, they continued to fund health departments who refused to fund gay community organizations, for example. Although some health departments, over time, funded explicit and targeted programs, there remained the perception that the gay community had educated itself, and that injection drug users were impossible to reach anyway, so resources were best targeted to increasing AIDS awareness in the general population. Even as the epidemic moved into communities of color and women, dollars targeted for those groups did not follow.

In 1992, with funding from The George Gund Foundation, AIDS Action evaluated a sample of prevention programs funded by the CDC through city and state health departments. The study, *Good Intentions*, (the attached copy is submitted for the record) supported AIDS Action's long standing contention that the most effective prevention programs were those developed and implemented by the communities to which they were targeted. In addition, *Good Intentions* documented that funds targeted to communities whose behavior placed them at greatest risk for HIV infection received nowhere near the proportion of prevention resources their proportion of the epidemic would suggest. State and local health departments were found to have large programs in place including hotlines, public service announcements, brochures, and other interventions targeted to the general public. Unfortunately, very few health departments targeted programs and resources to gay men, gay men of color, women, and people of color.

An evaluation of HIV prevention in your home state of California, Mr. Chairman, had similar findings. The evaluation, conducted by Dr. Philip Lee and his colleagues at the University of California San Francisco's Institute for Health Policy Studies in 1992-93, found that declining HIV prevention funds were prohibiting the State from appropriately targeting resources. In a state where men who have sex with men account for 77% percent of diagnosed cases of AIDS, only eight to nine percent of the roughly $15.1 million in state HIV prevention funds were targeted to these individuals at greatest risk for HIV infection.

In the fall of 1992, working with Congresswomen Nancy Pelosi's (D-CA) staff, AIDS Action set forth a process to develop policy recommendations to address the serious shortcomings I have just described. We interviewed a broad group of people with HIV, community activists, educators, policy makers, and government officials at all levels. Last spring, we published *A Blueprint for Reforming Federal AIDS Prevention Program*, (the attached copy is submitted for the record) which proposed restructuring federally funded HIV prevention programs, either administratively or legislatively, to emphasize community-based models of prevention. Our proposal reflected the underlying principle that behavior change will occur and be sustained only when the education effort emerges from the individual's own community and if the individual's social environment supports that change.

The *Blueprint*, which was also funded by The George Gund Foundation, emphasized community planning and implementation of prevention programs and recommended the creation of regional and state prevention planning groups. Communities at risk would participate in a joint process with their health departments to assess the community's needs regarding HIV/AIDS prevention and to structure a plan for implementing a community-based response. Our proposal spoke to process rather than substance because of our strong belief that prevention content is best determined within local communities—by groups most profoundly affected—using culturally relevant messages grounded in good behavioral science.

Legislation developed and introduced by Rep. Nancy Pelosi (D-CA) proposes to address legislatively our collective concerns about federally funded AIDS prevention programs. Her bill, H.R. 1538, The Comprehensive HIV Prevention Act of 1993, strengthens HIV prevention program planning and coordination across the agencies of the Public Health Service and also establishes state and regional HIV prevention community planning groups.

Fortunately the Clinton Administration has recognized the urgency of HIV prevention reform and has not waited for Congress to enact new prevention legislation. In partnership with AIDS Action, the National Alliance of State & Territorial AIDS Directors, Representative Pelosi, the National Minority AIDS Council, and other HIV prevention advocates, the CDC, in January of this year, developed and issued supplemental guidance to its 65 state, territorial, and local grantees to institute community planning for HIV prevention.

Approximately $12 million in new funds were provided to grantees to involve community-based representatives in planning HIV prevention activities. This process of community planning is an ongoing, collaborative one in which state and local health departments, other state and local social service agencies, nongovernmental agencies, and other representatives of communities and groups at risk for HIV infection work in partnership to plan and implement HIV prevention programs that respond to community-validated needs within defined populations.

Community planning is a significant paradigm shift for CDC, state and local health departments, and the field of public health. Fortunately, a majority of parties view community planning as an opportunity, not a threat, recognizing the need for significant reform in HIV prevention. This shift, however, has not been without significant challenges. CDC has put in place a number of programs to provide strategic technical assistance to health departments and community members as they enter into this new way of doing business. Unfortunately, CDC's efforts have been hampered by a serious shortage in staff to launch this new initiative. CDC National Center for Prevention Service's Division of STD/HIV Prevention, the division charged with implementing community planning, has lost 45 FTEs (full time equivalents) over the past 18 months. While we recognize the need to make government more efficient, HIV is a public health emergency and warrants investing staff resources to ensure that federal prevention programs are run smoothly and efficiently. In a time of reduced federal spending, if we can invest in more police officers to stem the rise in violent crime, we can also invest in more public health officers to stem the rise in HIV infections, which pose an equally deadly threat to Americans and are more easily prevented than homicide.

The second serious challenge to community planning was the Clinton Administration's failure to provide CDC with additional resources for HIV prevention programs in the FY 95 budget request released in February, and the Administrations proposed $10.3 million cut in its revised budget request submitted to the Congress in April. The community planning process now under way will result in state and local health departments identifying unmet prevention needs. Without a significant increase in resources to meet unmet needs, community planning will be a meaningless ritual and will pit HIV-affected communities against each other. The Administration has made AIDS programs a priority. Unfortunately, this has translated into only AIDS research and care programs being identified as part of the President's investment package. HIV prevention and AIDS housing programs are equally important parts of our nation's response to the epidemic. AIDS research, care, prevention, and housing must all be Presidential priorities and a part of future investment initiatives. Just last week, over fifty national organizations wrote President Clinton in support of including AIDS prevention and housing programs in future investment initiatives.

Fortunately, under the leadership of Reps. Pelosi, DeLauro, Lowey, Serrano, and Hoyer, the House has included a $63 million increase for CDC in the FY 95 Labor HHS appropriations bill. This increase will enable state and local health departments to meet new and under-funded prevention needs identified through the community planning process. We look to the Senate to follow the House's leadership in making HIV prevention a priority.

While community planning is a welcome change, the Federal Government must not abdicate its role in providing leadership for HIV prevention to communities. The two key elements of successful HIV prevention in the United States should comprise the top and the bottom of a pyramid: the foundation of the pyramid is active community involvement in the planning and implementation of programming, while the top of the pyramid is strong and courageous national leadership. Thus, power should "bubble up" from the community level, rather than "trickle down" from the top.

The Administration must be commended for unprecedented leadership from Secretary Shalala and Assistant Secretary for Health Lee. Secretary Shalala's aggressive support of CDC's public service announcements promoting the use of condoms to prevent the spread of HIV is a welcome change from her predecessors' prohibition of such efforts. Dr. Lee is to be commended for initiating community planning and launching the development of the first HHS-wide HIV prevention strategic plan. For the first time, the nation's health officials recognize AIDS as our country's leading health problem. Not since Dr. Koop have we had a Surgeon General like Dr. Elders, who stands up to political pressure and tells the truth about AIDS and HIV.

While the leadership of our nation's health officials is welcome, greater leadership is needed from the President, business leaders, and leaders in the entertainment industry. AIDS continues to overwhelm the average American. It is a disease that is too terrible and too difficult to understand. Most Americans continue to believe AIDS cannot happen in their neighborhood, or in their family. Frank and more aggressive leadership is necessary if we are to galvanize the nation to take action against the AIDS epidemic both here in the United States and throughout the world. The leadership of this nation must finally be resolute in efforts to end this epidemic.

We also need strong leadership to provide an integrated vision of what prevention should be. We believe that prevention must he centered on the needs of the client and would like to recommend several ways in which prevention can be more firmly rooted in the real life experiences of people at risk for HIV.

Prevention must-be centered on the needs of the client, not the needs of the public health system or public health officials. Prevention is client-centered when it is grounded in the reality that interrelated behaviors of alcohol and other drug use and unprotected sexual intercourse lead to HIV infection. Yet our HIV prevention programs typically offer simplistic interventions that address sexual behavior *or* drug use, but rarely the two together. Unfortunately, human behavior is just not that simple. Indeed, it is very complex.

We know, for example, that the sexual partners of injection drug users are often unaware of their partner's current or past drug use. Studies document that crack cocaine significantly heightens sexual drive. Other studies have documented the practice of exchanging sex for drugs. Among adolescents, sexual activity often is unplanned and occurs after drinking or drug use, with one study finding that almost one-half of adolescents with unplanned pregnancies had been drinking and/or using drugs before the act of intercourse that resulted in pregnancy. Implementing separate HIV prevention and drug use prevention programs just doesn't make sense.

The very structure of our federal HIV prevention programs perpetuates this lack of integration in HIV prevention. CDC's prevention programs are based primarily in the Division of STD/HIV Prevention and largely address sexual behaviors. The HIV prevention programs administered by the Center for Substance Abuse Prevention tend to focus on the risks of needle sharing, often failing to address aggressively and clearly the relationship between sex and drugs. This separation is reinforced at the community level. Community-based HIV prevention programs are forced to combine multiple funding streams in an attempt to build comprehensive programs.

Prevention is client-centered when it meets the real and immediate needs of people who are at risk. It is naive to think that people who are addicted to alcohol and other drugs can readily change the behaviors that place them at risk for HIV infection in addition to other sexually transmitted diseases (STDs). Drug treatment on demand is primary HIV prevention. It is appalling that in most major cities individuals who want to quit drugs must wait months for a place in a treatment program.

Even if drug treatment on demand were a reality, not all drug users are ready to enter treatment. Therefore, the federal government must promote and fund needle exchange as an effective strategy for preventing HIV infection among injection drug users. The CDC commissioned a comprehensive study of needle exchange programs, which was conducted by Peter Lurie, M.D., at the Institute for Health Policy Studies at UCSF. Study results, released in September 1993, found that needle exchange programs reduce needle sharing. The study further found no evidence that needle exchange programs increase the amount of drug use by needle exchange pro-

gram clients or change the overall community levels of injection or non-injection drug use. In fact, providing clean needles is for many drug users their first link to treatment and the beginning of the difficult journey to clean and sober living. This Committee should remove restrictions on federal funding of needle exchange programs contained in the Substance Abuse and Mental Health-Services Administration (SAMHSA) Substance Abuse Block Grant, which is being reauthorized this year.

Prevention is client-centered when programs address the reality of adolescent sexuality, the existence of gay teenagers and young adults, and the failure of the "head in the sand-just say no approach" to adolescent HIV prevention.

The CDC reports that young people aged 18-21 were significantly more likely to report having had sexual intercourse (81.7%) and to have had four or more sexual partners during their lifetimes (41.9%) than 14-17 year olds (43.4% and 13.3%, respectively). But nearly half of 14-17 year olds report having had sexual intercourse. This is compelling evidence of the need for comprehensive sexuality education, including HIV prevention beginning in the pre-adolescent years.

Unfortunately many HIV prevention programs for adolescents are neither comprehensive nor client-centered. Earlier I stressed that behavior change will occur and be sustained only when the education effort emerges from an individual's own community and when the individual's social environment supports that change. CDC's guidance states that the community planning process must include those who reflect the population characteristics of the current and projected HIV/AIDS epidemic in a given jurisdiction as indicated by reported AIDS cases, HIV data, and other relevant surrogate markers, including age. HIV prevention programs for young people must be designed *with* and not just *for* young people. Community planning groups must have young people as full participants in the planning process. Young people deserve and must be assured a place at any table at which policies are made that affect their lives.

In addition, prevention programs for young people. must be truly comprehensive. They must include information about both abstinence *and* contraception. Evaluations of "abstinence-only" curricula have found flaws such as medical inaccuracies, religious biases, and racial stereotyping. Supporters of "abstinence-only" curricula have waged a disinformation campaign about the effectiveness of condoms. The CDC, the Food & Drug Administration, and the National Institutes of Health have stated definitively that latex condoms, when used consistently and correctly, are the most effective preventive measure against HIV and AIDS for those who choose to be sexually active. Furthermore, evaluations of several programs that only discuss abstinence have proven that these programs are not effective in delaying or reducing teen sexual activity.

While the majority of adolescents and young adults are at risk for HIV infection, male to male sexual contact is still the number one way HIV is transmitted among teens. HIV prevention programs for young people must recognize not only the reality of adolescent sexuality, but also the reality that not all adolescents are heterosexual. Young gay men are often not effectively reached by HIV prevention programs grounded in the gay male community. Therefore, schools, after school programs, Boys & Girls Clubs, and even 4-H must embrace the diversity of adolescents and provide life saving HIV prevention programs that respond to the needs of gay, lesbian, bisexual, and transgender teens. And, the federal government must support such efforts.

Educators and local school boards must not be impeded by Congressional restrictions such as those recently amended to H.R. 6, the Elementary and Secondary Education Act that prohibit educational agencies receiving funds under ESEA from implementing or carrying out programs or activities (instruction, counseling or other school services) that are supportive of gay or lesbian students and that restrict the content of sexuality education programs to "abstinence-only" curricula. These restrictions send a clear message that our nation does not care if young gay men nor sexually active adolescents become infected with HIV.

Prevention is client-centered when it acknowledges the mental health needs of individuals at risk for infection and the impact of oppression and abuse on behavior.

Prevention programs largely fall short in addressing underlying motivations for high-risk behavior. PSAs, brochures, and videos abound which tell how HIV is transmitted and what people can do to protect themselves. Unfortunately, most prevention efforts don't take into account the impact of oppression and abuse on sexual behavior and drug use.

A 1991 study published in the *American Journal of Public Health* (1991;81:572-575) found that people who reported childhood sexual abuse, compared with people

who did not, were four times more likely to be working as prostitutes. Women who reported abuse were nearly three times more likely to become pregnant before the age of 18. Men who reported a history of sexual abuse had a twofold increase in prevalence of HIV infection relative to unabused men. Identification of sexual victimization may be an important component for management of risk factors for HIV.

For people living in an environment without support and community, sexual contact serves as a way to feel connected and valued. For some who are struggling for a sense of belonging and self-worth, drugs and sex prove an effective, albeit short term and ultimately harmful, escape from the reality of their beleaguered lives. Prevention programs that are client-centered must be responsive to these real life experiences.

For some, prevention may be simple. Knowledge about HIV transmission and skills to engage in healthy behaviors may suffice. But for a young gay man of color, struggling with low self esteem, not knowing whom to trust, and living in a world that defines his sexual orientation only by what he does in bed, setting limits and practicing safer sex is a tremendous challenge—a challenge not met through a simple brochure or video.

For gay men living in large urban gay communities devastated by the epidemic, practicing safer sex and managing chronic depression with something other than drugs or alcohol is a tall order. Runaway youth, fleeing an abusive home, surviving on the street through prostitution, and numbing their pain through drugs, are not likely to change risky behaviors until they have a place to live, and a job and have begun to heal from the abuse of their past. Teenagers, growing up in middle America struggling to make sense of their sexuality, without factual information about contraception, the skills to set limits and make healthy choices are unlikely to make a successful transition to adulthood.

Prevention must be about helping people to discover who they are in a way that is not defined by unprotected sex and alcohol and drug use. Prevention must encompass all that enables individuals to feel good about themselves, to feel cared for and valued, and to know they can turn to people, rather than to sex and drugs, for help.

Through community planning, the federal government has finally acknowledged the importance of empowering voices within communities to be partners in prevention. Mr. Chairman, you have long been one of the strongest and most compassionate voices in the Congress when it comes to the issue of AIDS. We urge your continued support of the Administration's implementation of community planning and hope you will join with AIDS Action in urging the Administration to take the next steps in reforming HIV prevention. AIDS Action and the community-based AIDS education and service providers we represent are committed to prevention pregrains that are client-centered. We look to you for leadership to help us create a world where all Americans can be healthy and productive citizens, free of the tragedy of HIV and AIDS.

Mr. WAXMAN. Mr. McAlister.

STATEMENT OF ROBERT O. McALISTER

Mr. MCALISTER. Thank you, Mr. Chairman. I am Robert McAlister, the current Chair of the National Alliance of State and Territorial AIDS Directors.

Our public health agencies are directly charged with either stopping the further spread of HIV or to coordinate programs within our communities that will accomplish this end. Affecting behavioral change in large numbers of persons is a huge challenge, especially since we are expected to affect sexual and drug-using behaviors. Interventions that we know to be effective are not cheap. There are no quick and dirty shortcuts to changing the behaviors of populations, especially given the huge numbers of persons at risk in this country. Despite these obstacles however, prevention remains vastly preferable to letting the epidemic run its natural course and accepting the enormous human toll that that would entail.

Let me echo Mr. Studds by saying that this disease is eminently preventable if the right interventions are implemented at the client level. I have cited several examples of programs that there is growing evidence about that suggest that they are, in fact, working at

the community level today; and those are in the full text of my testimony.

We, as directors, feel mystified that the Congress has seen fit to allocate such modest funding for prevention while giving us a mandate to stop this epidemic. Indeed, last year only 9 percent of the total Federal outlay for HIV was spent by the Centers for Disease Control and Prevention; the rest went for research and care. I respectfully ask, is this not one explanation for the enormous outlay of resources needed now to provide care for the persons who have become infected?

We frequently are told that the appropriations are so modest because we can't prove that our efforts at preventing HIV are working. We are asked to provide proof that prevention programs work, yet by their very nature, prevention programs are designed to make nothing happen. Proving effectiveness of such strategies is a tall order, especially given the woefully small dollars that have been earmarked in the past for evaluation. Even if our prevention interventions stop only 1 percent of the new cases of HIV from being transmitted, they are cost-effective, given the enormous costs of care associated with this disease.

Despite the frustrations of the last several years, I am heartened to report that we are entering a new era in our struggle against this disease, thanks to the strong leadership of the AIDS Action Council, of Representative Pelosi and of many others that you have heard from today. This era is called HIV prevention community planning.

The new Federal requirements that have been recently established by CDC constitute a true sea change for us in public health at the State and local level. There are special challenges and special opportunities is that go along with this sea change. It will be difficult, but I am also convinced that community planning may offer tremendous potential for us to finally stop this epidemic. Permit me to elaborate.

HIV risk reduction involves personal choices on the part of persons at high risk and cannot be forced. They must be voluntary, and the persons who make those choices must sustain those choices. In order to achieve this goal, community planning will develop community level programs that rely on the knowledge and the experience, that is, the expertise of persons at risk to guide us in determining what may best be done to make this personal choice happen, by individuals.

We are now busy forming partnerships in the community to develop consensus approaches, each tailored to local community standards. But to succeed in this effort, many of our agencies will have to change our traditional approaches to prevention, a process that is truly going to be time-consuming and difficult. In order to get our citizens to reduce their risk, our government must take greater risk in our fight against AIDS. Some of our programs that we have worked hard to develop will be rejected by our community planning groups, and States are prepared to make whatever changes are necessary in order to develop true consensus at the community level around the next generation of our prevention programs.

During this important new era of community planning the Federal Government must also take risks as well. I am honored to represent my health department colleagues in the development of a community planning initiative at the highest level that has been formed by Dr. Phil Lee. We are pleased about that effort, but we believe that the administration must also increase its investment and improve its coordination of prevention research. Part of the Federal Government's strategic HIV prevention plan must include proposals to strengthen both prevention research and evaluation.

Finally, of critical importance to us, Congress and the administration must refrain from tying our hands at the local level through set-asides and prohibitions from implementing effective prevention interventions such as needle exchange programs. Paramount in this area, it is critical that the Surgeon General certify the effectiveness of needle exchange programs and that Congress remove the restrictions on the use of Federal dollars for this essential prevention intervention. It is quite likely that many of the community planning groups are going to put this as one of their highest priorities once they get to the priority-setting phase of community planning this summer.

We appeal to the Congress to acknowledge the importance of prevention programs and to adequately provide us with the funding to do our jobs properly and to back us with patience as we and our community partners push the envelope in search of the right answers for each of our communities. We aren't building bridges or doing drugs with these precious prevention dollars.

Your investment in us, if successful, will avoid the tangible, not produce it. We are saving lives that, once saved, are taken for granted as never having been in jeopardy, and most of those who will be spared are from populations the society has already marginalized—the gay, the poor, the drug afflicted and persons of color.

Please stay the course, recognize the importance of prevention and fund it adequately. Thank you.

[The prepared statement of Dr. Robert O. McAlister follows:]

STATEMENT OF ROBERT O. MCALISTER

Good Morning, Mr. Chairman. I am Dr. Robert McAlister and I am the HIV Program Manager for the Oregon Health Division. I am here today in my capacity as the Chair of the National Alliance of State and Territorial AIDS Directors (NASTAD). Our organization represents the nation's chief state and territorial health agency staff who have programmatic responsibility for administering AIDS health care, prevention, education, and supportive service programs funded by states and the federal government.

These public health agencies are collectively charged with either directly stopping the further spread of HIV or to coordinate programs in the community that will accomplish the same thing. Usually fatal, HIV spreads silently through populations that already are experiencing discrimination, poverty, substance abuse and other serious health problems.

Prevention of HIV has challenged public health agencies in unprecedented ways. Traditional control measures used for other sexually transmitted diseases, although valuable, have proven to be hopelessly inadequate to control the spread of this virus. Furthermore, many taxpayers are impatient with what they perceive to be slow progress and will not tolerate risk *reduction*, but expect somehow that the risk be **entirely eliminated**.

Moreover, effecting behavioral change in large numbers of persons is a huge challenge, especially since we must affect sexual and drug using behaviors. Interventions that we know to be effective are not cheap. There are no "quick and dirty"

short cuts to changing the behaviors of populations, especially given the huge number of persons at risk in this country. And sometimes, when a population does reduce its risk, the change is not sustained; relapse may be common.

Despite all these obstacles, prevention remains vastly preferable to letting the epidemic run its natural course, and accepting the enormous human toll that this will entail. And, let me be very clear—this disease is preventable. Evidence and research data are mounting that indicate we do indeed have interventions at our disposal that work and that are working in many jurisdictions across the country. Effective interventions include those that are more intensive and involve one-on-one counseling opportunities where a professional or a peer talks to individuals and works with them to reduce their high risk behavior over time. Other examples include: the one-to-one counseling and peer education program for gay/bisexual adolescent males in Minnesota which showed a 60% reduction in unsafe sexual behaviors; the bar-based interventions with gay men developed by Dr. Jeff Kelly focusing on changing the behaviors of community leaders; the efforts of outreach workers with prostitutes in Massachusetts and in crack houses and other street settings; the peer-to-peer counseling project for inmates at correctional facilities in Florida; and the peer education program in Ohio—"Stopping AIDS is My Mission"—to reach African American adolescents to reduce their risk for HIV.

Perhaps the most striking evidence we have is the effectiveness of needle exchange and other programs directed at injection drug users (IDUs). For example, evidence from the State of Connecticut, where the purchase and possession of up to ten needles and syringes from pharmacies was legalized in 1992, indicates that IDU's changed their major sources of syringes from unsafe on the street to safe from pharmacies and decreased the multi-person sharing of syringes.

We AIDS Directors feel mystified that the Congress has seen fit to allocate such modest funding for prevention while giving us a mandate to stop this epidemic. Indeed, last year only 9% of the total federal outlay for HIV was spent by the Centers for Disease Control; the rest went for research and care. I respectfully ask, is this not one explanation for the enormous outlay of resources needed now to provide care for the persons who have become infected?

We frequently are told that the appropriations are so modest because we can't prove that our efforts at preventing HIV are working. We are asked to provide proof that prevention programs are working. Yet by their very nature prevention programs are designed to make nothing happen. Proving effectiveness of such strategies is a tall order, especially given the woefully small dollars that have been earmarked for evaluation. Even if our prevention interventions only stop 1% of the new cases of HIV from being transmitted, they are cost effective, the enormous cost of care associated with this disease. And the dollar costs don't even begin to address the changes wrought in our culture by the loss of so many young, potentially productive Americans.

Despite the frustrations of the last several years, I am heartened to report that we are entering an exciting new era in our struggle against this disease. Thanks to the tireless efforts of Representative Nancy Pelosi and the thoughtful work of the AIDS Action Foundation, public health agencies across the country are forming unprecedented partnerships with community representatives to improve our HIV prevention programs. Called HIV Prevention Community Planning, this process is being implemented by all state, territorial and local health departments that receive HIV prevention funding from the Centers for Disease Control and Prevention (CDC).

These new federal requirements recently established by CDC, call for public health agencies to engage in an open and inclusive process that involves people from outside the government in the planning and implementation of HIV prevention programs. This is a sea change in the way we do business, and presents both special challenges and special opportunities to us in public health. But I, am convinced that, difficult though it may be, community planning offers enormous potential for us to finally stop this epidemic.

Let me elaborate a bit. HIV risk reduction involves personal choices on the part of persons at high risk, and cannot be forced; they must be voluntary and the persons who make the choices must sustain those choices. In order to achieve this goal, community planning will develop community-level programs that rely on the knowledge and experience—the *expertise*—of persons at risk to guide us in determining what may best be done to make this happen.

We are now quite busy forming partnerships with the community to develop consensus approaches, each tailored to local community standards and values, that have the best chance of empowering persons at risk to change their lives. To succeed in this effort, many of our agencies will change our traditional approaches to prevention, a process that will be both time-consuming and difficult.

In order to get our citizens to reduce their risk, government must take greater risks in our fight against AIDS. Some of the programs we have worked hard to develop will be rejected by our community planning groups, and states are prepared to make whatever changes are necessary to stop the further spread of this virus. Many persons at risk will have to significantly change the way they view government, to trust agencies that they have traditionally viewed with suspicion. And other community leaders, though not at risk, will need to serve as arbiters, mediating disputes, fostering popular support for programs intended to serve the underserved and those at special risk. These changes will be slow, painful, and in many cases the outcomes won't be obvious for years. To begin thinking strategically, for the long haul, has not been easy; we are used to fighting a war against this virus, and most of my colleagues are still dealing with HIV using crisis management tools. Community planning will allow us to take the offensive.

During this important new era of community planning, the federal government must take risks as well. First, the federal government must engage in community planning at the highest levels. I am honored to represent my health department colleagues in the development of a federal HIV prevention strategic plan under the leadership of the Assistant Secretary for Health, Dr. Phil Lee. Second, the Administration must increase its investment of prevention research. Part of the federal government's strategic HIV prevention plan must include proposals to strengthen both HIV prevention research and evaluation.

Finally, of critical importance to AIDS Directors, **Congress and the Administration must refrain from tying our hands at the local level through set-asides and prohibitions from implementing effective prevention interventions**. Paramount in this area, it is critical that the U.S. Surgeon General certify the effectiveness of needle exchange programs and that Congress remove restrictions on the use of federal dollars for this essential prevention intervention. Congressional prohibitions and limitations on needle exchange, condom distribution, content of educational, materials, and social marketing strategies, undermine the integrity of the community planning process, a process that relies on the community to help determine the interventions that are needed.

We appeal to the Congress to acknowledge the importance of prevention programs, to adequately provide us with the funding to do this job properly, and to back us with patience as we and our community partners push the envelope in search of the right answers for each community. We aren't building bridges or developing drugs with these precious prevention dollars. Your investment in us, if successful, will *avoid* the tangible, not produce it. We are saving lives that, once saved, are taken for granted as never having been in jeopardy. And most of those who will be spared are from populations that society has already marginalized—the gay, the poor, the drug afflicted, and persons of color. Please stay the new course, recognize the importance of prevention, and fund it adequately. Thank you.

Mr. WAXMAN. Thank you very much, Dr. McAlister.

Mr. Studds has to leave. I want to recognize him first.

Mr. STUDDS. Thank you, Mr. Chairman. I apologize. I want to thank and express my respect for those of you on the panel who are living with HIV/AIDS for doing what you have a lot of practice doing, which is mastering rage and trying to make it work in an useful way. It is a very heartwarming thing to see, and it has an impact, believe me.

I also want to express my appreciation to the CDC folks who have stayed to hear you. Dr. Lee had to leave, but he heard most of you, and Dr. Curran and Dr. Satcher are here.

I sometimes regret the formality and almost sterility of the congressional hearing format where you sit there and read statements at us and sometimes we have the discourtesy of reading them back at you as if you come here to hear us. I almost wish I could wave a magic wand and have the CDC come back and you could have a discussion. Since the format doesn't permit that, maybe you could sort of pretend they are there. They really are behind you, but it looks like they are in a fairly good mood.

Since you do have the leadership of CDC with you at the moment—and notwithstanding your prepared statements which are

very eloquent, I think, without exception—is there something else you would like to say? We don't always get the chance to have the number one folks at our left hand. What would you like to say or ask of them, now that you have a chance, beyond what is in your statement? You don't have to, but I figured you might want to.

Mr. AGOSTO. I would like to ask what kind of consideration CDC is giving to secondary AIDS prevention education.

Mr. STUDDS. I may totally disrupt this hearing.

Mr. WAXMAN. Why don't we do this? If you want to comment or question, we will give them a chance to respond for the record. That would make it complete, and of course, we will share the answers with you. This is not the only opportunity, I hope, that you get together with people from CDC.

Mr. STUDDS. Does anybody else want to say or ask anything?

Mr. COBURN. I had the privilege of serving on an external panel last summer, particularly one that looked at young people, and I want to continue to urge the CDC to be extraordinarily aggressive with our Nation's schools and youth-serving agencies across the country in addressing this epidemic for young people. I am heartened by many discussions I have been hearing at CDC about the needs of young gay men, but I think that much more aggressive leadership is needed in the education community, in churches and after-school programs to reach all young people, young people in middle-class households, growing up in suburbia, young people living on the streets, homeless, addicted to drugs; that all of these young people are a responsibility and all of these young people need explicit and effective messages, and I hope that the CDC will continue to provide more aggressive leadership with youth-serving institutions.

Mr. MCALISTER. Mr. Chairman if I may pick up on a point that Mr. Coburn made earlier having to do with trying to make our prevention programs more client-centered, more focused on the client, in Dr. Curran's remarks you were told that we in public health at the State level were asked to serve an additional approximately 1 million clients in our counseling and testing sites with the same amount of Federal dollars in a 12-month period. This did happen and, in fact, is one of the reasons why I believe that there is such a dearth of data out there that shows the effectiveness of well-crafted counseling and testing programs; because soon after Magic Johnson's announcement, any semblance of having well-crafted programs in place to deliver that service became pretty much of a sham.

It is very much like creating an elegant and small and intimate atmosphere in a restaurant with a very selective menu, very carefully crafted to provide the right kind of atmosphere for a select group of people in the community, and then having someone go into the community handing out coupons saying you can get free food at this place; and by the way, we were told that we have to serve everybody who comes to the restaurant. The menu starts getting cut, a lot of things fall off the table in terms of quality of service, and at that point, any hope of having a demonstrable impact on prevention I think became problematic.

So hopefully one of the things that will occur as community planning teams address the issue is that they will recognize that with

proper quality assurance and with a true client-centered focus and with targeting to identify only those populations that truly provide public health value in being served through a federally funded counseling and testing program, those will be the populations that we target; and the program itself will be retooled to be much more client-centered and of much higher quality.

Mr. STUDDS. Mr. Chairman—I want to thank you, Mr. Chairman for your consideration.

Mr. Zamora, as you know, it was your testimony to which I alluded earlier, and you seem not terribly frightened of 50-something doctors behind you. You have also done something which I didn't think any human being could do. You persuaded me to watch MTV. You will pay for this.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Studds.

You all work with people whose behavior puts them at high risk of infection. You also all know that this behavior varies widely by age group and geography. Do you all agree that community planning is the most useful way of making community programs effective? Does anybody disagree with that?

Mr. MCALISTER. I would like to try and respond by saying I think it is certainly an important additional step in our quest to find the effective magic key that unlocks this Gordian knot called "What will it take to prevent the spread of this disease in our country? " I believe that what we are seeing is ushering in a new era of participatory public health that will spread much beyond HIV prevention programs and will incorporate the principles of community planning into a lot of other public health programs where we have also been somewhat, I think, guilty of not involving our communities and the consumers of those prevention services in a substantive way.

So we are excited about potential for community planning not only as it relates to helping us find—through dialoguing with those communities and involving them in planning our programs, in finding out what will help prevent spread of this disease amongst their peers, but will also translate into a ground swell of enthusiasm on the part of the community to involve itself in other public health efforts.

Ms. FOX. I couldn't agree more with what my colleague said. The National Minority AIDS Council is consciously optimistic about community planning, but we believe that the best intervention efforts are those that are locally based.

We have the privilege of being a technical assistance provider around parent inclusion and representation. I myself am a TA provider and have been to a number of sites. Thus far, the kinds of things that I am seeing out there in terms of engaging the community are very promising. We think that community planning for prevention is the best way to go at this point.

Mr. WAXMAN. Even with those people who are so marginalized and not part of any community?

Ms. FOX. One of the difficulties we learned around the implementation of the Title I of the Care Act, and we see that many lessons are similar, is the difficulty of engaging people not of the AIDS

community but who have the best inroads into some of the most disenfranchised communities.

I think that one of the challenges for community planning will be to do that; will be to reach into communities where you have people who are advocates for or have ties with populations that traditionally don't come to the table, that don't see themselves as impacted by AIDS, don't see themselves as at risk for AIDS, and that don't want to be associated with that. So that is certainly one of the challenges, one of the messages that we have been taking out on the road.

Mr. WAXMAN. Mr. Rose, the CDC external review committee gave fairly harsh criticism of the referral system at counseling and testing sites. Do you agree that people who test positive have a hard time finding the appropriate follow-up care?

Mr. ROSE. I worked in Queens, New York for a long time, going around to hospitals, usually to women on their death beds who had never received any services whatsoever. Even the ones that had been tested for one or another reason, usually through drug programs, had never received access to any kind of comprehensive care.

I don't perceive that as having been changed immensely.

Mr. WAXMAN. Mr. Agosto, what do you think about it? Do you think other programs do better? Do Ryan White programs have better secondary prevention——

Mr. AGOSTO. I don't think—we still don't have a comprehensive, even through Ryan White programs, a program that provides secondary prevention education. We have some initiatives coming out from community-based organizations, but we don't have a coordinated effort.

There are a lot of things that can be done like a PCP prophylaxis campaign. GMAC put one campaign out. We are working in one targeted at communities of color, but it is important for people with AIDS to have good health care, to have knowledge about their treatments so they can make well-informed decisions.

Mr. WAXMAN. Much of the epidemic among black and Hispanic Americans has been among young gay men. Have government primary prevention programs targeted black and Hispanic gay men and do you believe that efforts aimed at white gay men are effective with all gay men? Are there cultural difference in what makes an effective prevention message?

Mr. AGOSTO. I saw a report published by the U.S. Conference of Mayors and it was an assessment of services provided for gay men of color in five cities. The report clearly said that there are not enough programs out there addressing the specific needs of gay men of color—cultural needs, linguistic needs, et cetera.

Mr. WAXMAN. Will you submit that report to us so we can have it for the record?

Mr. AGOSTO. Sure.

Mr. WAXMAN. Mr. Zamora, what do you think about that issue? Do all the programs aimed at gay men apply when we are talking about black and Hispanic gay men?

Mr. ZAMORA. Definitely not. I as a gay man of color, my language and my needs and my wants are very different than the general gay community, and any program that is going to educate me or

reach me has to be specific to my community. It doesn't take a genius to realize that my background and my attachment to my family is going to be very different than a white gay man.

So when you look at that, the programs that try to reach me have to be totally different and be in a different language.

Mr. WAXMAN. People look at young people who know about AIDS and still take risks—it is hard to understand why people would take that kind of chance with their lives—especially true when risks are foreign to them, say when older people are straight and younger people are gay or use drugs. You work with these young people. What is effective? Is it fear that will get them to change their ways? Is it peer pressure? What do you think would be most effective?

Mr. ZAMORA. Well, just coming to fear, I think fear is very effective for about 5 minutes. And then it doesn't work. I think like any—it is normal for us, if you—if you want to scare us, then that is OK, but you better give us options, so that when we could act on that fear and do something to change our behavior.

But one of the problems that I see is that we try to scare young people, but we don't give them any options. We don't say now that you are scared and want to do something to change your behavior, this is what you could do. We don't give them that. So they are scared, and it points to a point where they say, well, anything I do I am going to get AIDS anyway, so forget it, and they go and have unprotected sex or whatever it is that is putting them at risk.

And one of the reasons that I could go to any school, any group, and ask them how do you get HIV and AIDS, and they will be able to tell me the three general ways that you could get it. We have this myth that information by itself changes behavior, and that is totally not true. If information by itself changed behavior, then none of us would be smoking, everybody would use their seat belt, in my opinion, Reagan would never have gotten reelected. We have the information about what those things do to our lives. Yet we still go ahead and do them. And it is because information by itself does not change behavior. It needs to be a lot more than just information.

Mr. WAXMAN. Dr. McAlister, what do you think about that?

Mr. MCALISTER. Thank you for asking, Mr. Chairman. I recently heard an interesting presentation by a respected leader in the field of social marketing, Dr. William Smith, from Academy for Educational Development, who stated that among other things, two very important criteria need to be simultaneously met in order to get a population to change its behavior, regardless of whether you are talking about selling them soap or selling them condoms. And they, first of all, need to perceive that it is possible to do this.

Second, they need to believe that it is socially acceptable to do it, that is that there is a social norm surrounding—it is OK to go ahead and do whatever it is you are trying to get them to do. And finally, they need to perceive that it is fun. They need to perceive that whatever it is you want them to do is going to bring them pleasure. And I think in order for us to market and successfully sell prevention programs that stick, that last longer than 5 minutes, and I agree completely with the fear lasting about 5 minutes as an impact, in order to make programs stick, we are going to

need to get the populations to acknowledge them as possible, as socially acceptable, and make them fun.

Mr. WAXMAN. Mr. Zamora, you have been working with individuals, especially individuals of color, and I guess you can respond to their individual concerns and cultural differences, but you are also working in the mass media with MTV. Do you think the mass media is an effective way to reach people and to slow the spread of HIV or encourage infected people to get early treatment? Or are the airwaves too broad, too institutionally intensive to reach people effectively?

Mr. ZAMORA. I think the mass media by itself is not going to be effective. But I think if we send the message over—I think in order for prevention to be effective, it needs to be repeated and it needs to be coming from as many different messengers as possible. So I think that definitely the media not only has a responsibility, but it could be very effective in trying to reach a population.

Mr. WAXMAN. Anybody else have a comment on that?

Mr. Rose.

Mr. ROSE. We are tending here to talk—we have all tended to talk primarily about men. And men are powerful in sexual and domestic situations. They can—their world can be penetrated by interventions in order to get them to change their behaviors.

To a great degree, many women, particularly poor women, don't have these options. We have to spend more time thinking about how we can provide them with the tools that they need to depend—to protect themselves independently.

Mr. WAXMAN. Dr. McAlister, you talked about fun, pleasure, people want to continue to have sexual pleasure. And then we tell them condoms. Is that inconsistent? Is there a complaint about that? Do you think it is effective strategy?

Mr. MCALISTER. I certainly think it is an effective strategy to continue to promote the use of condoms. They work and they work very well, indeed. But I also think we need to temper our discussion of condoms with some realism and acknowledge the fact that it is a significant intrusion on a person's sexuality to be asked to wear a condom. Not just every now and then, but consistently from now on for the rest of your life, which is what many persons at high risk are being asked to do.

Our experience with injection drug users suggests that it is relatively straightforward. Once you get them in the right setting to teach them how to properly clean up a dirty needle and disinfect a syringe or to properly access sterile syringes, the paraphernalia and pharmacy laws permits that. But it is a much taller order to try to get them to consistently use condoms, because it is a significant intrusion on a man's sexuality to wear one of these things. Let's be quite frank about that.

However, having said that, it is also a tremendous benefit to be derived from taking that extra relatively small additional risk and compromising one's sexuality to wear it. So we need to be honest in communicating that the risk benefit of wearing condoms is way, way on the benefit side for sexually active men with multiple partners.

Mr. WAXMAN. Mr. Rose made the comment about women. Let me ask you, Ms. Fox, what programs can work for women, especially

women who can't control all aspects of their exposure or don't even know that they are at risk?

Ms. FOX. Well, frankly, we don't have a lot of programs that are at least developed with Federal dollars that I would call successful and so many of the other efforts targeted to women at the grassroots level are still very much in the early stages. But some of the programs that we need, for instance, within women of color, many of the women who are at high risk are women who are injecting drug users, so we need programs that look at those particular needs.

We also need programs that take into account the possible effects that domestic violence, if a woman is positive, and confronts her spouse or her partner, it oftentimes puts her at risk. We also need programs that look at the multitude of needs that women might have, for instance, issues dealing with children or issues dealing with caretaking. And we also need just more of a concerted effort to understand that the kinds of intervention efforts that we use with the general population do not necessarily work with women, that there is a whole host of other kinds of social factors and health considerations that come into play. So I guess what I am saying is that we would like to see programs that are specifically geared by and for women.

Mr. WAXMAN. Mr. Zamora, give me your thoughts about—you talked about other options that you have to offer to young people. And one of the options we keep on hearing about, condom use, Doctor McAlister talked about the clear benefits of condom use. Is that a successful strategy? Is that working?

Mr. ZAMORA. I think that to push condom use could be successful, if you are being honest, if you are being open and clear about the information you are giving. I think one of the things, to me, as a young gay man that I kind of—it anchors me, is that when I hear things like you could get AIDS through sex and, yes, that is true, you could get AIDS through sex, but sex is a lot of things. And I want to hear the kind of sex—about the kind of sex that I want to have, or that I am having. I want to hear about anal intercourse, I want to hear about more specific things than just sex. Because sex, you know, is different from person to person. And the kind of sex that I have is very different than other populations. And I want to hear specific messages about that kind of sex.

Mr. COBURN. Mr. Chairman, if I could add, I think one of the things that we have done has been very unsuccessful in helping people make a transition into adulthood that is not defined by sexual intercourse; that somehow to be a grown-up and to be adult means having sex, and the way we define sex is having intercourse. And I think we all know in this room that there are a whole lot of things that are pleasurable and that are involved in sex that don't involve intercourse, and that don't involve risk, and that we shy away from helping young people talk and feel comfortable about those things, and therefore leave them totally powerless to set limits, to communicate, you know, what they can do that they feel good about that also doesn't put them at risk.

Mr. MCALISTER. Mr. Chairman, in our health department, we explored the possibility with some convenience store operators in our State of marketing condoms aimed at youth by putting them on the

shelves. And they were told in no uncertain terms that that really wasn't going to be possible, because the kids would steal them. They didn't feel comfortable in bringing them to the counter and purchasing them, picking up on Jay's comment about our inability to properly communicate about the sexuality that our youth are experiencing.

The approach that we have taken in our State to dealing with that is to welcome public-private partnership with a group called Project Action, who have actually put up condom machines in youth-oriented establishments that vended the machines by the youth putting in a quarter and purchasing the condoms. They held focus groups to determine that the kids would really, in fact, be willing to spend a quarter for a condom. And then they went out and did an awful lot of shoe leather type work at the community organizing level to get merchants who cater to young people in the Portland area to permit these machines to be put up in their places of business, in the rest rooms and in other places. And it is—up to now the evaluation we have done on it in our public health department has been working with them on evaluating. It has indicated that it truly has been a successful intervention. And so we are very excited about this social marketing approach to condom delivery for youth and we are hopeful that it will be expanded in some other sites around the country.

Mr. WAXMAN. Dr. McAlister, many of the localities are now being called upon to develop prevention strategies and programs, have never done it before. What kind of support and technical assistance do the States provide to these local groups?

Mr. MCALISTER. Mr. Chairman, we are trying to give them everything we have got. We are trying to provide as much support and as much—not only copies of original literature, articles, but also layman summaries of those articles as we can. Because many of the representatives of these planning groups are people who do not have technical backgrounds, who in many cases wouldn't understand the full text of a scientific article even if we presented it to them. So we are trying to figure out ways that we can provide synopses and short bullet summaries of the intervention strategies that we know to be working.

CDC has been giving us an awful lot of technical assistance in this area. We have been given a community planning handbook that was developed by the academy for educational development that is getting rave reviews among our planning groups in our State. In our State, we are doing local planning, so we have got maybe as many as 30 different groups that are going to be doing this. And a lot of the people who are trying to weigh these different possible strategies don't have any knowledge of social science or behavioral science.

Mr. WAXMAN. Ms. Fox, what about your organization, what response do you have for that?

Ms. FOX. As I said, CDC selected five national minority organizations to do technical assistance around parenting inclusion and representation. From the point of view of my agency, we are primarily working around those issues with communities in color. I know that NAPA is working around those issues to ensure the inclusion

of people living with the virus. And we have been assigned to two regions of the country.

We have about—I guess about 15 different sites. Thus far, we have been out to seven of those various sites. A lot of the issues that I found to be of concern is basically the amount of information that people are supposed to absorb, and also the level of expertise that they feel they have to attain, backed up against the very short time lines that are associated with this program. But we have also just been—we basically have been telling people to give it time, that it will be a matter of time. We have made efforts to explain how community planning came about, what is expected of the participants, and we have also done some technical assistance with health departments.

Mr. COBURN. Mr. Chairman, if I could add, I think, you know, as I said, we have been very supportive of CDC's implementation of community planning. I think one grave concern that we do have is the cuts in staff positions at CDC. I think we all appreciate the need to downsize the Federal Government. Unfortunately, I think CDC has been hit with a staff cut of 15 percent on average in the divisions that are responsible for implementing this new initiative. And we are very much concerned about CDC having the staff capability to provide the kind of oversight that this new initiative needs.

Mr. WAXMAN. Dr. McAlister, let me ask you this question. Overwhelming AIDS cases in this country are gay men, drug users, aside from the hemophiliacs. Do you think we are making a mistake to be talking so much to all people, all young people, including those who are heterosexual about condoms and connection of sex and AIDS? Do you think we make the mistake, spending as much money on that overall approach and do you think we ought to direct our efforts in the prevention area to specifically the gay male population and drug users, taking into consideration that there are differences culturally, geographically, with those of color?

Mr. MCALISTER. Mr. Chairman, I do not think we are making a mistake in trying to communicate with as many sexually active, both young and older Americans as possible. I do think we are making a mistake to spend significant amounts of our limited prevention resources in those strategies. I think that communication is one thing. Putting money where our mouth is is something else.

Again, I think we need to reserve the investment parts of our programs for the populations that are truly at demonstrably highest risk. That is where this epidemic is continuing to unfold. It is very easy for us to look down the railroad tracks and see the train headed towards the sexually active heterosexuals, as we have seen in central equatorial Africa. But the fact is the train is going through the gay community and through the injection drug using community in our country right now, and that epidemic is real, and we need to be spending most of our money and target most of our prevention resources to those populations.

Mr. WAXMAN. Anybody else want to comment on that? Mr. Coburn.

Mr. COBURN. I couldn't agree more. It is a real tricky line, the example of the gay community. I think that it is important that we acknowledge that our community has made significant changes in

behavior. But somehow I think with some folks putting forth that message is the hidden message of, well, therefore the Federal Government and the public health establishment doesn't need to take care of the gay community, because they have already taken care of themselves, and that the reality is for, you know, gay men living in communities that have been ravaged by AIDS, coping with the grief of losing 50 of their very best friends, that trying to practice safer sex ordeal with their chronic, you know, depression without drugs, is an awfully tall order. And that our community needs and deserves the leadership from public health, and that we as a community also need to reinvigorate our prevention efforts to deal with the long term of living in an epidemic that is now in the middle of its second decade.

Mr. WAXMAN. Well, you have all been very helpful in coming before us and answering these questions and giving us your testimony, and this hearing is to update the committee and the Congress on where we are and continue our oversight and to evaluate these legislative proposals that we are going to need for the future. I thank you very much for being here. That concludes our hearing for today. We stand adjourned.

[Whereupon, at 12:13 p.m., the hearing was adjourned.]

86-462 (72)

ISBN 0-16-046687-3