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SENATE COMMITTEE ON HEALTH & HUMAN SERVICES

Senator Diane Watson, Chair

Hearing on

AIDS IN MINORITY COMMUNITIES

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INTERIM HEARING

SENATE COMMITTEE ON HEALTH & HUMAN SERVICES

AIDS IN MINORITY COMMUNITIES

STATE BUILDING

ROOM 1138

107 SOUTH BROADWAY

LOS ANGELES, CALIFORNIA

MONDAY, DECEMBER 14, 1987

10:15 A.M.

Reported by:

Evelyn Mizak
Shorthand Reporter

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P R O C E E D I N G S

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CHAIRPERSON WATSON: I would like to call the hearing to order of the Senate Health and Human Services Committee to look at AIDS in the Minority Communities.

The staff members that we have with us, on my right and your left is Jane Uitti, and Sylvia Zetter, who was in the seat next to Jane a few minutes ago.

I'd like to wish all of you a good morning, and welcome to this hearing on AIDS in the Minority Communities. Today we're going to hear from many experts on AIDS, and from community outreach persons, and persons of color who have been exposed to AIDS, or who are at risk of exposure.

The California AIDS picture is quite different from the total national picture in AIDS demographics. For example, around half of the AIDS cases nationwide result from high-risk homosexual behavior. In California, this behavior results in over 80 percent of our cases. And while drug use accounts for one-third of the incidence of AIDS cases nationwide, it represents only 5 percent of the cases in California.

However, as the percentage of cases in California attributed to drug use continues to rise, and as the rate of growth through homosexual transmission continues to decline, California is beginning to move towards the demographic breakdown we are seeing around the rest of the country. The bad news is that higher numbers of minorities are becoming infected.

I hope that today the Department of Health Services and the Department of County Health Services will give us whatever statistics they have. These are pretty new and broad at the current time, but we do hope that whatever rough and dirty statistics they might have, they'll be able to give to us.

Well, I guess we can call it the not-so-bad news, and that is that California is still in the early stages of the heterosexual transmission that is much more prevalent on the East Coast, so we can still take preventative measures to slow down the spread of AIDS as it relates to the general population.

There are some interesting statistics on the way AIDS is affecting minority communities nationwide and right here in our own state. Around the rest of the country, Blacks and Hispanics are disproportionately affected. Although representing 12 percent and 16 percent of the general population respectively, they represent 24 percent and 14 percent of all AIDS cases nationally.

However, here in this state, the Department of Health Services tells us that Blacks represent 9 percent of all cases in this state, and Hispanics represent 11 percent. Although these figures are lower than national figures, the rate of growth in minority communities is certainly a cause for alarm. The rate of increase is much faster in minority communities than the non-minority communities. The Department of Health Services and other organizations will present data here on the growth, I hope, during their testimony.

Although the Center for Disease Control doesn't require a breakdown of other minority populations, we have representatives from the Native American and the Asian-Pacific organizations who will discuss the spread of AIDS in those populations.

Our agenda is organized into several sections, starting with State and local government perspectives, testimony from health care providers and researchers, and followed by observations from the community-based AIDS and minority organizations.

We do hope that at the end of our hearing, if there is time left, then any of you in the audience may feel free to come up and testify in front of the Committee.

Just last week I went into New York with our Select Committee on AIDS. We toured one of the major hospitals in the City that has done the foremost research and has an effective program dealing with AIDS victims.

We also went into the State Department of Education, and we had people there from Corrections also, to hear of their program. We went into a very interesting program. It's a community-based, nonprofit, volunteer organization, former addicts, who are volunteering their time to go into the shooting galleries, to go to where people are who use needles that are circulated around among the group -- the IV drug users. These are the unreachable people, but this very brave and courageous group has volunteered to go in and seek these people out. And the stories are very frightening; they're very grim. But the

light at the end of the tunnel is the fact that they are going to where these people are, and they are making a difference.

One story that I recall is of an abandoned building. And by the way, "20/20" did a story on Yolanda Herrera, who is the Executive Director. This woman has a full-time job as a medical social worker. In her part-time, in the evenings and on the weekends, she heads up this program. They go into these shooting galleries, usually abandoned buildings. The people who are really running those -- I wouldn't call them programs -- running the shooting galleries are very street-wise and sophisticated. These buildings are almost inaccessible. There are no stairwells, no elevators, so you have to literally put your feet in the slats in the wall to get up to the third and fourth floors where they usually operate. They do that so law enforcement can't get to them easily. And all over the floors there are dirty needles, and spilled blood, and all kinds of works that they use in this kind of trade.

She went in there with cameras. And they allowed the cameras in only because she approached them in the vernacular, she approached them with people they're familiar with, and she approached them offering help. They allowed the cameras to come in, and those of you that saw "20/20" know the rest of the story. They were able to film people injecting the drugs into their veins and going through what they call a "bunting", where they put the drug in, take it out, take blood out, and put it back in to give them a faster and more continuous fix, and without any thought of threat to their very lives.

She goes in to educate these people. They take with them kits. In those kits they will have bleach; some will have needles, sterilized needles, and instructions, and booklets and condoms.

And they are realizing some bit of success now, but I guess the painful part about it is that most of the people there in the shooting gallery had no idea about the way AIDS is spread. They had no idea about how it would threaten their very lives, and more so than their lives, the lives of their lovers, their spouses, and the people within their household if they had a home.

So, there is some courageous work going on in programs across the county. New Jersey also has a similar program to that. We went into the Gay Men's Health Center, and in New York they're doing quite well. They have no public monies that come to them, but most of their money is money that's raised through charitable organizations. It looks like they're doing quite well; they're building a new facility, and they are curbing the spread of AIDS among homosexual men and women in the City of New York. They're doing a stellar job, and there'll be more on that report at a later time.

We will follow the agenda as best we can. If a person is absent, we'll just go right over that person's name and try to pick them up as they come in.

We have divided up our speakers. First we'll start with State and County people, then we'll talk with people from hospitals, physicians and so on, and then our third category will

be to hear from community organizations who assist minorities, and our final statement will be with private industry and any individuals in the audience that wish to speak.

I'd like first to call up Thelma Fraziear. She's Chief of the Office of AIDS with the Department of Health Services.

If you do have handouts, if you'll just hand them to our Sergeant, then we'll get them. And any written testimony you have, we would appreciate it, and this will be circulated among other Members of the Committee at a later time.

MS. FRAZIEAR: Madame Chairwoman, ladies and gentlemen, I'm Thelma Fraziear from the Department of Health Services, representing Dr. Kenneth Kizer, Director, Department of Health Services.

I have some written testimony which I have passed out, and therefore what I will do is just kind of brief that, rather than attempting to read the entire testimony, to give you a little brief background of the Office of AIDS and when it was created, and then go into some statistics, and from there into a little bit more focus on the Office of AIDS.

The Office of AIDS was created in 1985 to provide information and education, epidemiologic investigation and surveillance, research and treatment to address public health problems related to AIDS. Initially, our first year, full year of funding, which was 1985-86 or '86-87, the major emphasis was put on the homosexual community. And many of our dollars went to provide information and education for that population.

With the information that the AIDS problem was moving into the minority population, we have put more emphasis on that population in this current fiscal year. But first some statistics. As of October the 31st, 1987, there were over 10,000 cases of AIDS reported in California, of which 11 percent were Hispanic and 10 percent were Blacks. This is a contrast to the total population in California of 7½ percent Blacks and 19.8 percent Hispanic.

There is a total population in California of Asians, 5.2 percent, and yet the AIDS cases are only slightly more than one percent in that population.

Nationally, Blacks and Hispanics compose 24 percent and 14 percent of the total cases respectively -- I'm sorry, they're the total populations nationally. However, they comprise 35 percent of the IV drug user population.

Homosexuality and bisexuality account for 87 percent of all White AIDS cases in California. In comparison, 69 percent of all Black AIDS cases and 78 percent of all Hispanic AIDS cases are in the homosexual/bisexual risk category. Intravenous drug use accounts for one percent of all White AIDS cases in California. In comparison, 9 percent of all Black AIDS cases and 6 percent of all Hispanic AIDS cases are attributed to intravenous drug use.

In California, there have been 53 pediatric AIDS cases, of which 47 percent are White, 10 percent are Black, and 17 percent are Hispanic. Nationally, minority children compose 77 percent of the 641 pediatric AIDS cases.

To give you a little bit more information, I pulled some statistics as of October the 31st, 1987. The Blacks in those cases were 1,002 or 10 percent, which was 63 additional cases since last month. Hispanics were 1124, or 65 additional cases since last month. In California, minorities represent 21.5 percent of reported cases. In the pediatric population in California, 19 percent were Black and 32 percent Hispanic. Of the total pediatric population with AIDS, 47 percent were instances where the parent was at risk of having AIDS.

One of the other things I asked staff to do was to look at a difference between what happened last month and -- I'm sorry, what happened last year and what has happened since the end of August, 1987. Prior to 9/01/87 [sic], there were 606 Black AIDS cases. In between 9/01/86 and 8/31/87, there were 300 cases diagnosed for that year, or a percent increase of 52.3 percent. Prior to 9/01/86, Hispanics were 649; there were 377 cases diagnosed between 9/01/86 and 8/31/87, for a total of 58.1 percent. Asian prior to 9/01/86, 77 cases; 44 diagnosed between 9/01/86 and 8/31/87, for a total of 57.1 percent.

The increase in minorities, while it was 20.6 percent of the cumulative AIDS cases prior to 9/86, it was 23.4 percent of all cases diagnosed between 9/86 and 9/87 in one year. As we can see, there is an increase in the minority population relative to AIDS.

The Office of AIDS currently has a total budget of 47 million out of a total State budget of 63 million. Out of that 47 million, 11.6 percent is in education and prevention. Some of

that money is utilized for statewide projects; the other is used for education for the target high-risk population. That's 6.8 million. Out of that $6.8 million, approximately 33 percent is going into the minority community. Out of that also, we also have some minority projects. We currently have seven minority projects at approximately $100,000 each. Five are housed in minority-based organizations; the other two are in Saint Mary's Medical Center in Long Beach and Visiting Nursing Association of San Diego County. These dollars were given out so that we could do a needs assessment in the minority community basically to find out what are the needs of the minority, and what kinds of services should we be planning.

What we have looked at next year in terms of use for those dollars is to combine those with our case management systems and assure that out of the total pilot project case management budget of $5 million, that at least 25 percent will go into the minority community.

Some of these dollars are also used for literature. I know this gets to be a touchy subject in terms of the Department's approval for literature, but we do have a committee that is set up to approve all literature that is developed or distributed with State dollars. We take a look at those and try to make sure that at least they are sensitive, and that there is not the use of street language.

There is some concern that we are censuring this to the extent that it is not relevant to the various communities. While I will not say that is not happening, I think we have to be

sensitive in terms of spending State dollars for what, in many instances, could be considered offensive and could, in essence, create some problems for the entire program as well as the literature that is given out.

There have been some risk reduction guidelines just recently developed we will incorporate into every last one of our contracts. These were worked on by various people within the community. That at least will be in use out there.

Looking at our projections, we have figured that the incidence of AIDS in the minority population/IV drug user population will increase, specifically as it relates to pediatric AIDS. It's an area that we haven't taken a look at, but we have seen some increases in that population, and we will be putting further dollars into that.

I did contact Alcohol and Drug Abuse relative to their money that they had received this year to find out exactly what the use of those dollars were for. I'm told that it is used for education and prevention and treatment -- and some treatment slots. So, we will keep working in this area.

For the next fiscal year coming up, at this point we are still within our existing budget, we have decided that we will go with what we call multi-year contracts, so that some organizations will have contracts for two years, some for three years. We will take one-third of those dollars and put it back out there for new projects that can come in for funding. This will be at least $3½-4 dollars, and out of that $3½-4 million, at least 85 percent will be going into the minority community.

I will stop at this point to see if there are any questions.

CHAIRPERSON WATSON: Yes, thank you for your statements, Ms. Fraziear.

I am troubled, because I have been traveling around the country, visiting State Departments, picking up information, and bringing it back, and I'm embarrassed. I'm saying this for the general public. I am embarrassed that the State now, running to have the largest number of AIDS patients -- and I understand just today we went ahead of New York; is that correct?

MS. FRAZIEAR: I'm not sure. I left at 6:30 this morning. We were about even with them.

CHAIRPERSON WATSON: Yes.

That we are not spending more in education. As you were speaking, you mentioned 11 percent for education and prevention. That is a disgrace. It has nothing to do with you, Ms. Fraziear. We determine how much money goes into the budget, and I'm holding the Legislature and the Executive Branch responsible for that. This is more a statement than it is a question.

We are spending 33 percent in the minority communities for a needs assessment. We just realized that Black people get AIDS too; that's a new button that is out now to tell us that we're at risk.

But I'm really troubled, because we have not learned yet how to go about doing an outreach program. We did establish a department when we found out we were really in the middle of a crisis, and I'm really pleased to know that Ms. Fraziear is

heading it up because I know of her sensitivities, but she can only do what we allow her to do.

I'm not putting you on the spot. I'm using the opportunity in your presentation to make these statements of my frustration.

It is a statewide disgrace that U.S.A. Today, December 4th, reports that 17 states and the District of Columbia now require AIDS instruction in schools, and California is not listed. We have the largest population. We're putting millions of dollars. We have a $47 million budget, and no mandatory educational program. That is a disgrace.

Coming from this Committee, this Committee Chair, will be legislation. Senator Gary Hart heads up the Select Committee on AIDS and put together the trip to New York. He is going to reintroduce a piece of legislation that was vetoed by the Governor. That legislation would have required the development of a video tape to be used in grades 7-12, and we got some kind of response back from the Governor's Office in his veto message that is troubling at best.

We're sleeping through an epidemic. We're sleeping through a crisis.

And Ms. Fraziear, I hope that you will recommend to the Governor that unless we put money into education, we're going to lose the battle. Now, the $47 million in that budget is going to go for naught unless we start with some preventative methods.

I'm going to take this opportunity to ask, what is on the drawing board for an educational program that is required in our schools throughout the State of California?

MS. FRAZIEAR: Before I answer that, let me make some corrections.

When I talked about the 33 percent for minorities, that is not all in needs assessment. Only 700,000 of that is, not even out of the 6.8, is needs assessment. That's a different pot of money.

Out of the 6.8, 33 percent is going into the minority community.

CHAIRPERSON WATSON: Where is the other going?

MS. FRAZIEAR: That's statewide for the other high -- not statewide, but that is for the other high-risk populations, the homosexual/bisexual.

CHAIRWOMAN WATSON: No, I drew on that 33 percent in the minority community. This is a minority AIDS hearing, so I am zeroing in on that statement.

MS. FRAZIEAR: Okay. What we have done this year, even though the Governor did veto the education bill, we did take $350,000 out of our money and give it to Department of Education to do some training in the schools.

CHAIRPERSON WATSON: What are we doing to require schools? Are we making a recommendation?

MS. FRAZIEAR: We're making recommendations more than requirements.

What we have done this year, while it is not getting to the students per se, we are paying for training in continuation schools, which is a group that is very high-risk. That's at least a start.

We have not required that Education do anything. I don't see that on the front burner. It might happen, but we will continue to work with the school systems.

CHAIRPERSON WATSON: I appreciate your response.

What occurs to me is that we need to start with our young people. They are becoming sexually active in elementary school. They, too, need to understand.

I saw a very sophisticated curriculum that was developed by the people in New York's Department of Education. They developed it in conjunction with the Legislature, with the Governor's Office, community groups. Each segment of the community that would have interest in the area sat down and talked about how we should start orienting young people to be able to protect themselves from the menace that threatens all of us. And what I saw was not offensive. It was something that I think most parents would want their children to be a part of. They appeared not to have had the kind of opposition that we have when we talk about sex education or AIDS education in our schools.

Of course, you get the moral ethical arguments, but they did not bog themselves down with those. They offer an opportunity for parents to be able to keep their children out of those classes, but they are doing something.

I would hope that in the very near future, that the Department of AIDS of recommend that we do something in this regard. Even if it doesn't come from that direction, there will be those of us that will be introducing legislation. I know that

we'll have your cooperation, and I know that you will be willing to share the information that you have given us this morning and any additional information that you have.

Just know that we're going to be moving down this line, because I think if we don't get into education, we are just fighting windmills. So, we're going to be pushing in that direction.

Thank you so much for being here today.

MS. FRAZIEAR: You're welcome.

CHAIRPERSON WATSON: I'd like to call up now Dr. Caswell Evans, the Assistant Director with the Los Angeles County Department of Health.

Dr. Evans, thank you so much for the letter that you sent to me in response to my letter on the Inglewood Women's Hospital. It seems like we're highly in the news today, but I do appreciate your response. That helps to clear up the reason why I sent the letter.

DR. CASWELL EVANS: Thank you.

Good morning, Senator Watson, other distinguished Members of the Health and Human Services Senate Committee.

I'm pleased to address you this morning on a very important matter of AIDS in the Black and Hispanic communities. As the third ranking U.S. metropolitan area in terms of numbers of cases, Los Angeles County faces a mammoth problem in terms of its fight against AIDS.

As of the end of October, 1979 [sic], we have reported 3,869 cases of AIDS. Of that group, 2,420 individuals have died.

Of the 3,869 cases, 14 percent of that group, or 542, would be Black, and 15 percent of that group, or 594, are Hispanic.

CHAIRPERSON WATSON: Can you give us those percentages again, please?

DR. CASWELL EVANS: Total cases: 3,869; percent Black, 14, representing 542; percent Hispanic, 15, representing 594.

The majority of cases in Los Angeles County, that is 70 percent, to date have been amongst White homosexual males, and the local gay community has, for the most part, responded promptly and compassionately to this disease.

Black and Hispanic communities, however, have yet to fully come to grips with this epidemic, and it is on this point that I will focus my remarks this morning.

It is my belief and observation that local minority communities may be at a higher risk for contracting AIDS, especially in the future, when compared to the White heterosexual population. This may be happening for several reasons. One reason is the disproportionate share of minorities constituting the local IV drug using population. To date, 3 percent, or 109 cases of AIDS in Los Angeles County, are among strictly heterosexual IV drug users, and 11 percent of total cases, regardless of sexual preference, reporting having used IV drugs. Of the 109 heterosexual IV drug users, 39 percent of the cases are Black, and 32 percent of those cases are Hispanic. This would compare to only 28 percent of those cases as being Caucasians.

The effect of the IV drug using population on AIDS in the future and certainly now, particularly in the future, cannot be under-stressed [sic]. If we look at New York City, for example, New York City now reports over half of their cases coming directly out of the IV drug using population. Correspondingly, over half of their cases are now coming out of the minority populations.

In Los Angeles County, with an estimated core population of IV drug users in excess of 80,000 individuals, we estimate, based upon our most recent seroprevalence survey, that approximately 5 percent of those individuals are now seropositive for human immunodeficiency virus, or HIV. If that is the case, then that leaves approximately 76,000 individuals who are IV drug users who are at high risk for contracting this disease who would be seronegative. We know that that group is substantially minority. That is the reservoir that represents a very dramatic and potent second wave of AIDS that we need to address and address immediately, because that represents a substantial opportunity for disease prevention.

While the West Coast generally has a much lower seroprevalence rate of human immunodeficiency virus, or HIV, when compared to the East Coast amongst IV drug users, there are preliminary indications that the rate on the West Coast is climbing, and that AIDS cases among IV drug users are likely to be the second wave of disease.

If this does occur, there will be many more minorities impacted than Whites since the local IV drug users are disproportionately from minority communities.

Worsening the picture is the fact that IV transmission -- HIV transmission among IV drug users, and between IV drug users and their sexual partners, is the principle bridge to the heterosexual and pediatric transmission of the virus. For example, to date in Los Angeles County, we report 21 pediatric cases of AIDS; 12 of those cases are transfusion-related. But when we look at the 9 cases where it's the parent who is at risk, 100 percent of those 9 cases, all 9 children, are minority.

Thus, we are clearly no longer talking about a disease spread amongst consenting adults, but also a disease that will spread amongst minority women and children.

Another reason why I and a number of persons working in this area believe that Blacks and Hispanics are more at risk for AIDS is the traditional taboo that both cultures place upon heterosexuality [sic] and bisexuality.

CHAIRPERSON WATSON: You mean homosexuality?

DR. CASWELL EVANS: I meant to say homosexuality and bisexuality.

CHAIRPERSON WATSON: You said heterosexual.

DR. CASWELL EVANS: Oh, I'm sorry. I've got a cold coming on and my ears are plugged up. I can't even hear what I'm saying. I meant to say homosexuality and bisexuality.

HIV transmission in AIDS becomes even more dangerous when the problem is not acknowledged. The difficulty of discussing AIDS openly in minority communities has meant that many persons have been exposed to this inevitably fatal disease as a result of lack of information or embarrassment over discussing the modes of transmission.

It is clearly an urgent matter for both the public and private sector to deal with even more intensely than we have to date.

At this point, I'd like to summarize briefly the AIDS education and prevention activities conducted by the Los Angeles County Department of Health Services and currently taking place in minority communities.

We have minority staff in the Black and Hispanic communities within our overall AIDS education program. We provide outreach through training sessions, presentations, coordination of conferences for community leaders, liaison with community planning groups, and coordinate services among subcontract agencies. We provide health education services intended to prevent the spread of HIV infection to schools, community organization, and public agencies, and we will soon be undertaking an AIDS health education program in County detention facilities.

We are not providing these services alone, however. There are growing numbers of private, nonprofit agencies also providing these services in minority communities. However, the numbers of those agencies are still far too few.

It is too early to say how successful our health education efforts have been; however, we do plan to measure the level of community understanding of AIDS through a knowledge, attitude and behavior survey to be implemented through a subcontract agency.

However, as long as some groups within the population, minority or otherwise, still engage in high-risk unprotected sex or share needles, our efforts will have not been strong enough or our messages clearly not well aimed. While the basic message needs to be the same for all ethnic and racial groups, we are in error if we send the same word out to all groups without making modification for its cultural context. Each of us learns within our own experiential frame of reference, language, and subculture. Our experiences in any one area, especially in an area as personal as sexuality or drug abuse, strongly dictate how we receive and interpret information, and what sort of information we're willing to consider. One's educational level is clearly a factor. Regardless of the ethnic makeup of the audience, presentations and educational materials need to be clearly understandable by the recipients. This may sometimes mean presenting information in a pictorial format with little written or didactic material if it can be assimilated easier by the audience in that way. What I am advocating is giving the same message to everyone, but packaged to meet the specific needs of each group.

Just as it is vitally important to consider the cultural and experiential background of any group receiving AIDS education and services, it is equally important to consider where the persons are receiving this information. I believe that information on AIDS must be disseminated to minority communities in the widest possible array of venues. We have to look at this problem with new eyes and get the message out to the whole

population. There's obvious worth in sending the message out to more traditional institutions, like schools, mental health and drug treatment programs, prenatal, family planning and health clinics, but in each of these cases, the message is getting out to only segment of the population. The audience that needs to hear the message, perhaps modify its behavior, and at the very least develop a greater understanding of AIDS, is certainly wider than groups that would be attending the previously mentioned services.

We need to get the word out to the entire population, and we think how to do this so that we can reach the widest group in the most effective manner, churches in the minority community are obvious key focal points for dissemination of AIDS information. But there are large numbers of places where people congregate and wait, and it's in these locations that they might be available to hear a message, or read a message. We need to consider a location such as supermarkets, local physicians and dentists offices, fast food restaurants, movie theaters, video rental stores, convenience stores, malls, and others.

The only distinction between these sites is the location where the message is given out and the impact of the location upon the message. A message delivered through a church would obviously need to have a different wording when compared to one delivered through a convenience store or a family planning clinic.

Our goal is to disseminate the information in an accessible, useful format that does not turn off the audience and

is acceptable to the community standard. We need, however, at the same time to be frank and direct in our terms so that they are understood and so that people can act upon the information and change their behavior accordingly.

You have asked whether the State is doing enough to provide AIDS education to minorities, and what it needs to do to improve its efforts. To my knowledge, the State is not providing any source of direct or educational efforts related to -- direct services or educational efforts related to AIDS. Its involvement to date has consisted of financial support to communities in local areas to fund educational programs and services in the community, and certainly this is a very important area of assistance.

The State should continue to monitor local efforts as to where these monies are going and what communities or groups are receiving the benefit of these services, and continue to identify gaps. However, the State's increased involvement in reviewing proposed AIDS educational material could prove, in the long run, to be more of a hinderance than an assistance. The whole state would benefit, though, from frequent statewide public service announcements, or any other display of statewide public policy on AIDS issues. This would be particularly helpful if the messages were directed to specific groups, such as teenagers, drug users and pregnant women, especially in the minority communities.

As an example, there have been recent legislative efforts to develop and implement a statewide policy on AIDS education for our school children. If this were enacted at the

State level, my Department would stand ready to provide implementation assistance to Los Angeles County schools. This would represent a productive stance on a statewide need that should be instituted at the local level. This would be a good State-County collaboration.

In closing, I'd like to add one final comment. I believe it is of the utmost importance that if and when the State contracts for services directly with community agencies, that they inform and involve local health departments and jurisdictions so that we can avoid duplication of our efforts and better coordinate our activities.

I thank you very much for this opportunity to address the Committee, and am prepared to answer any questions if you have them.

CHAIRWOMAN WATSON: Thank you very much.

It has been reported that the Department has been a bit slow in utilizing the State funding. Maybe it's because you've been studying the issue, trying to see which is the best way to move. I'd like you to comment on that.

I'd like you also to comment on what the Department's actually planning. We probably will entertain several pieces of legislation at the beginning of January that might enhance what will take place in the counties.

Can you give us some outlines, a description of what you plan to do in the new year?

DR. CASWELL EVANS: Regarding our expenditures, we have initiated a five-year planning project to help us identify the

issues, the magnitude of the problem, and to lay out some of our options over the five-year period so that we can address AIDS in a broader time-frame as opposed to just one-year planning and budget horizons.

Some of our delay in spending our funds has been to get a better sense from some of the preliminary information coming out of the five-year plan, so that our funding endeavors and our projects can be in keeping with the overall intent of that five-year plan.

We would expect, however, that all of our expenditures will be completed as planned within this fiscal year, and don't feel that the delay in any way jeopardizes that activity.

For the future, I think, as I stated, I think it's very important for additional statewide policy, especially in the area that would encourage AIDS education in schools. I think that the potential for young people to increase their risk of transmission is growing, and is growing rapidly. I am very concerned about the potential for a far rapid spread of HIV in our communities, as represented through the IV drug using population. I don't think that we have thoroughly come to grips with that issue, either at the national level or at the State level or the local level.

Per the data that I reported to you, we would have, per our estimate in Los Angeles County, approximately 76,000 IV drug users who are at high risk by virtue of that activity. This group represents the largest known reservoir of potentially IV positive [sic] individuals, and that is the group that I think we

need to really come to grips with. We need to be thinking in terms of increased treatment facilities. We need to be talking in terms of increased methadone maintenance slots, because if there is a prevention opportunity, where we have a known and calculable risk, it is clearly in the IV drug using population at this point in time.

CHAIRWOMAN WATSON: Your five-year plan is being developed at the current time. How long will it be before you finish the plan and get to some programs?

DR. CASWELL EVANS: Well, we're not putting our current year's activities on hold. We do have programs underway. We do have services underway. So, our system is not on hold pending the outcome of the five-year plan, but we would have the five-year plan available to us by February, 1988. And we would expect that that plan, therefore, will be quite useful to us in finalizing our budget proposals for 1988-89 and subsequent years.

CHAIRWOMAN WATSON: In looking at the way we have expended our money, appropriated our money in the State of California, a great majority of our money has gone to research and to testing, researching various drugs and treatments, and testing programs. Not enough has gone for education and prevention.

In your presentation, I heard you speak of contracting with a private concern to go out and test the attitudes among people, if I have it correctly, in the minority community. If not, you can correct me. And I'm a bit concerned that we don't continue going down the path of putting a lot of our money for

AIDS into this kind of research, and formulating surveys and so on, and not really getting into programs.

I would like to see a quantum leap made by the State first, and I think your recommendation that the State inform the local Department of Health Services when we fund community programs is a good one, and one that I intend to take back, so that you will know what we're doing. But I think we need to get about the business of getting out and doing outreach.

I am not quite so sure that I heard you describe what outreach programs are that are in existence now, and what you would be, say, in '88 promoting. Can you just run those back past me very quickly?

DR. CASWELL EVANS: I tried to summarize them very quickly.

We have subcontracts, for example, with community agencies that would provide conferences, seminars, meetings with community groups and community leaders, to provide education to those individuals sort of on an each-one-teach-one sort of format. So that these leaders can go back to their respective organizations and provide some leadership there.

We work with school systems, community organizations that have an interest in AIDS, and we work with community organizations where we feel that they should have AIDS on their agenda but don't appear to date to have AIDS on their agenda.

Certainly in addition to that, we are providing alternative testing, both on an anonymous basis and we're also developing the confidential capacity for confidential testing.

There's a great deal of health education that goes on with that activity.

In our drug areas, we're bringing on line additional methadone maintenance slots. We work with each of our drug contract agencies to ensure that they have a designated --

CHAIRWOMAN WATSON: Excuse me, on that methadone maintenance and the methadone program.

How large is that program in Los Angeles County?

DR. CASWELL EVANS: In terms of the numbers of slots?

CHAIRWOMAN WATSON: Yes.

DR. CASWELL EVANS: I don't have the specifics of that, Senator Watson. We are enhancing, though, the number of slots that we do have. I'm just not at this point in time -- I can get that information to you, but I just don't know offhand the number of slots that we do have. But I do know that we are enhancing those numbers of slots and bringing more on as a method of trying to get more people from relying upon intravenous drug use.

CHAIRWOMAN WATSON: I guess I'm not hearing what I'm listening for, and that is, programs that the County has set up directly to affect those who are at high risk in minority communities as you are contracting out. And I hear what's intended, and I hear the maintenance to increase in their number of slots in the methadone maintenance program, but I don't hear enough about what the County is doing directly.

You're the base that we're going to have to depend on at the State level. And certainly, we need to inform you when we go directly to community-based programs. But I think the County has

to be the collective spot that handles these programs. I think when we talk about outreach, you have your hands on the community at the local level. I think you are going to have to do more in direct programs to the high-risk community.

There are outfits out there that have been doing some things that are innovative and creative and effective, but to serve the masses of people in L.A. County, and we're at such a crisis level that I don't think these small community-based facilities are going to have the resources to do more.

You talked about $100,000 appropriations. That's a couple of salaries, and rent, and other kinds of sort and hard materials that are necessary.

I think the County, like our county hospital system, is going to have to be the resource of last resort.

I certainly just recommend to you that if you can do more in terms of direct outreach, we will try at the State level, I will try at the State level, to see that the funding increases to the county level -- because I think that's where the action is, and I think you've got your mechanism and your structure to handle such direct programs. I think I'd like to see you do more in that area.

DR. CASWELL EVANS: I would certainly agree. It's a very high priority with us.

Frankly speaking, though, we have put in a lot of time getting more community organizations to recognize AIDS as a priority need in the community and encouraging those organizations to look at AIDS as an issue that they ought to be

spending their organizational resources and energy on. That effort is now paying off, and we have increasing numbers of organizations who want to work with us, and at the same time, we are prepared to work with them. So, I'm certainly encouraged by the future. I couldn't agree with you more.

CHAIRWOMAN WATSON: There's one of the hospitals in the County system that has been working. They have organized a program out of their Department of Family Medicine. What they're doing is, they're training their doctors, their resident doctors and interns, who then work with the family, and from the family to the schools. And these programs are operated by doctors, those who know something about this disease and how it affects the body. And they're training others like themselves to go out and train people within the educational community.

This is something that has struck me as very useful, and I intend to put together maybe a piece of legislation that would use that as a pilot, because I think that if we can bring the medical community directly into it, and especially into these community groups that you're trying to convince that they have a role to play, I think we're on the right track.

There is too much misinformation out there. There's too little understanding, especially in the minority community. I think people don't really understand the biology of it. And I think we're going to have to use the medical community more.

I just mention that to you, and I hope to talk to you at another time about what I have planned.

Thank you so very much, Doctor. I appreciate your testimony.

DR. CASWELL EVANS: Thank you very much.

CHAIRWOMAN WATSON: Dr. Pat Evans, Associate Medical Director with the AIDS Office, from the San Francisco Department of Health.

DR. PATRICIA EVANS: Good morning. My name is Dr. Patricia Evans, and I'm here representing Dr. David Werdegar from the Department, who is head of the Department of Public Health in San Francisco. I am the Associate Medical Director of the AIDS Office for the San Francisco Department of Public Health, and I'm also the Branch Chief of the Prevention and Education Section.

I have submitted some written information to you. One of the things I'd like to point out is that the last sheet report that you have is our monthly statistics from July of '81 through 11/30 of '87. And as you can see there, we've had a cumulative total of 4,111 cases of AIDS, and 2,458 deaths of AIDS.

In terms of ethnic minority breakdown, if you go to the second page, you'll see that Black constitute 6.4 percent of that total population; Latinos 7.2 percent; Asian-Pacific Islanders 1.8 percent; and Native Americans .1 percent.

I applaud this opportunity to testify regarding AIDS in minority communities in relationship to Blacks and Hispanics. However, I would like to express the possibility of an apparent oversight, but I see that in the testimony that will follow, that the Asian communities as well as the Native Americans are going to be represented. These two groups are oftentimes overlooked

because they tend to be lumped together in the "Other" category relationship to the statistics, nationally as well as statewide. And it's understandable why these communities are oftentimes overlooked.

As a Black female, I do not profess to speak for all minority communities, nor can I speak for the entire Black community which is heterogeneous, as are other minority communities. There are other speakers who, I'm sure, can better address the needs of their respective communities.

I would like first to provide some additional background information on ethnic minority statistics from San Francisco. Since 1981, when only 4 minorities were represented in the statistics -- 2 were Black and 2 were Latinos -- there has been a 56-fold increase in minority AIDS cases, with representation also from Native Americans as well as the Asian communities.

If we look at the Asian community, the total number of AIDS cases is 72. Of these cases, 32 or 44.4 percent are Filipino, 17 or 23.6 percent Japanese, 15 or 20.8 percent are Chinese, and the other cases are represented by the Vietnamese, Polynesian/Hawaiian, and other Asian communities.

Prior to 1987, there were no Native Americans noted until information from that community made us go back and look at the cases that had been reported, and two cases were actually identified who had died in 1986. This number has now increased to three.

Other differences exist among minority populations as well. For example, approximately 82 percent of the AIDS cases

among Blacks are gay/bisexual men who do and do not use IV drugs. For the Latino and Asian communities, these numbers are 93 and 89 percent respectively, compared to 97 percent for White males.

The national statistics differ significantly from these in San Francisco, as you had mentioned before. But the State of California will not forever be protected by the Rocky Mountains. Unless effective strategies to reach minority populations are developed, the national statistics will become a reality here in California.

I'd like to point out why I think that ethnic minority communities are at increased risk, and I have some statistics here in relationship to the rates of syphilis in San Francisco for 1987, looking at primary, secondary, and early latent syphilis. If we look at the ethnic breakdown, we look at White males, there were 90 cases; amongst Blacks it was 186; Latinos and other, 132; and Asians 8. If we look at the female cases, we're talking about 9 for Whites; 88 for Blacks; 36 for Latinos; and only 2 for Asians.

We tend to look at rates of syphilis because reporting seems to be much better than the reporting for gonorrhea. And I got this information from Dr. Gail Bolan, who indicated that generally speaking, syphilis is reported 80 percent of the time, whereas gonorrhea may be reported only 50 percent of the time.

So, if we begin to look at statistics from the substance abuse community, we can see that there is also increased risk for minority populations. Between July and September of 1987 in San Francisco, there were 1,688 admissions for detoxification for

polydrug use. Of these, 56 were White; 27 percent Black; 14 percent Latino; 2 percent Asian; and 2 percent Native American.

For alcohol detoxification, there were 8,034 admissions, with 58 percent White; 26 percent Black; 10 percent Latino; 1½ percent Asian; and 2 percent Native American.

Comparing these figures with the 1980 census data for San Francisco, Blacks and Native Americans are over-represented since they constitute 12.4 and .4 percent of the total population respectively in San Francisco.

In San Francisco, the Department of Public Health has played a central coordinating role for planning, development, implementation and funding of AIDS programs for the community as well as for the minority community. I would like to just briefly describe how we see our role there.

Because of the bureaucracy -- and I know that you've heard well of bureaucracies -- we have found it's to our advantage to actually subcontract the monies that we get in to provide the education to the community. It also became very apparent at the very beginning of this epidemic from the gay/bisexual community that the gay/bisexual community would not accept the word of the Health Department. This, too, seems to be the same within the minority communities, and our programs seem to be functioning much better when we use well-respected, community-based organizations to really provide the word in relationship to this particular problem.

The success of any of these programs, again, is predicated on the use of these community-based organizations who

can actually access the targets groups that need to be reached. Each of the risk behavior groups is unique and must be dealt with separately. Because denial still exists within the minority communities, more labor-intensive programs will be needed to educate the populace. Use of the media must be allowed, as evidenced by the surveys conducted in the Black and Latino communities in San Francisco by Polaris Research and Designs Corporation, as well as by Fairbank, Bregman and Maulin.

I'd like to point out -- because you've mentioned the use of surveys -- we have found these to be extremely helpful in San Francisco. The surveys provide us with the information that we need to develop our educational program. The follow-up surveys also assist us in redesigning and redefining the educational messages that need to be given to the community.

For example, in the Black survey conducted in San Francisco this year, we learned that the Black community does not even see AIDS as the number one problem. They still -- you know, the heart disease people, hypertension and other people have done a very good job, and so these things are considered the number one and two priorities. So, before we can even begin to access this community, we're going to have to start before the educational messages about AIDS. We're going to have to give people the information that AIDS is a number one priority in their own community now.

With respect to disseminating information, we have found that our efforts have been hampered by the cumbersome process for review and acceptance of materials for distribution by the State.

I'm talking about State-funded projects. Currently, the process requires approval or disapproval of the final product after all production costs have been incumbered. This places agencies at extreme risk, especially when the State does not agree with the material produced.

And as you heard Ms. Fraziear mention, they will not allow the use of slang. I'm not sure how we're going to reach the IV drug using population -- some of the teenagers that we have to reach are in school as well as out of school; some of the high-risk women that have to be reached and also the gay/bisexual community; ethnic minority community -- unless we do use languages that they understand and that they can relate to. And if the State continues to use the no-slang proposition, then we will not be able to reach these communities with State funding.

CHAIRWOMAN WATSON: Just a comment.

I couldn't agree with you more. In my query of the various program directors in our recent trip to New York, I said, "How are you successful?"

The first thing they do is, they send former addicts out. These are people that are known in the community -- this is with the IV drug user. So I would imagine the gays and so on, and they're doing a real good job, I feel, in the gay community -- but among the minorities, they sent people out that looked just like them. They were former IV drug users. They knew the street vernacular, and they do street talk.

Putting it in writing is another thing. However, I am sure that there are some ways that we can express the language in

a way that can be received, and I think it can be done in an inoffensive way.

We must get beyond our narrow-minded bias in this state. I hear the discussion and the arguments, because that's where they are in my Committee, and I couldn't support what you're saying more. I'm hoping that we can awaken the people of the Legislature in this coming session to the crisis we have on our hands. We've got to reach these people. We have to target these people. We have to do outreach.

I think what we need to do -- as you have mentioned and Dr. Evans has mentioned, and I think Ms. Fraziear was trying to say also -- that we need to find the groups that have been successful within the community, using their own resources, and buttress those groups. Give them the resources to be able to design a program that's workable, and get our hands out of it at that point, because we're not really addressing the problem, as I see it.

Thank you for making that comment. You may continue.

DR. PATRICIA EVANS: I'd just like to describe briefly our process for getting educational materials through our Department, because anyone who has a subcontract with us that is producing educational materials has to go through our review process.

As the Branch Chief for Prevention and Education, I have to review all the materials for the medical content to make sure that it's medically correct. Prior to that time, the community-based organization has groups, and they develop focus groups.

Focus groups are the target population that the material has to reach. And the focus group provides that community-based organization with information about the content of that piece, how it -- you know, whether or not it seems to be reasonable to them. Is it really going to make a difference for them.

And then from the focus group, the community-based organization takes that information back and redirects their particular content. It comes into our office for the medical review, and then if it is federally funded, we also have a Center for Disease Control review panel that reviews if for the reasonableness of the material. And what that means is, whether or not a reasonable adult will object to the materials being produced.

It is interesting that in terms of that panel, it is multi-ethnic: it has one gay on it; it has women; it has men on it, so it's a very well-rounded group. And they have not found any of our materials thus far to be objectionable.

CHAIRWOMAN WATSON: Do you have a description of this procedure that you use that we could have?

DR. PATRICIA EVANS: I will send that to you.

CHAIRWOMAN WATSON: Thank you.

DR. PATRICIA EVANS: AIDS information and counseling needs to be disseminated in whatever arena that will allow the target groups to be reached, formal and informal. And I agree with you that we need to get people out on the streets. Along with these approaches, nontraditional approaches must be tried.

For example, in San Francisco, we do have a street outreach program geared towards IV drug users who are not in treatment. This was done in conjunction -- Drs. Harvey Feldman and Patrick Biernacki have actually pulled this particular program together. They go through a full training process with their street outreach workers, who oftentimes are ex-IV drug users. So, they know the vernacular of the streets; they know where to go. They know who to see, and they know who are the leaders of those particular areas because they figure that out from ethnography. And they, in turn, go to the shooting galleries, because we do have some in San Francisco; they will go out on the streets to reach the IV drug users who are not in treatment. They provide them with one-ounce bleach bottles and instruct them on how to clean their works. They also provide them with condoms and a little printout on how to utilize condoms as well as give demonstrations, if they need them out on the streets, and also they provide them with other AIDS education information. For those who wish to get into treatment, referrals are made. For those who wish to seek medical care or social services, referrals are made, too.

CHAIRWOMAN WATSON: Dr. Evans, I just want to tell you that the people in the ADOPT program get their containers from California, and they are printing up their own labels. They don't have any money, and so they print up their own labels.

But I must commend us for at least giving them the little plastic bottles they're using.

DR. PATRICIA EVANS: You had also asked a question about mandatory testing, and I think the issue should be more mandatory education. And mandatory education would be much better in the sites that you have mentioned, such as in the jails, in the family planning clinics, perinatal clinics, and elsewhere.

One of the things that we do in San Francisco with alternative test sites that we pride ourselves on is the fact that it is an anonymous program. There have been evaluations of this program recently conducted by Havassey and Moulton, entitled, "Evaluation of the San Francisco AIDS Antibody Alternative Test Site Program, 1987." And one of the questions that was asked of the people who went into the clinic was whether or not they would use it if it were not anonymous. And from the table that I submitted to you, 46 percent of Whites said that they would not go for testing; 28 percent of Blacks said no; 44 percent of Latinos said no; and 40 percent of Asian and Others said they would not go for testing if it were not anonymous.

Again, for us, anonymity also means voluntary, and I think that's the key.

And again, to provide the mandatory education to the other areas that you've mentioned, such as the sexually transmitted disease clinics, substance abuse clinics, I think, is a key that needs to be done.

I would like to make the following recommendations. I think the use of surveys in minority communities are a must.

CHAIRWOMAN WATSON: Let me stop you there.

How are those surveys given?

It was interesting listening to one of the workers in New York. She said that she was talking to a group of Black people who were highly at risk, and she mentioned that the AIDS virus was transmitted through the semen. This one woman said, "Oh, my husband's not a seaman, so I don't have any problem."

(Laughter.)

CHAIRWOMAN WATSON: That's an actual case.

DR. PATRICIA EVANS: That's right.

CHAIRWOMAN WATSON: And they go on and on and on. I can entertain you for the rest of the morning with those kinds of responses.

DR. PATRICIA EVANS: I can agree with you there.

What we have done in San Francisco, we get the money and we subcontract it out to a group. And this is all done through a competitive bid process.

In terms of the two groups which have been done so far in the minority community, one was done by Polaris Research and Design Corporation, which is a minority-owned program. The other one was done by another research firm which is White, but they did it in conjunction with a Latino community-based organization, so that there was a base from which they could work.

Also, in our RFP process, prior to it going out, the research design is set up by our office. We have researchers in our office who know exactly how many people need to be surveyed for us to get any statistically significant information from different cells within that particular group. So this is how our surveys are conducted.

We resurvey the population to ascertain whether or not the educational efforts that we have conducted during that year have been effective. And also those resurveys to redefine and redesign our educational messages that need to go on for the following year.

So, I think that these are extremely important.

We have done, in terms of the Asian community, we have looked at trying to access that community, so we did a mini-focus group for that particular population. We do know that there are over 32 -- there are 32 Asian communities in San Francisco. And so, we are going to conduct a survey. The groups we will look at will be those groups most affected in terms of the AIDS cases, so we're talking about the Filipinos, the Japanese, Chinese in terms of the three highest.

The other thing, too, I think the establishment of a local review board, which would be much more helpful for us at the local level, rather than having the State review educational materials. And what I would recommend is that for those communities which have a Center for Disease Control panel already established, that these be looked at as that local review panel.

I'd like to stop here and entertain -- also, I'd like to see mandatory education rather than mandatory testing, and also to increase the utilization of nontraditional approaches to access the hard-to-reach populations.

We also need to evaluate whether or not those nontraditional approaches really do work. I think that is key, because just say that we're going to do it doesn't really mean that it is effective.

I'd like to stop here and entertain any questions.

CHAIRWOMAN WATSON: You mentioned a community review group. Would you elaborate on that?

DR. PATRICIA EVANS: Yes. As I said, in San Francisco we have the Center for Disease Control panel which we are required to have when we produce educational materials with funding from the CDC.

CHAIRWOMAN WATSON: So that's official CDC --

DR. PATRICIA EVANS: That's correct. And this is really in relationship to our alternative test -- not to the alternative test site program, but to our health education and risk reduction program. So, all of our materials will have to be reviewed by that committee. And that is to see whether or not a reasonable adult would object to the material.

And again, I still review it for the medical content, and there's still the focus groups, which are the target populations that we are trying to reach, that review the material to see whether or not that material is really going to give them the message that we're trying to get across.

So, there are three levels of review in San Francisco currently.

CHAIRWOMAN WATSON: The structure would go through the County Department of Health Services?

DR. PATRICIA EVANS: Yes, that's the way it functions currently.

CHAIRWOMAN WATSON: Good input.

No further questions, and thank you very much. We appreciate your testimony.

Now, Dr. Sandra Hernandez from San Francisco General Hospital, AIDS Activity Division.

DR. HERNANDEZ: Good morning, Senator Watson, Committee Members.

What I'd like to do today is actually talk less about statistics and a little bit more about the people that I see in the outpatient department and the inpatient hospital ward for AIDS patients at San Francisco General.

I came on there in July of this year, when it became clear that in San Francisco, the AIDS epidemic had in fact gone way beyond the gay White male population, and that in fact what we're beginning to see in San Francisco General Hospital were a great number of gay and bisexual Latino men.

I came on to the clinic at that time to address really a need at that time for a Spanish-speaking physician who was culturally sensitive to the issues around bisexuality and homosexuality in the Latino culture.

What I'd like to do is point out to that despite the fact that it's true nationally that we are over-represented in the categories of risk factors -- including heterosexual transmission, pediatric cases, women cases -- in San Francisco of the 300 Latino cases to date, 86 percent of them are in homosexual and bisexual men. How many of those are bisexual we do not know.

But what I'd like to do is try and bring this home little bit and present to you a case of a bisexual man who I take care of at San Francisco General, to try and point out three main points: one is regarding mandatory testing; one is the problem of bisexuality that we have not yet come to grips with, both because the potential for heterosexual transmission is real and the potential for spread into the pediatric population is likewise real in this bisexual component, of which we really don't know because we count bisexual and homosexual men in the same category group.

Three months ago, a gentleman presented to the emergency room, which is a very typical place for all people of color to present initially with their AIDS diagnosis. This gentleman is a 35-year-old man originally from Mexico who has lived in the United States for ten years. He's married and has two children, ages three and five. He presented to the emergency room at that time with what was felt to be appendicitis.

He was taken to surgery. He had had no previous medical history, had never been hospitalized, and had never received any blood transfusions. He was taken to surgery. His appendix was in fact inflamed. It went to the pathology department, and the pathology returned positive for Kaposi sarcoma.

The patient was then interviewed by the physicians who had admitted the patient regarding any risk factors for HIV disease. He denied any risk factor whatsoever, including any homosexual contacts in the past and any previous blood transfusions. He said he had been married for six years to a

woman from Mexico, and that they were monogamous, with these two children.

At that time I was called in to see the patient to obtain a history in Spanish -- he is primarily monolingual Spanish, although does speak some Spanish [sic] -- and as well to address the issue of whether or not he should be antibody tested since he had Kaposi sarcoma, which to date in this population would be considered an AIDS diagnosis even without antibody testing.

He actually was consented for antibody testing via an interpreter before I saw the patient. His antibody status came back positive.

At that time I saw the patient in house when he had presented, shortly after his Kaposi sarcoma was found in his appendix, with his first episode of Pneumocystis pneumonia. At that time I spoke with both he and his wife. I again took a history in Spanish from both of them, and he adamantly refused any homosexual contacts.

During the time of his hospitalization, however -- we do have an AIDS ward. The AIDS ward was full at the time this patient was admitted, and so he went to another floor in the hospital, and when a bed opened on 5-A, the inpatient service, the patient refused to go to the ward, stating that it was a gay ward. I was contacted by the house officer team at that time and said, "We'd like to move this patient to 5-A, but he's refusing to go. What should we do?" I said, "Nothing, leave him there and I'll come speak with him."

We talked again at that time, and again his perception of the way he contacted this virus was that he had had hepatitis in his last trip to Mexico, and that he felt that he got the AIDS virus at the same time that he got hepatitis.

This patient refused to go up to the 5-A because it was a, quote, "gay ward", and at that time we had members of the Shanti group -- a volunteer organization that does emotional support -- visit the patient. And it turned out that this woman, Shanti worker, had met this patient in fact at the time he was in the company of other homosexual and bisexual men. It eventually did become known that in fact he had had homosexual encounters, although the quantity was not known.

I continued to see this patient in San Francisco General Hospital on the AIDS ward. I have recommended to him and his wife, both jointly and separately, that she be antibody tested. She has refused antibody testing because she fears that her medical records will then be subpoenaed, and after her husband dies, both she and her children -- despite the fact that they are both American-born -- will be exported back to Mexico.

I bring this case to your point primarily because I think that one of the best ways to educate people about AIDS is to personalize AIDS. And it's very hard to do that when we hear numbers.

I also bring it to your attention because I think that the bisexual component has been largely overlooked, primarily because we don't know where to fine bisexual men, and when we find them they're at home with the wives and their children. And

that they represent the same threat to heterosexual society, to children, that intravenous drug using does. And in San Francisco, in fact, the vast majority of Latino cases remain in homosexual and bisexual men.

And finally, to address the issue of mandatory testing. The federal government added on required antibody testing for people applying to amnesty, as I'm sure you're all aware. What has happened as a result of this mandate for antibody testing is the fact that nobody's applying for amnesty, either because they fear they will be antibody positive, or for fear that in fact the whole amnesty program was never meant to actually get people to become legal citizens of this country.

What it has in fact done to the case that I presented to you is kept the woman -- who potentially is at risk, who potentially is antibody positive -- from seeking any medical care whatsoever, never mind antibody testing.

I have discussed safe sex guidelines with both the patient and his wife, and the problem once again is a cultural issue of the use of condoms, which, quite frankly, has by virtue of the cultural as well as religious historical phenomena, not been very widely accepted among Latino people. And so, in addition to the tremendous task that we have of saying what is safe sex, we then have to begin to overcome many of the cultural taboos around these very tangible items called condoms.

This case struck me and frustrates me tremendously, primarily because this woman is still under no medical care, and because he continues to deny what we would consider presumably bisexuality.

I have discussed their sexual relationships quite frankly with both of them, and his wife told me something that I think is very important, and that is that, and I quote -- she spoke to me in Spanish: "My husband's the father or my children. He is my husband. What he does outside of the home is not my business. I'm his wife, and I'll stick by him to the end, and I don't want to have any more questions about any potential sexual contacts outside of the home."

CHAIRWOMAN WATSON: Now with that, how are we going to then do surveys to find out from these populations what the real situation is?

DR. HERNANDEZ: Thank you for asking that.

Pat mentioned the surveys that were done in San Francisco. What I'd like to do is tell you about the survey that was done in the Latino community. Bilingual-bicultural people were sent out using census block data to determine the population, which primarily is in the Mission District in San Francisco. They went to 400 people in the Latino community and administered primarily 89 percent of them in monolingual Spanish; questionnaires regarding attitudes about AIDS, knowledge of AIDS as a health risk, and also some information was obtained regarding areas that would be available to do AIDS education.

Things were very surprising in that survey because it was overwhelmingly the opinion of the people that answered the questionnaire -- they were paid $10; people came into their home. It was done in their language, in their home -- and what came out of that survey was something that is quite surprising to most of

us who know Latino people or are Latino people, and that was that in fact Latino people, 96 percent, felt that AIDS education should be done in schools -- something that you've already addressed earlier and I think is very important.

And in addition to that, that most of their health information comes from radio and television and not from written materials. This probably has somewhat to do with educational levels. About 60 percent were at high school level or less in terms of formal education. And it's something that we have known in fact to be true, despite the fact many of the pamphlets that were originally printed in English were then subsequently translated, almost literally, into Spanish and given out at various health clinics and the emergency rooms in San Francisco. That in fact, very little information had really gotten out by that means.

There was a video that was produced through State funding by the Department of Public Health that was contracted to the Latino AIDS Project. This video is a video that reviews all the risk factors for AIDS in a soap opera format, which is very popular among Latino people. The video has been very, very widely used in the Southwest, on the East Coast. It's been taken to Mexico, to the border towns in Mexico. And despite the fact that it's quite frankly deals with many of the -- all of the risk factors for AIDS, it was overwhelmingly received when it was publicized on Channel 14, it was shown on Channel 14, the Spanish television station in San Francisco. And the comment from all sections of the Latino community was that this was information that we needed to know.

There is some controversy about whether or not the State's going to fund this again because of very explicit, quote, "explicit statements" and various language that's used. The video is done in Spanish.

So that I think that in what is really a very conservative culture, if you will, both sexually as well as somewhat politically, this video was very well received, despite the fact that it has now run into a lot of bureaucratic tape in terms of funding to the organization that developed this.

I think that it's important to realize that the Latino people need to have materials developed that are developed by Latinos, not merely translations of things that have already been written in English, because this is really not very successful.

It's interesting that the woman that's married to this patient I presented to you called me at clinic and said that she had seen this video aired on Channel 14, and that she didn't know that the various risk factors that were mentioned there were ways to get AIDS. So even she gave feedback to this. I think we did reach her through the video if we haven't been able to reach her through other more usual means of contact and follow-up on contacts to get antibody testing.

CHAIRWOMAN WATSON: I am troubled by the fact that we now have English as the native language and the only language of this State of California, and therefore our ability to put materials in other languages will be somewhat in doubt in the near future.

I must agree, so much is lost in translation, because words, maybe in the Hispanic language as well, but in Japanese and Chinese have different meanings, different ways of expressing a concept. And if we're really going to get across to these target groups, we're going to have to put it in the language that they can understand, simple. And I don't know how much conflict we'll have with the current statute that says English is the language.

I think it allows or opens a window for discrimination in this regard, and I will be paying a close look at that. I'm sending out a message, too, to Ms. Fraziear to look at this issue so that we don't accidentally back into that window, where we can't get materials out that really reach the target populations.

DR. HERNANDEZ: Dr. Evans mentioned that the use of community-based organizations that are already providing culturally sensitive services -- care, education programs -- that the way to develop materials is to use the organizations that are there and that have already been doing culturally relevant work. I think that that is really been the success of the program, because we've seen in San Francisco that it has been successful.

CHAIRWOMAN WATSON: Denial will be a large part of the reaction, not only Hispanic but in the Black community as well, because this kind of behavior still is not acceptable. So, we have to deal with that first and figure out how to break down that barrier before we can move on.

I do appreciate your testimony. Thank you very much.

DR. HERNANDEZ: Thank you.

CHAIRWOMAN WATSON: At this point we're going to take about a 3-5 minute break, please, so that the person doing the recording can exercise her muscles.

(Thereupon a brief recess was taken.)

CHAIRWOMAN WATSON: I'd like to resume our hearing now. If the audience will take their seats, we can go ahead.

I would like to just alter the agenda just a moment to be able to hear from Ms. Fowles, who is the Commissioner for the Public Health Commission, before she has to make an appointment in Long Beach.

MS. FOWLES: Thank you, Senator Watson.

I'd like to say good morning to all of you and thank you for this opportunity to speak to you.

I am the Public Health Commissioner for the Second Supervisorial District in Los Angeles County, representing Board Supervisor Hahn.

My concern is the issues addressed by Dr. Caswell Evans from our Department, and from Dr. Pat Evans from San Francisco, and Dr. Sandra Hernandez are very, very important, and I wanted to reiterate and support their ideas, particularly around the issues of trying to reach minority community members in the language and in the areas in which the live.

It's extremely important to note that the County of Los Angeles has seven areas in the area that I service -- Inglewood, Hollywood, Linwood, Compton, South Central L.A., South East Los Angeles and South -- those are the seven areas that have been pinpointed as at greatest risk, not only for AIDS, but also for gonorrhea and for syphilis.

We find that the medical descriptions of people who have passed from AIDS indicate the presence of syphilis in the tissue, particularly the neurological tissue, and --

CHAIRWOMAN WATSON: Let me just ask you here, do you know if there is a rise in AIDS and gonorrhea in the last --

MS. FOWLES: We are having difficulty tracking it because the number of people who are reporting to the clinics that are doing the testing is not high for the residents of the area. We're finding that what's happening is that people from outside the area are coming to the clinics inside the areas that are identified as at highest risk. That's due to the fact that they do not want to have the test in their neighborhood, of course, and they want to make sure that they do have access to anonymity and complete secrecy on the part of themselves.

The situation that I'm addressing, however, is the fact that one of the physicians who spoke earlier had mentioned that people are not aware of the biology involved. They are not aware of the actual technological things with cells, and how the virus operates, and how you prevent the virus, and what happens with your immune system.

I think it's very, very important that outreach programs be funded. That outreach programs which address the cultural diversity of the minority community be addressed by those persons who are at highest risk, and that we look at ways in which members in the community can get to other members in the community within themselves.

I have recommended in one of our Public Health Commission meetings that those persons who are involved actively in AIDS education, in AIDS treatment, and in AIDS prevention methodologies try accessing other avenues to the Black and Hispanic communities -- liquor stores, churches, all the corner clubs, whatever small gatherings there are.

I would also recommend that if any of the small community organizations, or any of the subcontractors for doing AIDS education, plan to be involved in a successful way, that they do utilize the recommended survey methodologies that have been discussed already, and that they do that with the idea of literally cruising the neighborhood.

We know that Los Angeles is unique in the sense that people are identified by the cars that they drive. The vehicles have a great deal to do with attracting attention, particularly of the younger people in the neighborhoods, the 15-18 year olds, and those people who would like to model themselves after the 15-18 year olds, that what in gang terminology is called the "want to be's", those who are between 10 and 14. So, we find that the young people in the Black community and the Hispanic community, that the young adult community in the Black community and this Hispanic community are at greatest risk. We find that they are at greatest risk no only because of the presence of the virus, but because their immune systems are already depressed due to the fact that they are not eating properly. And when you look at the latest issues of information coming out of various medical journals, we find that there is a correlation between those

persons whose overall hygiene and nutrition bases are weak, and they become more susceptible to all kinds of sexually transmitted diseases and other germs, not to mention the AIDS virus itself.

So I would like to simply reiterate the need for expanded alternative methods of education, and to look at more creative means of reaching the people that we know are going to be at highest risk for developing AIDS over the next five years, so that we don't wait for that five-year period to expire, because those people will be expiring as the time goes on.

Thank you very much.

CHAIRWOMAN WATSON: Thank you.

Cleant Stain with the Minority AIDS Program, St. Mary's Medical Center.

MS. STAIN: My name is Cleant Stain. I'm with the Minority AIDS Program at St. Mary's Medical Center.

Our program was recently funded by the State Office of AIDS to provide comprehensive case management and treatment services to minority AIDS and ARC persons living in the South Bay area. Our target area consist of about 14-15 cities surrounding the Long Beach area.

The case management system that we're using at St. Mary's Medical Center involves case findings, assessment, planning, monitoring and evaluation. Our whole system in dealing with the minority person with AIDS and ARC is very active. The case finding involves going to Harbor/UCLA and identifying minority clients with AIDS and ARC, and coordinating services from St. Mary's Medical Center.

I think that education and prevention is very critical in this AIDS epidemic. However, we must not forget the clients are the Black and Latin persons living with AIDS in our community. In the South Bay area, the faces of the epidemic are changing. The people who are coming into receive concrete services, like financial grants from volunteer organizations, are changing. And as they're changing, the resources are drying up.

We're having problems with having physicians. There's a physician shortage. A lot of our physicians in the South Bay area do not want to accept Medi-Cal, and most of our Black and Latin clients are either Medi-Cal recipients or have no insurance at all.

So, some of the -- I can think of one example of how the resources are drying up in our area. In Long Beach, we have six hospice homes or shelters for clients with AIDS. In two of the homes, there are two undocumented people living in these homes, and an organization in our area has been paying rent for this person for the last five months. Because of the changing faces in the epidemic, they have decided that they no longer want to support an undocumented person in the home, so now that means that that person is going to be living in this home and there'll be no resources coming in to pay for his rent.

Also what we're seeing is the Black community is very apathetic to the needs of other Blacks with AIDS.

I brought three of our clients with us to testify on some of their experiences that they've experience first-hand. The areas that they'll be addressing are: housing, community responses, and special needs of the IV drug users.

First I'd like to introduce Earl Hobbs.

CHAIRWOMAN WATSON: And as each person speaks, would they give their name and whatever affiliation. Speak right into the mike because we are recording this.

MR. HOBBS: Good morning, Senator Watson.

My name is Earl Hobbs. I'm a Black male gay person with AIDS.

I've been listening all morning about the funds that have been set aside for research and education, which is definitely very important, especially in the Black and Hispanic communities because of so many fears that we've had from ages ago, but I haven't heard very much said about what's being done for the persons with AIDS as far as the services that are available to us, the funding.

Whereas, I worked on one job for the State for 19 years. I'm now without a job, having problems with Social Security for almost a year. And at the present time, I'm depending on a White basically gay funded organization to support me. And there is not very much support, financially, for the Black male with AIDS, whether gay or IV drug user.

I think that there should be more funds made available for Black and Latin persons with AIDS. And it's important that the State not include the minority funds in any type of comprehensive AIDS program, because if the Blacks and Latin PAWs are thrown in with the White PAWs, minorities will get the leftovers, and we need to continue separate funds.

There needs to be the thought of looking at separate housing for gay and IV drug users. There are many cultural issues that are different. A lot of IV drug users have probably in the past had to rely on a gay person through sexual favors in order to gain money to sustain their drug habit, and they would not be very comfortable living with them, because there's already a resentment of the fact, "Well, I had this problem, and I had to do thus and so in order to gain funds," in order to keep their habits up.

They're different issues, because some of them having to live on the streets, and just different cultural issues that are involved.

I feel that if I was an IV drug user, and I had to, say, prostitute myself in order to gain money for my drug habit from gays, I would not want to live with them. It would be uncomfortable if that were me.

For example, when I became sick, I had lived in a family situation in a home with other people for about eight years. Three days before I was discharged from the hospital, I called the house and was told that my furniture and all my clothing had been put in the garage. That put me in a situation where I had nowhere to go. Had it not been for St. Mary's Minority AIDS Program and Cleant Stain, I would become -- would have become a street person with AIDS, which is not very conducive as far as me trying to prolong my life.

I think some of the issues need to be geared toward what can we do for the patients that have AIDS, because there are a

lot of things that we need, not just always financially, but we need moral support. I have no insurance. If I were to die tomorrow, I have to money to bury me. These are things that should be looked into because I feel that I deserve something. So I have this disease? I have to live with it, but I'm trying to live with it the best I can.

CHAIRWOMAN WATSON: Let me ask you this. You have worked in government for 19 years. You have no Social Security? You're having trouble with that?

MR. HOBBS: I worked for the University of California in Los Angeles. And up until about five years ago, we did not pay into Social Security. We had a private retirement fund, which when I stopped working was only worth about $6,000, which I had to support myself on that.

And I don't have ten quarters in the last -- forty quarters in the last ten years as far as drawing Social Security, so now I have to go for disability, which my original diagnosis was ARC. I also had some pulmonary problems because I have had a lung removed. So, even based on that, they still wouldn't.

Now I have the diagnosis of full-blown AIDS, so more than likely I'll probably get the money. But there's a possibility that by the time they finally give me some money to support myself, I may be in no position to even take care of myself.

CHAIRWOMAN WATSON: Let me ask Ms. Stain this: Does your program assist in trying to work through the bureaucratic maze?

MS. STAIN: Yes, we also coordinate many of the services at the Department. Yes, we do coordinate services for our clients to negotiate -- to move through the difficult system at the Welfare Department.

In Earl's case, when he first brought the paper to me, we called and we got a State hearing for his case. So, he will probably be getting funds from SSI very shortly. He was not able to get disability, so we were able to coordinate through Project Ahead, which is a White gay organization, to pay his rent for him. Then we're utilizing food banks from AIDS Project Los Angeles and Christ Chapel in the Long Beach area to supply food for him.

Some of the things that we've been able to do for our ARC clients who are not eligible for SSI or Medi-Cal is, at Harbor, I've been able to get the nurse coordinator and the physicians there, if our clients with an ARC diagnosis show some disability, so at that point they write on the progress notes the ARC diagnosis, and give a four-month disability, which assist in providing some o the concrete services.

But yes, I am working with our clients who move through the system.

CHAIRWOMAN WATSON: Thank you.

MS. STAIN: Now I'm going to let Sammy Evans say a few things. He's got three points he'd like to bring up on community response.

MR. EVANS: Good morning, everyone. My name is Sammy Evans. I'm a 34-year-old Black male. I do have ARC, too.

I just got released out of the hospital, but that's not why I'm here. I want you to know something. I have been through it, too, so when I talk, you can see experience talking; it's not just make believe.

When they pulled me in, they said --

CHAIRWOMAN WATSON: Speak right into the microphone. We'd like to get your words down.

MR. EVANS: They said I had something. Anyway, it was killing me. The doctor said three weeks to live, I would have been dead. I had Legionaries Disease, then they came back found brain [unintelligible], and all this is all from the virus.

Many times I get depressed. I'm doing better now because I see people are interested in me when I go to a meeting, Ms. Watson. There are just some times it's hard to sit up and talk about it. It's real hard. You see, I'm an emotional person anyway, so I really want to sit up and tell you how a portion of the pain, you know, having such a disease. For some reason, I'm scared of it. My mind is not saying to take it. It's just got a serious open fear there. I don't know what it is, but I feel my spirit and God say, "Go ahead." I'm not going to mess with it. It's that simple.

Nobody can understand what I'm saying, but that's a spiritual statement. I've said this and I'm done.

Ms. Watson, you know, I think a lot of -- are these your workers?

CHAIRWOMAN WATSON: Yes, these are staff people.

MR. EVANS: I think your workers -- I'm not saying they don't -- need to take time some days and take those previous selves, push them up, over their ears, and listen to the what the people are crying about. Or not say, "Oh, look at that bum. I hope he don't come near me."

Do you see what I'm saying? That's what I really sincerely feel. I feel myself breaking down.

CHAIRWOMAN WATSON: We do appreciate your statement. We're sensitive to what you're saying.

We know it's going to take outreach, and that is exactly what it is. We've got to get out on the streets and treat people with human dignity.

So thank you so much for bringing that point to us.

MS. STAIN: Next we'd like to have Willie Bell talk about some of the special needs of the IV drug users. Willie's come here from New York within the last three months and has been diagnosed with AIDS.

MR. BELL: Good morning, Senator Watson.

CHAIRWOMAN WATSON: Good morning.

MR. BELL: I've been using drugs for over 18 years. Just before I came out here to California, I was coming out here to get a job with one of my friends, get me a job. I was going to come out here and live. His mother died, she passed away, which -- he had to go to New Orleans. He never came back.

The only money I had left for motels and things like that was gone. Went real fast. My father and myself slept on the street. I got really, really sick. I was real sick, so I

went to a sentimental hospital, and they transferred me to Martin Luther King. In Martin Luther King, that's where I was diagnosed as a ARC person. But I believe that this started way back in New York before coming out here to California.

I believe, you know, to help try to get to a point where we can help other people -- prevent other people from doing this, getting ourselves involved, it's like you said, to outreach them. Really, you know, determined. I'm being determined right now to beat -- because I want to beat thing thing. If I get hold of somebody, I get on it, you know. I appreciate that.

CHAIRWOMAN WATSON: Let me ask you this. You've been a drug user for 18 years. Do you exchange needles with other people?

MR. BELL: I believe so.

CHAIRWOMAN WATSON: Did you have any idea what risks you were under?

MR. BELL: No, I was naive to all that.

CHAIRWOMAN WATSON: How do we get this word to a person like you? Did you go to the shooting galleries?

MR. BELL: Yeah, it was a shooting gallery.

CHAIRWOMAN WATSON: How do we get that word to you? How do we educate you? What would you listen to? Who would you listen to?

MR. BELL: The preach.

CHAIRWOMAN WATSON: I beg your pardon?

MR. BELL: The preacher.

CHAIRWOMAN WATSON: The preacher at the church? Do you go to church?

MR. BELL: Yes, I go to church a lot, a very lot.

CHAIRWOMAN WATSON: Would your buddies be there in church to hear this?

MR. BELL: No, but see, I think it's just like this outreaching, you know, and just changing the environment. The environment of, you know, of drug users is really down. You know, we walk the streets. You can tell it's just a place of drug users, you know.

It's about to change -- it's about changing the environment, having a full curriculum so we wouldn't even think about using drugs, you know. These kids come home from school -- I asked this kid one time. You know, I saw him riding a bike, and he had what looked like a cigarette pack in his sock, right? I said, "What you doing smoking at your age?" You know? He pulled it out and it was a stack of money, you know?

So, you know, it's about get it to the people, you know, and you can change the environment.

CHAIRWOMAN WATSON: How do we fight the drug issue? That's what's creating a lot of the problem when a kid like that can walk around with $3,000, and you're talking about an 18-year-old working for 3.35, you know. How do we combat that?

Well, you might not have all the answers, but I'm throwing these things out.

MR. BELL: I'm trying to figure it out myself, because it is a battle. And I keep people -- a lot of young people that I'd like to try to do my best to help them out.

All it is, everything's a support system. We are going to have a support system out there in the street, every day, every day, every day, begging, or doing whatever you can do for them. I think that's the only chance.

Because I was in programs in New York, the Phoenix House program.

CHAIRWOMAN WATSON: What was the name of that one?

MR. BELL: Phoenix House.

CHAIRWOMAN WATSON: Yes, I've heard of it.

MR. BELL: Yes, very good program. I was in that, and that's what got me off these drugs. I was in there --

CHAIRWOMAN WATSON: Are you still clean?

MR. BELL: Yeah, I've been clean for a year and a half now, you now. That's a fantastic program.

It just needs all reaching out and getting that support. Once you have that support system, things will fall in place. And the main thing's the environment; trying to change the environment, you know. Try to have a more full curriculum for the young brothers and sisters out there, you know, because they don't have nothing, you know.

They sit -- I watch -- I've been out here for like four months. And all I see was standing in front of their houses selling drugs on the whole block. I can't believe that, you know. Right out there in the open, just standing out there selling drugs, you know. That means that they don't have nowhere to walk to to play ball or, you know --

CHAIRWOMAN WATSON: If they did, would they go?

MR. BELL: I would say so.

CHAIRWOMAN WATSON: When the prospect is making $100 an hour as opposed to going over and straining up to try to learn something, or put a ball over a net --

MR. BELL: It's a very aggravating thing, you know, but just need people to go out there. Look at each one, you know, just one, and then that one could reach another one. It might affect. It's a reach out.

CHAIRWOMAN WATSON: I hope all of you can beat your current physical condition so we can look at you as prospective trainers or prospective programmatic people to get out there and help others like yourselves.

MR. BELL: And that's going to take a lot of money, too. It's going to take a lot of money because you really do use some support, you know.

Like, I'm living in a house of gay, and they getting their money from gay White people. I feel Blacks should be going out there and getting some sponsors for fundings, some houses for Black people, Black minorities, you know, because -- excuse me.

CHAIRWOMAN WATSON: Did you want to say something?

MR. EVANS: I'm just telling him people give money. I spoke about that before, because basically for getting people, telling the people, you know, it just needs to come up to a higher mark in life. It's not buying all that gold. I mean, God wants us to look nice. It's not running out and buying a fifth, or whatever. I'm not saying that's wrong; do you see what I'm saying?

But when you see other things. Senator Watson, first [unintelligible] young man talking about the AIDS people. These children use that for something for somebody. You see what I'm saying? And that's what I really, really want to do, because I don't want to die, okay. The doctor person said I am going to die, and I'm not accepting it, okay? That's my faith. I won't accept it. That's what I'm saying.

Anybody got any kind of faith in God, real faith, you'll live. God really -- he never says "shut up". God has already healed people with AIDS. On Channel 40, on t.v., he heals two boys in casts [unintelligible] brought them in the hospital and he laid hands on them and prayed a prayer. The boys stretched to him; they slowly got up; asked for some apple juice; started walking a little bit. I said, "God, I thank you." Then he spoke to me, he said, "How can you do that if I don't take you down to the bottom and let you feel the pain and the hurt and the agony."

So now, I'm kind of grateful, but it hurts so much. Cleant knows what I'm saying, because when I go to her I just cry.

CHAIRWOMAN WATSON: Well, we do appreciate the testimony from the three of you.

Ms. Stain, did you want to --

MS. STAIN: Yes, in closing, I would like to urge that monies continually go into separate funding for care and treatment of minorities with AIDS and ARC, and to really seriously consider any type of inclusion of minorities in a comprehensive AIDS program.

CHAIRWOMAN WATSON: Thank you.

Dr. Lifshitz, Committee on AIDS, with the Los Angeles County Medical Association.

DR. LIFSHITZ: Good afternoon. I'm Aliza Lifshitz, M.D., a physician in private practice in Los Angeles and a member of the Los Angeles County Medical Association, which has 10,000 members. I'm also a member of the Committee on AIDS.

I sincerely appreciate the opportunity to express my views. I am also encouraged by the concern that the Senate Committee on Health and Human Services has shown for the AIDS crisis, particularly as it affects minorities.

As you know, Black and Hispanic people in America are suffering disproportionately from the devastation of AIDS. There is every indication that this disparity will continue and that the impact of AIDS on Blacks and Hispanics will continue to increase.

More often that Whites, minorities contract AIDS by sharing the needles used to inject drugs. Addicts, who do not know that they are infected, subsequently transmit the virus to their heterosexual partners. As a result, half of the women with AIDS are Black or Hispanic women, and nearly 90 percent of babies who are born infected with the AIDS virus are Black or Hispanic babies.

There is mounting evidence that the relationship between intravenous drug abuse and AIDS and the subsequent impact on minorities has been underestimated. Recently, the New York City Health Department, after careful review, revised their AIDS

statistics to include a large number of AIDS deaths among IV drug users that had previously been excluded. Authorities now estimate that since the beginning of the epidemic, 53 percent of that City's AIDS deaths were connected to drug use.

In New York City, AIDS is the leading cause of death for men 25-44 years of age, and for women 25-34 years old. In New York City, more than 80 percent of women who have contracted AIDS are IV drug users or the sexual partners of IV drug users. And 86 percent of male IV drug users with AIDS in that city are Black or Hispanic men.

There have been almost 4,000 cases of AIDS reported in Los Angeles County since the epidemic began, despite the fact that we have apparently, and luckily, been spared the impact that drug-related AIDS has made on the East Coast. More than 90 percent of L.A.'s AIDS cases have occurred in homosexual and bisexual men, and only three percent in IV drug users; 15 percent of AIDS cases reported in L.A. County are Hispanics, although Hispanic people are one-third of the County's population.

The picture for local Blacks is worse, but still not as bleak as the one nationally. Black people, who are about 12 percent of the population of L.A. County, are 14 percent of those with AIDS.

Early and persistent efforts at education by a few dedicated community leaders, understanding churches, and strong families all deserve some credit for this record, but the avoidance of drug-related AIDS is more likely the primary reason. Studies show that IV drug addicts in Los Angeles are less likely

to be infected with the AIDS virus than in any other major city in America. Well over half of New York City's IV drug addicts are infected, but less than two percent of addicts surveyed at treatment centers in Los Angeles are infected.

According to the Centers for Disease Control, the State of New York and California have reported about half of the country's AIDS cases, with New York slightly ahead of California. But while New York has reported only one-third of AIDS cases involving children, and Florida and New Jersey have each reported 13 percent, California has less than 7 percent of AIDS in children. And in Los Angeles, there have been 21 babies with AIDS, 9 of them infected at birth by a parent.

The low HIV infection level among L.A.'s IV drug addicts may be due to the presence of fewer shooting galleries for heroin addicts in Los Angeles and less subsequent needle sharing. Smokeable cocaine, or crack, also seems more popular amongst drug users in Los Angeles than in other cities. But in other cities, HIV infection has spread rapidly among IV drug addicts once started.

Most authorities believe that the AIDS epidemic started on the East Coast, and that the epidemic there is more mature. In California and Los Angeles, we have an opportunity to save a substantial number of people, a large portion of them minority women and children, from the horrors of AIDS. It is an opportunity that we must seize and act on quickly.

We must greatly expand drug treatment facilities, including both methadone maintenance clinics and support

counseling groups, such as Narcotics Anonymous. We must encourage every person who suffers from the illness of drug addiction to seek treatment and make that treatment available.

Currently, Medi-Cal covers only methadone treatment, which many minority addicts avoid because people in their communities still consider them to be junkies. The approach used by Narcotics Anonymous, which is modeled on Alcoholics Anonymous, should also be covered by Medi-Cal. A new drug, Levo-Alpha-Acetylmethadol, or LAAM, shows promise as being more effective than methadone and should be approved for treating heroin addicts immediately.

Drug addiction is an exceedingly difficult sickness to manage, and we should recognize that treatment for many addicts will not be successful. Thus, we must try as hard as we can to teach IV drug addicts how to avoid getting infected with AIDS and how to keep from infecting others.

So far, our experience with AIDS indicates that convincing people to modify their sexual behavior to stop the transmission of the virus is not easy. However, we have made substantial progress. Most gay White men are now aware of AIDS and how to protect themselves from it. To a lesser extent, homosexual and bisexual Black and Hispanic men are learning to change their behavior.

Minority IV drug addicts do not want to die from AIDS anymore than do gay White men. Outreach programs operating on the streets, as proposed by the Minority AIDS Project, can reach IV drug users. We can teach drug addicts how to clean their

needles and not to share their needles. If necessary, we should seriously consider supplying them with clean needles.

We must make a special effort to reach young people who are susceptible to both drug abuse and AIDS. Rather than mandating a curriculum on AIDS for our schools, I suggest directing schools to teach students about all of the health risks that threaten our young. Teachers cannot tell children about AIDS without also talking about premature sexuality, sexual identity, drugs and alcohol. Each local school district should be allowed to take their own approach in dealing with these complex problems, but they should not be allowed to ignore them.

We must also make a special effort to educate the minority women. While some allege that the threat of AIDS to heterosexuals has been overstated, the current threat to the minority woman is real. Minority women must learn about the risk of AIDS to them and their unborn children.

There are more threats looming. On December 1st, AIDS antibody tests became mandatory for all applicants 15 years of age and older for the Immigration and Naturalization Service Amnesty Program. Since the INS has indicated that those who test positive will be deported, this requirement has the immediate effect of driving underground those illegal immigrants who are most at risk for AIDS. They now have a strong incentive to avoid medical treatment and AIDS counseling.

During the past several weeks, the Mexican economy has collapsed. This will most certainly trigger another flood of illegal immigrants into California. And in November, a police

officer from the LAPD Narcotics Division told the Los Angeles County Medical Association Committee on AIDS that black tar heroin from Mexico has recently become the main source of supply for heroin addicts in Los Angeles.

Most of the black tar heroin is smuggled into California is small quantities by illegal immigrants hoping to finance their entry into America. According to the police, everyone associated with the illegal drug trade is a potential addict. We may shortly have a whole new population of IV drug addicts, most of them poor uneducated Hispanics, and all of them potential victims of AIDS.

We must continue to direct substantial resources to AIDS prevention amongst homosexual and bisexual men of all races. But the consequences of failing to effectively deal with the threat of drug-related AIDS in the minority communities of Los Angeles can be seen in the grim picture from New York City.

We must not let it happen here.

CHAIRWOMAN WATSON: Thank you so much.

You mentioned that the distribution of sanitary needles might be one way. Would you elaborate on that? How would you see that being handled? From the Department of Public Health? Their methadone program? Should they be distributed through gay centers? Just how do you see that happening?

DR. LIFSHITZ: Well, it wouldn't be my first choice. I wouldn't recommend to go out and start giving needles to people. That would be my last choice after going through the other things that we talked about.

I would much rather see people, for example, in the programs in which reformed addicts have gone out to try and reach people that are still IV drug users, trying to explain to them the importance of avoiding drugs as the number one thing. Number two, trying to teach them on how to prevent contracting AIDS by cleaning their needles, either using bleach -- I would be more likely to recommend distributing bleach before distributing needles.

And just as a last resource, maybe in some instances of someone maybe wanted to buy a needle in the drug store without a prescription. Maybe that would be the way. I would not say that we should be giving them for free. That, I don't think, would be the best.

CHAIRWOMAN WATSON: They talked in New York about an exchange program -- you know, "take this needle for your needle," type of thing.

The first thought that comes to mind is that that puts government in a position of supporting the illegal use of drugs. There's a perception there when you provide those, but it's something that is there back in our minds that we need to look at.

DR. LIFSHITZ: I agree with you. And again, it would be one of the possibilities, but only if all the other things were tried first and would fail.

CHAIRWOMAN WATSON: You mentioned the testing program of INS of Africans that are coming in, and that too is troubling, because it's emphasizing or casting the aspersion on one group

over others. There are others that are coming into the country with as high a risk as the group coming in from Africa.

We know that there is a strain of AIDS that is rabid throughout certain parts of Africa. It has always been there. My understanding is that certain parts, especially on the east side, that the virus is transmitted from the bite of a green monkey and a bit of some other kind of insects. And that in certain areas it was known by the people in surrounding areas that that was the area where there was the withering disease.

DR. LIFSHITZ: May I just correct you in terms of the insect.

There hasn't been any case documented, as far as I'm concerned, in which an insect has transmitted the AIDS virus.

CHAIRWOMAN WATSON: What I heard is that the insects that live on the bodies of the monkeys --

DR. LIFSHITZ: Oh, okay.

CHAIRWOMAN WATSON: This is what I heard. None of this have I seen scientific information to verify, but it's just information that I have picked up.

And I am concerned. We've had this debate in the Legislature because some people will want to focus on Africa as where AIDS started. We certainly know it is a continent where there seems to be an immediate crisis, but I don't think that just emphasizing this one group over others is really solving or curtailing the problem.

I just wanted to make that comment.

DR. LIFSHITZ: I agree with you.

Just to add a little bit and expand on what you just mentioned, I would like to say that in 1968, there was one case described in the United States, in a 15-year-old boy, that at that time they didn't know what the problem or the cause of his death was. Nevertheless, they kept some of the blood, and they have documented now that he was suffering from AIDS. At that time there was no evidence of any transmission from him to anyone else.

I agree with you 100 percent. Where it came from at this point is probably not going to solve our problem, but it is interesting.

CHAIRWOMAN WATSON: Thank you very much, Doctor.

Dr. Ludlow Creary I do not see in the audience. Is there anyone here to represent Dr. Creary?

Dr. Peterson, Family Medicine Program at Harbor.

Dr. Peterson, I was stealing a little bit of your thunder earlier.

DR. PETERSON: Senator Watson, my name is Dr. Doug Peterson. I'm the Associate Chair for the Department of Family Medicine at the Harbor/UCLA Medical Center.

I don't know how anybody else in this room feels after this many hours of discussion, but I'd like to in some way insert a compliment to the gentlemen from St. Mary's Medical Center, who showed more courage, I think, in coming here, and more stamina than most of us would have if they were in their condition. What they are suffering is certainly much more important than the amount of stage fright that I have at this moment, and I would

certainly like to commend them and their sponsor and organization for including some people who actually have this disease in these proceedings, and your comment about perhaps having these individuals participate in further deliberations, I think, is a wonderful approach.

The L.A. County Harbor/UCLA Department of Family Medicine is developing an AIDS project under the name of the Stephen Hunt Memorial AIDS Project, honoring the life and the work of a recently deceased business colleague.

Our department is a training site for family medicine physicians, family nurse practitioners, and medical students, all of whom will be participating in our project which will combine education of health care practitioners with education of school children and their families, their teachers, as well as high-risk populations.

The materials which we are developing will be made available to four other UCLA affiliated family medicine residencies. The sum effect is that we hope that our efforts will be leveraged and that we will be educating those who'll be involved in the education of others, thus initiating a ripple effect which maximizes the return for the time spent.

The curriculum addresses 10 general areas: number one, describe the syndrome. Be able to convey the information in a format suitable for office staff, schools, community organizations, and high-risk groups.

Number two, describe common presentation of ARC and AIDS.

Number three, delineate groups at high, medium and low risk.

Number four, understand testing procedures and limitations of same.

Number five, perform high quality pre and post testing counseling.

Number six, describe methods of prevention.

Number seven, describe legal and ethical issues such as mandatory testing, confidentiality, and premarital testing.

Number eight, describe the treatment for common AIDS-related diseases.

Number nine, describe the potential economic issues as the syndrome progresses.

Number ten, describe community resources available to patients and their families.

The current copy and a printout of this curriculum has been forwarded to the Chair. And overview of how this curriculum might well be used includes the following:

Number one, participation by our faculty in the L.A. School District's Task Force for AIDS Prevention. We've had one meeting. I'm very hopeful that that will be very fruitful.

Number two, making presentations to all health education classes at high schools, junior high schools within the service area of our family medicine department, an area with a large percentage of minority students. Approximately 12 sessions will be held each semester. So far, we've addressed one school with great success.

Number three, make presentations to at-risk clients at Toberman's Settlement House in San Pedro, a resource for drug addicts, abused and runaway teens, and similar programs within the service area.

Number four, we expect all of our residents in family medicine to participate in a workshop presented by Minority AIDS Project of Los Angeles to increase their understanding of the particular problems facing minorities in the AIDS prevention and access to early treatment for AIDS. All residents in family medicine will participate in the AIDS Outreach Education Programs during their community medicine and other rotations.

Due to the rapidly changing nature of the statistics, the curriculum is continually updated on computer floppy disks, and copies of the disks will be distributed to the other family medicine programs and the L.A. Unified School District. Their assistance will be requested in the evaluation of the curriculum.

Questionnaires on AIDS information and on the usefulness of the presentation will be filled out by students and others attending sessions. Residents will fill out evaluations of the community medicine rotation, including the AIDS education component. Participating schools and social service organizations will evaluate the department of family medicine's participation at their institutions.

Last, total program costs including an estimate of the implicit costs incurred by other agencies in implementing this project, will be determined.

In closing, our department seeks support for this, what we consider to be a pilot project, which if successful, might be applied to other areas of the State of California.

CHAIRWOMAN WATSON: Dr. Peterson, we thank you for your testimony.

I'm looking very forward to working with you and other members of the staff of family medicine in trying to replicate this kind of program in other areas where it might be effective.

My staff will be working with you. We hope that we can see a piece of legislation come out of this.

For the audience, I think the family medicine division is a likely place for this information to come from, because you're dealing with people who know, number one, know biology of such a disease, work with patients, there's some trust between the medical provider and the patient. And I think you going out to the community to educate teachers and other people within the community is the way to go.

So, we're going to be looking more at your program, and looking at ways to replicate it in other areas.

So that you very much for your testimony this morning.

DR. PETERSON: Thank you.

CHAIRWOMAN WATSON: Dr. Emmett Chase, Medical Director at the American Indian Clinic.

DR. CHASE: Today I'd like to just talk about the Indian population in California as an overview, first of all; tell what services are available; what special problems face the American Indian population, and what needs the Indian population has in the State of California.

Currently California has the largest Indian population of any state. There's estimated to be 250,000 American Indians in California. Probably the second largest population of American Indians is 210,000, and I believe that's in Arizona.

Of that population, probably 97,000 are estimated to live in Los Angeles; 60-some thousand are estimated in the Bay Area. Most of the Indians are thought to be from out of state, including Alaska.

Currently the number of American Indians with AIDS is estimated to be around 50. The last report I got was 52, but I've had other reports that it was 72, and that's nationwide. Of this number, it's estimated that 25 percent came from California and New York; or 25 of the 50 cases came from California or New York.

I have no idea what the prevalence of homosexuality or IV drug use in the American Indian population is.

CHAIRWOMAN WATSON: Dr. Chase, let me just interject this here.

That's an interesting comment. The cultural patterns of the Hispanic male, maybe even the Black male, are somewhat commonly known. The Indian male, that is the Indians, period, that still is quite an unknown, even among the Indian community.

What I gather from this statement is that it's still an unknown. It's still very well hidden in the closet.

I'd like you to elaborate on that, because usually it's the forgotten minority when it comes to these kinds of statistics.

DR. CHASE: Yeah. On some reservations, it's thought that homosexuality is more so accepted than in the general population in the U.S. today. Also, bisexuality in some tribal groups is quite prevalent.

Other than that, I don't have the exact numbers and which tribal groups are involved in that.

CHAIRWOMAN WATSON: Is there much contact outside of the Indian community when it comes to homosexuality or bisexuality?

DR. CHASE: Yes, definitely, especially in urban areas like Los Angeles, San Francisco and New York.

Also, I was going to mention that IV drug use is more prevalent in and around urban areas. Probably the biggest IV drug problem in American Indians is in Arizona around the Tuscon area, as an example.

But prostitution and IV drug use does go on here in Los Angeles in the American Indian community.

Currently most people of Indian heritage depend on Indian Health Service for their medical care. The Indian Health Service recognizes a population of approximately 25,000 American Indians in California, and they provide services for this population. Of that service that Indian Health Service provides to the Indians of California, it's estimated that their programs are underfunded 40-60 percent, so adequate services exist in California for probably approximately 12,000 American Indians.

There are certain high risk problems with American Indians that I wanted to bring out as special issues. The first one is alcoholism. Alcoholism is rampant in American Indian

populations, and this is true on reservations as well as in urban areas. There are some communities that are affected; maybe 80 percent of the population is affected by alcoholism. And there's getting to be known more and more association exists between alcoholism and disinhibitions of not practicing safe sexual practices.

Also there was mention of the possibility that alcohol suppresses the immune system, and therefore makes it more susceptible to getting the disease.

Also, in the American Indian community, sexually transmitted disease rates are high. In fact, they're the highest of any minority group or any population in the United States. It's estimated that the American Indian population in Arizona, for example, has a syphilis rate that's seven times higher than the general population. The Alaskan native people experience a 25 times higher rate of gonorrhea infections than the general population.

Also, the American Indian population tends to be very mobile, and that's especially true for California because a lot of the people that live in California come from other states, and they go back and forth between their reservations and California. I would say roughly 80 percent of the Indian people in California do this on a frequent basis, holidays. Also, people from the reservations come to visit their relatives in urban settings and spend summers, for example, school kids, et cetera. So, there's a high possibility of exchange of infections because of this mobility.

The number of cases that actually known, the 50 AIDS cases that are known, are thought to be substantially under-reported because, as was mentioned before, American Indians are usually put in the "Other" category for reporting, and therefore we don't know the exact numbers that are reported. Also it's estimated that Indian Health Service itself serves only approximately 60 percent of the American Indians in the United States, and they're reporting, therefore, on a 60 percent of the population rather than the entire 100 percent.

The average age of Indians also tends to be young. I think the average age in most Indian communities now is around 25 years old. Also, the reproductive rate is high on most reservations, so there's a high sexually active young population in most reservations. Our fear on a national level is that once AIDS gets started in the heterosexual population on reservations, that it could rapidly spread within the confines of that reservation. Also, because reservations are small, closed communities, this adds to that effect, and I think that's been true as far as sexually transmitted diseases on most reservations.

As far as the actual number of AIDS cases in the Indian population in California, I have no good statistics. A lady from the CDC did a study on the Bay Area Indians on AIDS and got a 10 percent prevalence rate on a general population screen.

Next I'll move on to the needs in the Indian population. Obviously the California Indian population is in need of facilities. There just isn't enough facilities to go around to

serve the Indian population adequately. At a minimum, all Indian Health Clinics need to be provided, for example, with latex gloves, goggles and masks, and for most Indian Health Clinics at this time, those are considered luxuries.

Also, more staff is needed, especially health educators when it comes to educating people about AIDS and public health nurses. For example, our clinic serves an estimated population of 97,000 American Indians, and we have one public health nurse to provide for their needs.

The current staff that exists in Indian Health Clinics need to have adequate training about AIDS. Currently there's no training going on by the California Indian Health Service or the Federal Indian Health Service, so most Indian clinics are not receiving training for their providers about AIDS.

I referral network has to be established for Indian Health Clinics. This is especially true for the rural clinics that have no way of networking with the programs that exist in urban centers. Indian-specific health education has to be developed, especially regarding AIDS.

The Indian people of California need a strong political advocate. I think the State of California could be helpful in that avenue in asking for more funding for its Indian population from federal agencies, such as the National Institute of Health or the Center for Disease Control, et cetera.

Standards of care have to be developed for AIDS patients, probably, it seems, not just for Indian Health Clinics, but in community clinics in Los Angeles and California in general.

More research is obviously needed to better define the California Indian population.

I guess on a more practical level, I want to speak about some of the issues that we've had to deal at the local level at the clinic I work at. One of the issues is confidentiality of AIDS patients.

We feel that there is no set guidelines regarding confidentiality put forth by the State or the County. In fact, we asked the County of Los Angeles to get involved with our clinic in developing a protocol regarding confidentiality for our clinic. We put in multiple phone calls to the County, and they have not acknowledged them.

CHAIRWOMAN WATSON: Is there anybody here from the County that wants to respond?

I think the County people have left, but we'll certainly make note of that.

DR. CHASE: Also, I think the existing testing centers in Los Angeles, at least, are not doing a very good job of counseling the patients, especially the ones that are seropositive. I feel that they need to be counseled to go to facilities set up for the AIDS seropositive peoples that exist in Los Angeles. I guess those are all volunteer agencies; I don't know. But it's felt by most of the medical staff and providers at my clinic, and should be probably at all community clinics, that these people should have specialized care for their needs, their dental needs, their medical needs, and some clinics I know do exist in Los Angeles for their needs, and we can use those as

referral centers. But I think most of the testing sites that are anonymous are not doing an adequate counseling job in giving out this information of where they need to go for their further care once they're determined to be seropositive. Therefore, they're putting the general public at more risk, more known risk.

I think that probably I'd better leave it at that, and if you have any questions, I'll be glad to answer them.

CHAIRWOMAN WATSON: I was interested in your remarks, and I think your comments here are very valuable.

I did introduce a bill last year that would have established a counseling program for people with AIDS and their loved ones, because we found that these programs were sorely lacking and the support base is not there.

You also mentioned on your sheet that there needs to be an advocate, and certainly something like an ombudsman position is necessary, at least to work through the bureaucratic structure to get the information you need.

You also mentioned confidentiality. That has been one area that we have concentrated on in the last couple of years in terms of public policy. There are some general guidelines from the State level pertaining to confidentiality of patient testing, and so on. That's probably been the most talked about area and the most legislated area relative to AIDS. We need to get that information out to you.

I notice that you are at the American Indian Clinic. Is there a specific location, or is it a program --

DR. CHASE: It's in Compton.

CHAIRWOMAN WATSON: You might want to contact my office, and my assistant, Jane Uitti, and give you the information on confidentiality or any other aspect of legislation that we have already passed into law.

DR. CHASE: Okay.

I just wanted to mention about alcoholism and drug abuse.

I think the American system of medicine has done a very poor job in responding to alcoholism and drug addicted people. And I think the lack of concern and lack of training in medical schools in residency programs is at fault in this instance. And I think if we could get these people into treatment when they come in for their medical problems -- whether it be injuries, accidents, motor vehicle accidents, just coming into the emergency room for a blood alcohol level because they were stopped by the Highway Patrol -- if we can get these people into treatment and interact with them then, that we could do a lot to not only curb problems with that, but curb problems with AIDS and the spread of AIDS.

I guess that's the other thing I wanted to add.

CHAIRWOMAN WATSON: I think the onslaught of the AIDS epidemic is going to do a lot and go a long way in changing the way we deliver health services and the way government does its business. We're finding out there's a tremendous need for further research on minority populations, particularly the Indian population that sometimes gets lost through the cracks when we talk about minorities. They're not well identified since the

boundaries of the reservation are permeated by people who leave. It's hard to get the community in one spot to study it. It's not as visible as the Black community. Sometimes it's integrated in other communities -- the Hispanic, the Filipino, and so on -- so it's not easy to identify them. The names no longer are the identification like they used be, so we're going to have to do more in that regard. We have to do more in what kind of community services there are out there.

We talked a great deal about the protection of the health care workers as it relates to treating the AIDS patient. At one of the hospitals that we visited in New York, we're finding that the workers want to use a particular kind of glove, the latex glove that I have here. It's more durable; it's easier to work with, but there's a shortage in manufacturing because the demand is so great. So, the manufacturing industry is impacted; the drug industry is impacted; certainly all of the health care industries, the public health industry, counseling and psychiatric services, community-based -- I mean, it goes on and on and on.

So, we have a door of opportunity here to look at the way we deliver services, the way we go about -- the educational community is going to be severely impacted, too. So, whereas we look at it as a critical epidemic and negative, there also are some constructive things that will come out from our heightened awareness and our will to do something about it. I think we're going to be able to put together some systems that will have a positive impact on the general public.

DR. CHASE: Yes, I just wanted to mention also, like for example in family planning, we can give out condoms to people that have multiple sexual partners even if they are on birth control pills, as an example of what we can do to interact.

The other thing I wanted to try to get across was, I think we need to establish some consumer guidelines that consumers can recognize a safe clinic when they see one versus a not so safe clinic to get their medical services at. For example, if the providers aren't wearing gloves, they should aware that they're doing a disservice to their patients as well as to themselves.

The other thing is, I think that, regarding that issue on a practical -- I forgot my train of thought there, but I also wanted to say that the Reagan Administration will probably be going down in history as the administration that let an epidemic happen in the United States, and that's really unfortunate. In the United States, the number of people with AIDS is eight times that of any other country in the world, and we knew about AIDS ten years before the first case ever evolved in Los Angeles, the first diagnosed cases in Los Angeles. And that's really an unfortunate situation. And that goes to say that the public health services on the federal level have not done a very good job of protecting the United States public.

Also, I'd like to say that the way that most countries that have been able to protect their populations did it was by mass media materials. I mean, there were some countries like Sweden and Australia that did mass mailings. Everybody who had

an address in that country got a letter on AIDS and got information on AIDS.

I think that we're fooling ourselves if we just concentrate on specific target groups. I think it's good that we emphasize target groups, but I think everybody in the United States and California needs to know about the problems with AIDS.

CHAIRWOMAN WATSON: I do appreciate your remarks, Doctor. Thank you for sharing those.

Let's take another five-minute break.

(Thereupon a brief recess was taken.)

CHAIRWOMAN WATSON: I would now like everyone to take their seat so we can reconvene.

The last person in this panel is Dr. Genevieve Clavreul, Executive Director of the World Immunological Network.

DR. CLAVREUL: Good morning.

CHAIRWOMAN WATSON: Good morning.

DR. CLAVREUL: Thank you for inviting me here, Senator Diane Watson. It has been a long time since I've been in front of you.

CHAIRWOMAN WATSON: Yes, Doctor. Can you pull the mike right up so we can catch every word? Thank you.

DR. CLAVREUL: I just want to briefly thank you for doing the kind of hearing you are doing today. I think more information on AIDS is very necessary at this time.

Earlier this morning you said we did not need any more surveys, and we know the need to give out information on AIDS. I think you're very right here. I think for the last two years, we

have done survey after survey; we have had committee meeting after committee meeting all over the U.S. and in other countries.

About three years ago, I developed a system called the World Immunological Network in order to obtain, collect and diffuse information on AIDS on an international level. I feel that we are facing an epidemic, and we have to go beyond our borders to be able to deal with the disease. As it is now, we have fragmented education in different areas all over the U.S. As is true when we have fragmented teaching, we have also expenses that are far beyond what we need to do. As it is now, each AIDS project, each community agency, tries to do program after program, and their administrative costs are way out of proportion in order of what they are producing.

I feel we need to develop a system approach where high quality programs are developed and adapted to different areas without recreating the wheel every time to create a program. I am, therefore, with the Hospital Satellite Network, with a very well-established medical education network in the United States, which is on the air 24 hours a day, seven days a week, in about 1800 hospitals in the United States.

We just finished our first joint venture with Howard University and four other Black universities in the United States, sponsored by the CDC, to reach 50 churches within the Black community. The CDC did not allocate any more money so we could not reach but 50 churches. The program would be broadcast at the first of the year. But that's the kind of program we need to really look at, where we can with today's technology reach as many people as possible.

An example when you're talking about the Black community is certainly one of the ways to reach it is through the Black churches, and we should take a strong participation and joint venture with people like Reverend Mitchell in New York, Reverend Bean here in Los Angeles, and try to collaborate efforts among the people who have the technology to do it, the people who have the knowledge of the community itself, and get them involved together.

The Urban League in New York, for example, has done a lot of work and is willing to reach out, so maybe we could, through their Leagues all over the nation, develop some ongoing program.

I think the thing I would like to see approached when it comes to AIDS education is to develop a much more national type of program where larger amounts of money are located so we can disperse at a lesser cost to many areas. I think we need, first of all, to -- you mentioned earlier we need to reach the medical community, and I think you are very right on target there. The lack of knowledge of the American physician is catastrophic.

I will refer at this stage to a study done by Dr. Chuck Lewis from UCLA, which I would be glad to submit to you, which identifies the lack of knowledge among California physicians on signs and symptoms of AIDS. And even a patient could go to the office would probably unable to get identified as an AIDS patient, so I think that's a critical issue at this time, because I think a number of cases are not reported, and I think it's because sometimes it's a lack of knowledge on how to assess the

disease as well as the lack of knowledge on how to ask questions. We may identify the patient at-risk. Ninety percent of the California physicians are not asking the appropriate question to identify the risk behavior as it relates to AIDS, which I think has kind of traumatic consequences.

I think we need to also involve the health care and the large hospital corporation as well as the county hospital, and so on, to become better acquainted with the disease, teach their manager how to deal with it. And I think we need to teach the teacher to teach others. And I think that's where we have to do it, where people know and can adopt on a daily basis to their community. We have to do teaching in the schools, and I think the school system -- I just went to a program not too long ago given here in Los Angeles where parents and children of a high school were invited, many in the Latino community, and I think maybe five people showed up. I think that teaches us sometimes just even to have advertising within a parents' group and the surrounding neighborhood is not enough.

I think we have to give programs in the classroom when they have classrooms; not to do a special day on Saturday because nobody comes. I think you have to meet the needs of the people when they are there, because they don't want to hear the message in the first place, so how are they going to come? So you have to organize, I think, meetings where you're not surrounded by AIDS as the topic, but around other programs they are doing so we can reach them.

That day I saw a beautiful play by a theater group, you know teaching about safe sex and so on. The only thing I'm concerned, and not only the first time, when I see program to be delivered in the schools, I think we under-emphasize the value systems. And I think we need to also teach high standards. An example in this play, one of the girls expressed that she would like to have, you know, to have no sex, just study and be okay and good. And the rest of the group attacked her because she did not want to be participating in sex. And I think that's a little bit too much at this time. And that's about the second one I saw having the same tone. It's very quick, very brief, but the message is there: being good is not okay. And I think being good is okay today, especially today.

Also I think we need to develop some life conferences where people can, you know, interact and utilize, you know, what we have now, where we can have many city and many groups of different people asking questions and get responses to them, utilizing the leaders we have in the field.

I have been very fortunate. I received a communicator from IBM to help opening a 24-hour line between the Pasteur Institute and NIH just today, so it will help us to communicate international data. So, I hope that will be a stimulating factor for other Fortune 500 to help, to participate, and to go to other countries in the world to get connected to each other so we can communicate.

We have been in an AIDS crisis for many years right now. Would you believe that of today there is not a national data bank

on AIDS? There is not an international one for sure. I think that's one thing we need to get some of our government money allocated to. We need to develop that bank of data where all the information is there, not only the information of key scientists or of clinicians, but anyone who has done research, both the fundamental research as well as the clinical as well as education.

An example, when we especially talk about minority groups, I think most of the patients with AIDS or seropositive in those groups have a very difficult time obtaining knowledge about clinical trials. I think they are not in a favored position to participate in clinical trials for medication or treatment. And I think that's another thing that should be made available to a data bank, where they can access those trials, what are the criteria for belonging to those trials, and what kind of money is available to support them through those trials.

But I think most of all, I think the preventative aspect needs also to be reinforced. We know that AIDS is an immunosuppressive disease, and to have AIDS initial good health and high nutritional status really will not prevent the disease's progress at the rate it is progressing.

I think also we have to do a lot of emphasis on drug addiction, which is wonderful, and I agree with it, but I think we need to put the money on preventing drug addiction in our school system. Maybe approach it -- I mean, I don't have the answer on this one, but I think if we could prevent addiction, I think it would be a far easier way than to correct drug

addiction. I think maybe that's a possibility to look at when it comes to AIDS.

Myself, I have worked very closely with the CDC from the scientific point of view and research point of view. When it comes to the funding, I find the CDC not very responsive, and I think it's because maybe the criteria they are utilizing to give funding. As an example, when we went to the CDC with Howard University to obtain funding so we could reach as many of the Black community as possible, we could not obtain the necessary funding.

I think what we need to also emphasize at this time is the special responsibility of a lot of the people involved in the AIDS crisis. As you mentioned, Senator Watson, AIDS can bring the best in us and sometimes the worst in us, and I think maybe we should use a crisis to help us to work together. I feel it is the responsibility of some pharmaceutical firms who gain and will gain from the AIDS crisis to meet their social responsibility in supporting some of the education that needs to be done on AIDS as well as the insurance companies. Insurance companies have been from the beginning complaining about the impact of AIDS on their company and on their finance. I have personally contacted every insurance company within probably the United States at the top level to ask support to provide education for AIDS, and to this day I have no positive response whatsoever.

I will gladly send to you all of this literature as well as the ones from some pharmaceutical firms where I got the answer: "We do not have enough money today," or "We have already

spent enough money on AIDS. We are not wanting to spend any more." I think the same goes for the health care industry and the big corporations. Fortune 500, I think, should also participate.

Earlier you mentioned Africa. As you know, Africa is a pretty broad area which is very attacked today on the AIDS crisis. One of the things which is most needed right now is to have Africa connected with all other research labs so we can obtain better data. As it is now, all the data we have had of Africa is in two or three main cities. We have absolutely know knowledge of the disease in rural areas, and I think that's another thing that might teach us a lot about --

CHAIRWOMAN WATSON: Doctor, there is a Dr. Enrique Logan in Inglewood that has done quite a bit of informal research, and afterwards I'd like to give you her name and we'll see if we can get you a number. You might want to consult her.

DR. CLAVREUL: I would love to do that.

An example when we talk about cooperation, I've been very involved with working with Dr. Jane Goodall, who is of course as you know very involved with research in chimpanzees. And as you probably know, one of the best models that we must utilize in seeking the AIDS vaccine is a chimpanzee. We have known that for the last two or three years. We have a shortage of chimpanzees, and every chimpanzee we have in the United States are under control, so I think that, you know, maybe we need to coordinate our work together. Instead of keeping little chimpanzees in Africa, it would be kind of nice to raise some in

the U.S. As it is now, chimpanzees on the black market cost $10,000-20,000 in Africa, and for each chimpanzee we get out, they kill about nine of those chimpanzees. And all the ones we have here are under this control.

So when we're talking about AIDS, I think we need to develop a very systematic approach to the crisis, because we cannot get a vaccine without a good animal model. So when we're talking about education, it's a very global immunization that needs to be done. We need to educate scientists how to get chimpanzees. We need to go from the top to the bottom. And I would like to see maybe more emphasis on that.

Now AIDS is spreading to Singapore and Asia. And myself, I received a call from the government of Singapore the day before yesterday, and some newspaper people from Singapore who are totally unprepared to deal with the disease. So, we need to take some very active action on what's going on now.

I would just like to conclude in one point. Most of the AIDS projects have been sponsored and handled by the homosexual community, which I admire them for and I am very much in support. But I think at this time we really need to take a look at that, and I think we need to have maybe a strong leadership from the heterosexual community and the community at large to become involved with AIDS projects. Many of the leaders on the AIDS projects are themselves seropositive or are themselves being attacked by the disease. And I think we need to develop some stable leadership for those organizations on a long-term basis.

I thank you for allowing me to speak and I will answer questions.

CHAIRWOMAN WATSON: We appreciate your remarks.

When you were talking about the young people and the discussion group, and everyone jumped on the young girl who said, "I'm going to avoid sex," it reminded me of a story that my aide just gave to me that actually was said.

There was a class in a high school, and they were talking about AIDS and pregnancy among the sexually active teens. And one girl raised her hand and said, "I'm not sexually active. I just lay there."

(Laughter.)

CHAIRWOMAN WATSON: You see, we have a problem in communication with our young people as well as our non-English speaking people in trying to get the point over. I just had to mention that.

Do you think, Doctor, since you have been working with the world community in this regard, and you talk about standardized procedures, should we mandate a course on AIDS in medical training?

DR. CLAVREUL: Oh, I do. At this time I think it's mandatory. I think it is a beginning, because it's the only place we can affect it on a long-term basis.

We are in for a long war. This is not going to be over in five years, you know, and we are looking at least at the need of 10 vaccines, according to the top scientists in the world, so we have a long way to go.

And I just came back from Paris last night, where the agreement between France and the United States was finally signed on the agreement of when we discover the virus, so now everybody can work together with closer cooperation.

CHAIRWOMAN WATSON: It was mentioned earlier that we don't even know the questions to ask. If we did mandate a course, at least we could delve into how you go about examining patients.

Just recently we had to make a differentiation between the various component parts of the disease AIDS, because many doctors were declaring the death of a patient to be one of the component parts and not AIDS, and that's very misleading in our trying to get a handle on the numbers of patients. And I suspect there are many more who have died from AIDS than we know. Their death just had not been reported under that category because we are now able to link all the extenuating factors and conditions together under the title AIDS.

So, I think we ought to uniform our approach to this, and maybe mandating something in the curriculum would be the way to go.

You mentioned the churches. How does your program reach the churches? What form does that outreach take?

DR. CLAVREUL: Like I mentioned earlier, we are, I think, we are the biggest medical satellite in the world in the sense of, you know, being able to send an image. And what we can do with the technology and at very little cost is to put some temporary dish, you know, receiving dish, where any local in any

city in the United States, any churches in the United States, can receive the message we are sending. If we send it in the clear, we could do with a program where, to meet the needs of the community at large, the information has to be very specific for the community at large versus medical education, which we are specialists in. But let's say for the community at large, we can send it in the clear where any cable t.v. within the United States can pick up the message and transfer it in any home in the United States, or any churches, or any places where you can have a dish, you know, a receiving dish.

CHAIRWOMAN WATSON: You were only able to work with 40 churches. Was that because they did not have the ability to receive the message?

DR. CLAVREUL: The CDC did not want to allocate any more money.

CHAIRWOMAN WATSON: They were on a very limited budget in that regard.

DR. CLAVREUL: They did not have a limited budget. The money was there. As a matter of fact, it was a very large amount of money which had to be spent before October 21st. I would like to know what happened to the money.

CHAIRWOMAN WATSON: In the Black community, and possibly the Hispanic community, if there is an effort out of the church, the chances of the effort being successful are better than out of any other community-based program.

DR. CLAVREUL: I know. I have been very involved with the Black community for a long, long time. I was in Georgia for

eight years, and I worked with the sociologists who had specialized in Black communities, so I know quite well how to reach it.

I've been very involved with the Black Women Physicians Association, which I think should really help.

I know at the beginning of the AIDS crisis, I tried to reach the Black business community, and I could not get any response from that Black business community, but the Black Women Physicians were responsive. So, I think if we get the participation in the Black community of all the Urban Leagues from all over the U.S., and all the Black churches, I think that would be a good first step to reach the community.

An example is, we can have each reverend in each church, the week before, in their sermon mention the program, and we can equip those churches with a temporary satellite. A lot of the churches already have satellites, and that's another service which can be utilized. And this could be an ongoing program. It would cost very little to show the program every three months or every two months, because as long as the program is done, we can transmit it as many times as necessary at different times, different places and so on.

CHAIRWOMAN WATSON: At 11:00 o'clock on a Sunday morning we have a captive audience in most of our churches, and I really feel that we're going to have to put some of the responsibility and accountability there with our network. We are not lacking for places of venue because we've got thousands of them here in this city. And I was interested in what you were saying about working through those churches.

We have a long way to go to understanding how to reach out and do outreach in the Black community. Dr. Logan has done a lot of this. I mentioned her name to you, and I asked my staff person to contact you and give you her number. I'd like you to touch bases with her. She was President of the Black Women Doctors and the Physicians Association of Inglewood. She's one of the few people in this community who's an M.D. who is talking about the immunological aspects of the disease. She's dispelling a lot of the myths about Africa's role in all of this.

We've got to get beyond the myths. We've got to get beyond the hysteria and beyond anxiety, and really get into the facts and get something moving.

I do appreciate your testimony, and we'll be in touch.

DR. CLAVREUL: Thank you very much.

CHAIRWOMAN WATSON: You're welcome.

Sala Udin, Executive Director of the Multicultural Prevention Resource Center. Is Sala here?

Daniel Lara.

MR. LARA: Good afternoon, Senator Watson. My name is Daniel Lara. I'm the Program Manager for Community Education at AIDS Project Los Angeles, and I'd like to thank you for inviting me and my agency to participate in these hearings this afternoon.

The last time that you and I spoke, Senator Watson, you may not recall, but it was at Davidson Center at USC; I believe it was in June of July of this year.

I'd like to give you a little brief update as to what happened as of then. At that date I had the honor of being the

facilitator for a group of persons with AIDS, and we had a panel of six individuals. Within the last five months, two of those individuals have died; one is now at this point on life support systems; one is back in the hospital with another bout of Pneumocystis carinii pneumonia; one has gone back to street prostitution because he did not qualify for the amnesty and therefore would not receive SSI or Medi-Cal; and one has converted from ARC to AIDS, and his whereabouts are unknown at this point.

A lot has happened in terms of the work that we are doing and the lives of persons with AIDS.

CHAIRWOMAN WATSON: Let me just interject at this point for Dr. Clavreul.

You mentioned that six people attended an AIDS forum. At the forum that we had, there were two of them going at the same time. One was at the Davidson Center, and one was Quincy Auditorium at Exhibition Park. The other was at USC, within walking distance of each other. We ran our forum from 9-5. We finally ended up combining the two groups. The two groups all put together, we didn't have more than 100 people.

So, it was like a crushing blow to me in realization that we were going about it the wrong way because we ended up talking to each other. We looked around the audience. Here were all the technicians, the experts, the researchers, staff, and no one else except the people with AIDS that you brought in. And it came home to me that there was something that we didn't know, and that what we were doing was the wrong way to go about it.

While we make mistakes that way, people die. So we have to look at alternative ways. I think we're learning better how to do that.

I just had to say that, Mr. Lara. Continue, please.

MR. LARA: I'm going to pay myself a very high compliment right now, and I'm going to say that I see a lot of myself in you, in that I think that when you take an issue, you take it by the horns and you run with it. I identify with that procedure.

I hope that after the hearing today, you take the issue by the horns, by the tail, by the neck, whatever needs to be taken, and you drag it along with you. You come with a very, very high reputation. You have a great deal of prestige. You have a great deal of leadership, and I hope that you use that to help us fight this issue.

What I'd like to talk about is a little bit about the agency that I represent, and then give you some of my own background.

I am the Program Manager for Community Education. My responsibility is to develop curriculum and processes to take education to the Black, Hispanic, Asian-Pacific communities. AIDS Project Los Angeles is the oldest and the largest AIDS organization in Los Angeles. We have a staff, a paid staff, of approximately 100 individuals. We have a volunteer staff of 1,280 -- excuse me, that's our client staff, I apologize. We have 1,800 volunteers.

We -- our two major divisions within the agency are Client Services, which provides direct services to our clients who are persons with AIDS or ARC or their significant others, and our other major division is that of Education and Training, of which I am a part.

In our Client Services division, we currently have 1,280 clients. It has pretty much remained constant in that we lost approximately 6-10 clients per week. Our ethnic breakdown is pretty much predominantly White, self-identified gay males; 23 percent of our clients come from ethnic backgrounds, the predominance of those being Hispanic, the minority of those being Asian Americans.

The types of services that we provide to our clients are, in resident care have just opened a house which will house 30 persons with AIDS. We have another care facility which houses six persons with AIDS, but they're pretty much at the acute stage or at the end stage. We have food services, transportation services, and dental clinics, counseling for persons with ARC and their significant others, and still it's not enough.

Still we have waiting lists for our mental health services up to six months. So, if someone is in a crisis, they can't receive our services for six months. If someone is in need of dental care, they can't receive our services for one month. Many times that comes across as apathy to other AIDS service organizations, but in reality we are dealing with more than one-third of the client loads of persons with AIDS in the County of Los Angeles.

My own background. I kind of asked myself the question: How did a nice elementary school teacher get to here?

CHAIRWOMAN WATSON: I've said that to myself many, many times. That's my background.

(Laughter.)

MR. LARA: How did I get here? How did someone who was, a year and a half ago, teaching fifth graders who to transition from Spanish to English, how the Hell did I get here?

Probably the only way that I can recount that story is through a personal story, in that about a year and a half ago, I was invited to a presentation by a friend of mine to meet Paula Van Ness, who was then the Executive Director of AIDS Project Los Angeles. I was asked to come to the presentation because I tend to be somewhat opinionated and not real concerned as to how I phrase that. And it was felt that Paula needed to have some issues brought to her attention. So, I was kind of the ringer in the crowd in that I was going to bring concerns on behalf of the Latino community to Paula and APLA as a whole.

The long and short of it was, after my tirade to Paula, she came up after the presentation and said, essentially, "Put your money where your mouth is. Why don't you come and become a part of the agency?"

That was in May, and I said to her, "So what are you willing to pay me?" She said, "25,000 to start." I was making almost 42,000 -- this will be public record, will it not -- I was making almost 42,000, and I laughed at her and said, "There's no way I'm going to come to the agency for 25,000."

From May to June, my very best friend became diagnosed with AIDS. In trying to provide services and find services for him, there was nowhere. He is Spanish speaking; he's undocumented, and I went from agency to agency looking for services for him, and we could not find it anywhere.

I finally wound up at AIDS Project Los Angeles, and I figured the best way to move the agency was not from the outside but from the inside. So, I took the position and became a part of the agency. So, that's how an elementary school teacher became part of APLA.

I would be lying to you, Senator Watson, if I said in the year and a half that I've been with the agency that we have come 180 degrees. I can't look at you and tell you that that's a reality.

I can tell you that within my own division, however, we have made significant changes. I'd like to share some of those changes with you.

Some of the programs that I have instituted and those colleagues that have helped me develop is a program called Entre Nos, E-n-t-r-e, new word, N-o-s. Yolanda Ronquillo, who will give testimony also this afternoon, is part of that program.

The program follows more or less the Tupperware format. That is, we train a group of women who will then train or meet with women in their own community to deliver the message on AIDS. One of the things that we've found is that people generally don't want to talk about AIDS. So what we've done is, we've put that in the surrounding of general health care for women, so within

the presentations we talk about Pap smears, self breast examination, and STDs, and among STDs then we talk the issue of AIDS, we address the issue of AIDS.

One of the myths that exists within our community is that people will not come out to hear presentations on AIDS. I want to now state for the record that that is not true. I came in with that impression, that our community will not talk about AIDS and will not talk about issues of sexuality. That is a myth.

What I've seen has happened is, AIDS service organizers and AIDS service providers don't know how to present it in the format that is acceptable to our culture. One of the programs of which I am most proud is the Community Forum Program that is held in conjunction with the Los Angeles Unified School District's Adult Education Division. We have agreed to take our programs to the ESL Level One program, in which the students are primarily monolingual Spanish speaking. The lowest number that we have had in attendance to date -- and this has gone on for six months -- is 500. The highest number that we have had to date is 2,700.

Now, they're not coming to hear us. They're not coming because they think that AIDS Project Los Angeles is fantastic. They're coming because they've heard the format and the format works.

The format is divided into three components. The first is the medical presentation. We always have a doctor or a nurse, and if we can, we have them dress in a smock because the community identifies with that. They tie into and relate to the authority position that that doctor or nurse represents.

The second format is the psychosocial component, and if I could give a subheading to that it would be: What is it that's happening in our community that's keeping us from dealing with the issue of AIDS? And we address the issue of homosexuality, bisexuality and religion, and so on and so forth, that are cultural factors that keep us from hearing the message of AIDS.

The third component, which is probably the most powerful and the reason that people attend, is the testimonial part. We have a panel of persons with AIDS who will recount what it's been like for them since they've been diagnosed. On the panel we always have a woman and her child, a family member -- that is, a husband and wife team -- and then another gentleman or gentlemen who, if they choose to, will talk about their sexual history.

What happens, Senator Watson, is at the end of the presentation, it's impossible to distinguish who's on the panel and who is in the audience. Even in a group of 2,700 there is such a bonding and such a tie-in because the members of the audience can identify directly with the plights of the persons with AIDS.

I think it's imperative that we develop messages and programs that show that there is not a distinction among -- between the people who have AIDS and the people in the audience. Many times when I sit in my home, or I'm at my home and watch television, and I see public service announcements, and I see self-identified Anglos talking about their experiences, in my mind I say to myself, "Why should I listen to them? I don't identify with them." When I see brochures that come out that

have self-identified gays, I don't bother to read the brochures because I say in my mind, "I'm not at risk."

We need to develop identity within the community. We cannot continue to translate materials. It doesn't work. When the predominance of -- I'm very cautious when I say this because I don't want to generalize my own population, my own group -- but when we look at the reading levels, and based on my experience as a teacher, that generally we find that first generation, second generation Hispanics are not reading at the 13th or 14th grade level, and that's where the materials are printed.

We need to adapt materials that have a readability level of fifth and sixth grade and are tied into the culture.

Another thing that we're doing through AIDS Project Los Angeles is the development of a self-care manual. We have a self-care manual now that's in English, but it's directed to the person with AIDS and tells him or her how to take care of him or herself. What we found within our own culture is that when a person has AIDS, they immediately go back to their family. The self-care manual is directed to the extended family. The extended family includes mother, father, sisters, brothers, uncles, aunts, godparents, anyone who happens to be walking by or walks into the house at that time. The manual must outreach and take into consideration all family members.

The last thing that I'd like to talk about is the National Symposium which will take place on February 24th and 26th here in Los Angeles, and it will be targeted. It will be by invitation only. It will revolve around eight round table

discussions that we've identified that are pretty much germane to the Latino experience.

This is the first time that a national symposium has been planned by Latinos and for Latinos. The money is being funneled through AIDS Project Los Angeles. They are acting as the administrators on this symposium, but the entire committee is made up of Latinos; the entire responsibility comes back to us, and I think that that's the key point. We as Latinos, and as Blacks, and as Asian Americans, must be given the responsibility; responsibility re: resources, money, to implement and develop our own programs. But at the same time, we must hold those agencies which are in existence accountable for implementing programs that are responsive to the needs of other communities.

I know it's been discussed here that percentages of the funds coming down must be targeted to minority communities. I think that's true. But I also think that those agencies that are receiving funds must be responsible for developing programs that will meet the needs of other communities.

The last point that I'd like to make is that I think it's been discussed that money to be channeled from State directly to the County. I think that would be a major mistake, and I would like to talk about my experience in developing and funding our Spanish language hotline, which has been to this point monitored or implemented by the East Los Angeles Rape Hotline. The funds were approved in July of last year. It took us almost until February of the following year to get the funds in place. County response was -- I would over-exaggerate the

point if I said it was slow. The hoops through which we had to jump were impossible.

I think that monies and agencies must be given the opportunities to respond directly to State RFPs. If the money is channeled through County agencies, I think that we have essentially thrown the battle a year back.

I'd like again to take the opportunity to thank you, Senator Watson, for having us here. If there's any way that I can respond or help you in your battle, I'd be more than happy to.

CHAIRWOMAN WATSON: I am interested in, I guess, a repeated statement that you made that we have to be sure that we do more than just attend to these target groups, but look at the whole population, the population as a whole. And sometime in the recent past it was felt that the AIDS Project dealt with minority issues kind of on an incidental basis.

I am wondering if the emphasis is taken off of some of the under-served groups if we do not continue to deal with minority AIDS issues kind of incidentally? Are we ready yet?

I noticed your comment about the changes you thought the Project needed, and even with your presence those changes have been slow in coming.

If we take the emphasis off pushing for more minority group attention, would we lose out on our effort altogether at this point?

MR. LARA: I believe so. I think that we must keep the pressure on the agencies that are in existence.

AIDS Project -- I'm really glad I'm the first one here from the community organizations, because I'm going to say a lot of things that other agencies may say about us, but I think that a year and a half ago, or a year and three months ago, it would be very accurate to say that there were no programs in place and very little had been done to respond to the needs of other communities.

I think that's changing. I think there's very dramatic changes needed to occur, but the process is in place. I think that we'd be unwise, in my opinion, to take the pressure off of those groups that are now in existence and move it to other agencies.

What I would like to see, however, is that -- there are many, many agencies throughout the Black and Hispanic communities that are expert in their own particular field. What I would like to see is, for example, let's say a program or an agency that is expert in gang abuse, to be able to train that agency to become AIDS experts. That does not mean to bring on additional staff. That means that agencies such as our own would be responsible for developing training programs or working with those agencies to develop key persons in that agency that we would then augment their expertise.

CHAIRWOMAN WATSON: You mentioned in your presentation that people will come to AIDS forums, you just have to know how to present it to them. How do you get them there to make those presentations?

MR. LARA: One of the advantages that we have, or that I have, is that having been a former employee of the Los Angeles Unified School District, I very wisely kept my connections there, so I was able to go back to connections that I have with the adult schools and ask for their support.

I think that the programs, to answer your question more directly, I think the programs have to be formatted in a way that is understood by the culture. Yolanda Ronquillo will give testimony this afternoon, as I said, and she has developed a dynamic video. Sandra Hernandez gave testimony to that earlier. That's one way that the community will buy in.

There are materials out there now. We need to be able to use what we know.

I would agree also with the doctor beforehand that the time has passed, the time has gone, for doing more needs assessments. We know our community. We know what we need to do. What has to happen is, funds need to be released so that we can implement what we know works.

CHAIRWOMAN WATSON: So, I guess I hear what you're saying is that if you have an organized structure, like the adult schools at LAUSD, you could go in through those programs, and you have a captive audience there.

Has L.A. Unified taken a position on this? Are they allowing you to go in? Is it a more sponsored kind of program, or is this an informal thing that you've arranged from school to school?

MR. LARA: Although there is no formal contract between AIDS Project Los Angeles and the LAUSD, we do have approval from their Board Member, Jackie Goldberg, who also happens to be a member of our board. We also have approval from the division head level, so there is approval.

When we first went in six months ago, we had to go in literally holding hands with the American Red Cross because then it was safe. Since the response has been overwhelming, we've now been able to sever, or at least not have Red Cross with us on every presentation.

CHAIRWOMAN WATSON: Are just working with the schools in Jackie Goldberg's district?

MR. LARA: No, not at all. We're working throughout the Los Angeles Unified School District.

CHAIRWOMAN WATSON: It's interesting, because you know our parenting and our clinics in schools are meeting with a lot of criticism and opposition.

MR. LARA: That's an understatement.

CHAIRWOMAN WATSON: And this probably, you have the informal approval, it hasn't come before the Board yet as a formal program. I think it's smart to do it that way, and I know that Jackie is good on these issues.

But you are using an approach that I think might be very helpful to us in terms of trying to get some information over, the adult school. We were trying to do it through K-12, and we're having a great amount of difficulty doing that.

MR. LARA: I know that LAUSD is now implementing curricula that will be started at the secondary level. They received grants from CDC, I believe, in the amount of 325,000 for the first fiscal year, and I do sit on that task force, so I'm looking forward to what they have to develop.

CHAIRWOMAN WATSON: I'm glad to know that. That will make, probably, my bill get through a little easier, or somebody's bill anyway.

Thank you so much for your testimony.

MR. LARA: Thank you so much, and I hope that the next time that I see you that I can tell you that, because of your efforts, that we have saved lives rather than lost lives.

CHAIRWOMAN WATSON: I certainly would hope and pray to that.

MR. LARA: Thank you.

CHAIRWOMAN WATSON: I understand that Sala Udin has just come in, Executive Director with the Multicultural Prevention Resource Center.

MR. UDIN: Honorable Senator Watson, colleagues and guests, thank you for the opportunity to testify before this California Senate Health Committee on such an important topic as the effects of the AIDS epidemic on minority communities.

I would also like to thank the Senator personally for allowing us to capture her attractive image on our video, "Black People Get AIDS TOO". It has been well received.

I would remind the Senator that the last time we met was when I made an impromptu presentation on AIDS in the Black

community at the Speaker's State of the Black Family Hearing in 1986. At that time, the statistics I shared were received with shock and disbelief by many present. Now these numbers are quite well known thanks to the work of public servants like yourself.

There is much rhetoric these days about the AIDS impact on minorities, but I'm afraid the distribution of resources does not quite match the rhetoric. At the State of the Black Family hearing two years ago, I made the Legislators aware of the all-White, all-male AIDS Advisory Committee and asked that it be made more representative of Blacks, Browns, heterosexuals, minority gays, and women. Since then, the only change was to appoint one staff person from the Speaker's office who is a Black gay man. Fortunately, Brandy Moore has the integrity to speak for the interests of those omitted groups, but he's only one person. And nothing can substitute for those groups having someone in addition to Brandy to speak for themselves.

It is rather difficult for community representatives and service providers to speak intelligently about the needs of minorities because it is difficult for us to see the big picture statewide. We don't know what the State plan is, and what is priorities are, and how it plans to allocate funds to those priorities. We don't know who has done what or who's doing what. We usually just sit and wait for RFPs to fall from heaven, and we respond to the ones that seem to fit our capabilities.

Perhaps these questions will be clarified at the statewide AIDS and Minorities Conference being scheduled for the Spring of 1988. Perhaps also this conference could be an

opportunity for minorities to network and organize along professional lines and ethnic lines. A stronger constituency will help make the State program a stronger and better program.

When responding to the needs of the gay community, the State found a comparatively homogeneous community as compared with the disparate members of the minority community. Each group has different levels of involvement in the disease, and different cultural norms and communication patterns, all requiring different strategic and tactical responses.

At the top of the list, however, are minority persons with AIDS or ARC. In perhaps the twilight of their lives, PWAs deserve compassion and dignity. They deserve to live out their final days in a surrounding that is culturally familiar and sensitive, with services provided by their kind, their family, their friends, people who genuinely care.

Of course, some minorities are completely at home in hospices and other services set up to serve primarily White gay males. For others, it will represent an added stress and source of alienation. Housing, case management, nursing care, day care and other services should be designed for these populations also.

As you know, the State of California has made a concerted effort to increase the availability of antibody testing to heterosexual and minority communities. This is fine. However, most communities do not provide education and counseling services to persons who test positive. They may get brief counseling when they pick up their results, but that is absolutely insufficient. Most often, people who are in a state

of -- people are in a state of shock when they are told of a positive result and don't hear much of what is said in the post-test counseling session. They need help the next day, the next week. They need intense education, not only regarding the danger they represent to others, but how to delay or present the onset of symptoms and full-blown AIDS.

Minority gays and bisexuals are still under-served when it comes to education and prevention services. They fall between the gap of services to gays and services to minorities.

Intravenous drug users who are not in drug treatment programs represent the overwhelming majority of all IVDUs. They are not being reached. They can best be reached by trained ex-addicts working the streets, playgrounds, alleys, shooting galleries, et cetera. These programs are probably best housed in drug treatment programs so that the recruitment and referral can be accommodated when appropriate. But this implies that adequate drug treatment services are in place. Not so. More services are needed and not just methadone. Different people require different rehabilitative techniques.

Minorities constitute a large segment of inmates in the State's jails and prison systems. Inmates infected with HIV need to be monitored by the Department of Health Services to assure that they are afforded basic human rights, compassion, education and needed services. Many minority community members feel that inmates are simply being isolated like lepers.

Minority women may be the next hardest hit population because they are vulnerable to infection from so many different

directions, and they are often so powerless. Women IV drug abusers are frequently injected by their husbands or boyfriends, who have shared their works with several others. Most minority male IV drug abusers have sexual partners who are minority women, and many have more than one sexual partner. Very few use condoms.

Minority men who are gay have a high incidence of bisexuality which exposes minority women and often children. Homosexual activity in jail and prison is common place, frequently among men who consider themselves heterosexual and who, upon release, return to women who may themselves be exposed to HIV.

Minority adults who have multiple partners -- multiple meaning more than one -- sexual partners are at risk and are frequently not targeted in AIDS prevention materials. The same is true for sexually active minority youth. Most of the youth education is White-oriented and school-based; whereas, the most at-risk youth are minority and frequently out of school.

In order to have maximum impact on minority high-risk population, it will be necessary to be effective in educating and mobilizing minority leadership in the community. They play a substantial role in shaping some opinion among high-risk community members. Leaders must be trained and won over to the war against AIDS. Then they must commit to educate everyone in their constituency, as well as high-risk groups and the general community.

Community leaders can be very effective in mobilizing minority volunteers to provide services to PWAs and participate in fundraising and educational activities. Community leaders can be effective in recruiting entertainment stars and sports heroes to raise funds and conduct public education and persuasion.

Some minority stars have been recruited to raise money for White gay groups and haven't raised a dime for minority groups. This is not to condemn these efforts, but charity starts at home and then spreads abroad.

The State spends a significant amount of money on AIDS research, but not much of it goes to minority researchers or researchers doing work on minority issues. Dr. Amanda Houston Hamilton and the minority-owned Polaris Research and Development Corporation accidentally discovered, through a computer run, that the average post-diagnosis life span for all PWAs in California was approximately 18 months. However, when they isolated the life expectancy of minority women, it was 47 days. Why? We don't know.

But why should this revelation have been accidental? Because minority research, and minority researchers, are not a priority in the distribution of research funds.

My final suggestion is for a statewide minority information and training resource center. Such a center could offer an information library, print a regular newsletter, publish articles and materials relevant to minority communities, produce literature, videos, et cetera, provide training, workshops and conferences, as well as technical assistance consultation to communities upon request.

We beg your forgiveness for the lengthiness of this testimony, but we felt the need to be thorough.

Needless to say, I and MPRC stand ready to assist the Senator and the Health Committee in any manner helpful to our common cause of combatting and defeating AIDS in the great State of California, in the United States, and in the world.

Thank you.

CHAIRWOMAN WATSON: We appreciate your testimony. We were waiting to hear it. We remember you from the last time that you spoke in front of our legislative group.

Much of what you have mentioned we have discussed earlier in the day in these testimonies. Thelma Fraziear was in the audience. Every time I mention her name, it's a time that she pops out. I'm not trying to bring attention to the fact that you're not here, but I just wanted to say to you, I'm very interested in maybe the next step. Ms. Fraziear mentioned that there was a percentage of the funds used for the assessment in the minority community.

Maybe the logical next step, Thelma, would be to put together such a statewide minorities group, AIDS research group, or advisory group, or something, where we can really have some in-depth focus.

I was compelled by Dr. Chase who brings up the problems relative to the Indian group. And we know less about that group than any of the others. I am compelled by the information you brought to us before and you bring to us today as to how little what we know pertains to the Black community. The gentlemen that

were here, people with AIDS, spoke from their own personal experience of having nothing and no one to help them. And those that can find their way into a program attached to a county hospital are far more sophisticated than the majority of those.

So, maybe it's time to take that next step. We would certainly work with Ms. Fraziear and the Office of AIDS to see that such a committee or commission, or whatever we want to call it, might be established.

The person who serves on your committee from Speaker Brown's office can be very helpful, too. You might want to get in touch with him.

MR. UDIN: We're in close contact.

CHAIRWOMAN WATSON: Have him make that recommendation to the Speaker, because through his Assembly Office of Research something could be done there, too.

We'll be working on this, and Ms. Fraziear will work with you also in this regard.

Thank you very much for your testimony.

MR. UDIN: Thank you.

CHAIRWOMAN WATSON: I understand Dr. Samuel Shacks is in the auditorium now. He's representing Ludlow Creary.

DR. SHACKS: Senator Watson, distinguished Senate Health and Human Service Committee Members, participants and staff, it is my privilege to convey testimony from King/Drew Medical Center on the subject of AIDS in Minority Communities.

The presentation's goals are to offer comments on issues identified by the Committee and to express additional unique

concerns of minority health providers and subscribers here and elsewhere.

Today's hearing deserves our wholehearted enthusiasm and support. Few public health problems throughout the history of mankind have prompted equivalent concern and raised so many questions as this deadly disease. Importantly, the Chairperson's previous effort, interest, and leadership has enabled health improvements for all Californians. In continuity with such earlier achievements, a desirable outcome would be the identification of support to empower community-based health institutions to more effectively meet the medical needs of presently undersubsidized populations.

King/Drew Medical Center, by virtue of its location, mission and orientation, is ideally suited for the mutually related tasks of AIDS care, education and research. The Center service area consists of more than one million residents, 45 percent of which are Black, 30 percent Hispanic, 24 percent White, and the remainder are made up by other ethnic groups. Our institution is, in addition, committed to conduct basic and applied research in the health sciences directed toward the improvement of health of minorities.

Senate Health and Human Services Committee Questions, as to Question One:

> "In your opinion, are Black and Hispanic communities in California at higher risk for AIDS? If so, why?"

Our answer is yes. Lower socioeconomic group status or poverty heightens the likelihood of stressful experiences conducive to behavioral maladjustments. This, coupled with existing educational deficiencies, a highly transient population, and inadequate prevention strategies combine to negatively impact Black and Hispanic community health. Parental substance use is pandemic; sexually transmitted diseases are at epidemic levels; inadequate sexual preferences contribute to bisexual and homosexual contracts, and in utero human immunodeficiency virus transmission is affected by these and other risk behaviors. The absence of a minority AIDS resource center in Southern California further exacerbates existing needs of our community.

Question Two:

> "What types of AIDS education, prevention, and outreach currently operate in Black and Hispanic communities?"

To our knowledge, there is a consumer program of education and community outreach which operates with the support of local church and political leaders.

King/Drew Medical Center and the National Organization of Black County Officials, with CDC support, will soon initiate an education project for AIDS prevention in South Central Los Angeles. The King/Drew School of Allied Health has received funds to offer AIDS training to Allied Health students in a training the trainers activity. And there is the solitary federally funded Minority AIDS Project LA located outside of South Central Los Angeles.

CHAIRWOMAN WATSON: How effective is this program?

DR. SHACKS: We have interacted with Reverend Bean and a number of the Boards of Directors, and I think Dr. Jordan will probably be speaking more specifically to that, if he hasn't already done that today.

We find that it is limited based on the amount of resources that it's got, that it has little real impact inside of our service area.

CHAIRWOMAN WATSON: I know that Dr. Bean's work is well-known as an individual, but I --

DR. SHACKS: No, I was saying Reverend Bean. Dr. Bean is different.

CHAIRWOMAN WATSON: Reverend Bean is the one I'm speaking of, too. I know his work is well-known. I do not know the project, how effective it is as a project.

DR. SHACKS: It certainly answers a need that's more central in West Los Angeles. It is not large enough to take care of the needs as defined by institutions outside of our area, such as UCLA, USC, that's described the incidence and prevalence of this disorder in our area. And we haven't been able to do so in a responsible way due to lack of resources until this time.

CHAIRWOMAN WATSON: Do you know or have any idea of what the funding has been?

DR. SHACKS: At the present time, we have a federal grant through the National Institute of Allergy and Infectious Diseases, which started as of October 1 for about $300,000 a year for two years. That's to look at the sero epidemiology of HIV infection in South Central Los Angeles.

The National Organization of Black County Officials, that is an education project, and it's funded at about $100,000 a year, and it will provide for personnel resources located at King/Drew Medical Center.

Beyond that, there has been an attempt to garner funds from the County to provide for some additional consumer education in and around King/Drew Medical Center. I know of no other fund that's available in our community at this time.

The problem is even worsened when we look at the absence of testing sites in our community. One would have to go to Long Beach or to Roybal or to Ruth Temple as it presently stands. And one of the best kept secrets in our area is where is UCLA. So, that's a long ways away for us as well.

We're resource poor. We're even more concerned in that AIDS is not a problem that is disproportionately represented in terms of Blacks as a biogenic concern. It certainly is there because of some behaviors that we exhibit, but it is more of a problem because of weak infrastructure for diabetes, for sexually transmitted diseases. It takes away from what is already there and in place, and it makes it impossible for us to do an effective and efficient job with our current responsibilities.

CHAIRWOMAN WATSON: I was just saying to Judy that we need to increase the funding in this regard, and what we need to know from you is where it should go. Should it be research that will give us additional data, or should it be research directed as to what are the most effective programs? I think we are inundated with numbers coming out of CDC, coming of the State

Department, everyone who has spoken has had some numbers that they have presented to us.

But I heard what you said, and it looks like we're disproportionately funded to actually have programmatic resources there, available for people with AIDS. Is that correct?

DR. SHACKS: That's absolutely correct. And in terms of the depth of the problem, we have some information, as you have mentioned, that's come from CDC and other institutions locally, but we're not certain about the validity of certain of the data. We feel as though there's no one that we know of that's working in our health service area to acquire much of that information. It appears as though statistics is of significance to the way this information is generated.

CHAIRWOMAN WATSON: Dr. Evans from San Francisco mentioned that they were contracting to have a survey done to be able to get a handle on the attitudes that prevail. And she said they were making headway with that.

I've heard a couple of other people, too, mention successful survey input.

DR. SHACKS: Well, separating health perception from the prevalence of the disease, and there's certainly a real problem in terms of health perception.

I'm saying that in terms of the prevalence of the disease, the data, the base of that data is soft at the present time. We, in fact, are able to account for, unfortunately, four cases of AIDS in newborns since May of this year. I'm certain that that is not data that has been generally picked up and

distributed unless it's gone all the way through the system and is now --

CHAIRWOMAN WATSON: The press is doing a pretty good job with that.

DR. SHACKS: They're doing a fairly good job. We don't know whether it's over or under, though, in reality.

And there's the additional problem of individuals who seem to be dying from cardiopulmonary arrest with some other manifestations that may, in fact, be indicative of this problem. We don't know whether the diagnosis is being made where it should be made.

That really brings me to the point of where I would like to see the money spent.

CHAIRWOMAN WATSON: That's what I need you to tell us as a matter of record.

DR. SHACKS: I think that if we skip to the last page of this --

CHAIRWOMAN WATSON: You don't need to skip as long as you mention that before you finish your presentation.

DR. SHACKS: All right.

Proceeding through the questions, then:

> "Is the State doing an adequate job in preparing and disseminating culturally-relevant information to the Black and Hispanic communities about AIDS?"

The south health service area of Los Angeles lacks significant State resources for AIDS care, education and

research. In fact, the number of governmentally-sponsored minority sensitive AIDS activities -- such as clinics, counseling, and testing sites -- appear inadequate to nonexistent. In South Central Los Angeles, these activities are largely nonexistent.

"In what specific ways can these efforts be improved?"

Alternatives, we feel, to the already overburdened hospitals are needed because of the problems of infrastructure. There are now more than 3900 reported AIDS cases in the County of Los Angeles. Hospice care for minority persons living with AIDS is available only through the Minority AIDS Project of Los Angeles in any significant respect.

Minority community concerns involve the lack of adequate dental care, skilled nursing facilities, and voluntary testing programs for HIV infection. Such testing programs should be anonymous, free to the clients, voluntary, and operate to enable full public access; that is, more than two hours a day.

"At what community focal points should AIDS counseling, information, and testing be best integrated into Black and Hispanic communities?"

I felt that the suggestions that the Committee had indicated were highly appropriate, but in addition I would suggest that parents and guardians who make use of Headstart programs also have available AIDS education and prevention activities, as these are usually people in the reproductive period of life.

Provider training may be needed to improve current diagnostic skills, counseling for HIV positive persons and their loved ones, and to assure patient confidentiality. For this to be successful, collaboration between the State and local minority-focused institutions is needed to succeed with culturally sensitive projects.

"Should AIDS virus tests be mandatory for any segment of the population in order to curb its spread?"

We feel that this approach should be reserved until the biology of HIV infection is better understood, until it's known how frequent such tests would be needed, and therapy is available involving more than abstinence and education.

"What would be the impact of mandating testing of prisoners, pregnant women, known drug users, or other populations?"

There would be a false sense of security for individuals harboring HIV but lacking antibodies to the virus. Victims of HIV infection would be criminalized or, short of that, stigmatized. A significant percentage of HIV infected persons would avoid HIV testing and increase the overall population risk.

An additional issue for the Senate Health and Human Services Committee consideration. The AIDS Governance Committee at King/Drew Medical Center proposes that the State consider contracts in preference to grant mechanisms in funding research, service and teaching instruments. Adoption of this convention will improve minority institutions' ability to respond to State

initiatives. The ability to respond, coupled with institutional interest, will assure that a representative percentage of State resources impact minority communities and institutions.

On a second level, this strategy will elevate minority research participation above that of dispassionate conscription and eliminate the present inconvenience of location.

CHAIRWOMAN WATSON: On that issue, you are recommending contracts over grants.

Can you elaborate on that?

DR. SHACKS: Yes.

Generally when we think in terms of requests for applications, or request for proposals, we are thinking of a device in which much of what is being asked for will be novel to the institution or to the problem under consideration.

Much of the kinds of information, we feel, that's necessary to better understand who is affected and to disseminate information about AIDS already exists. Therefore, if it's in the form of contracts, it would be a matter of institutions identifying their capabilities and making bids as to the projects.

The turnaround time and the need for additional staff at places like King/Drew Medical Center would be favorably impacted through the contract mechanism; whereas, it may take weeks in order to respond to a grant mechanism.

In conclusion, the State is encouraged to make every attempt to empower institutions within Black and Hispanic communities to care for, study and teach residents about AIDS.

Adoption of the proposed strategy will extend State support to unsubsidized minority communities.

I thank you for the opportunity to provide testimony and would be happy, if there are other questions pertaining to this presentation or to King/Drew Medical Center, to so field them.

CHAIRWOMAN WATSON: Very good.

I get the idea now you feel that the granting mechanism is too cumbersome, and there are too many delays attending to that.

And then in terms of your recommendation, if we could channel resources into minority programs already operational -- hospital-based, university-based, or whatever -- this would be one way of going after the problem. Let them do the research; come up with the statistical base; come up with the actual programs and implement them.

DR. SHACKS: We feel as though that's the absolute best with the kind of fee that's associated with this problem in our community and the large availability of HMOs and others with less than sufficient private provider care. We have to almost look at this as a larger institution problem; a problem to be addressed by a larger institution. We feel as though that would allow for centralization and for dissemination of the information on a timely basis; would enable adequate and early training of those people who have responsibility, since that's been made an issue.

I'm sure you are probably already aware, CDC in fact recently funded the development of a video tape that was developed in cooperation with Howard University to address the

need for additional education of minority providers. And we feel as though one of the ways of making sure that everyone is about at the same point, making sure that the standard of care is high, is at this time to regionalize it to a center such as we would be able to provide.

CHAIRWOMAN WATSON: Two things: a question I raised earlier, whether we should require that doctors, as part of their course preparation, take a course in AIDS education, AIDS prevention.

DR. SHACKS: We feel as though there should be mechanisms for seminars and other training activities, workshops, that would be available.

As to the obligatory aspect of it, I'm not really certain that we're comfortable with that, but we feel as though it should be something that would be available and would be considered in --

CHAIRWOMAN WATSON: In the continuing education program?

DR. SHACKS: Yes.

CHAIRWOMAN WATSON: Okay, that's one way to do that.

The other is, Harbor General was here, Dr. Peterson. They've already started.

Are you familiar with that program?

DR. SHACKS: Yes, I am.

CHAIRWOMAN WATSON: That's something I'm very interested in because it's coming through the Family Practice Division.

One of the things I've been trying to do in one of my pieces of legislation is to be sure that the support base around

the person with AIDS has adequate training, has some exposure to counseling, so they will know how to work with the patient and how to work with their own emotions as they relate. Once you get that nuclear group oriented, then you move out to the community through the schools and so on. So, I'm looking at that as a model. I might carry some legislation to extend that model.

What do you think about that?

DR. SHACKS: We look upon that model with a lot of favor, but there's one additional element of it that we would like to have considered because everybody's situation is unique.

The fact that we have a medical school and we have students, we feel as though this is not simply a temporary problem, but something that will be around for a period of time. We feel that we must have the additional capability of bringing into the training activity early on students who would be entering health care fields, and particularly students who are in medical school.

CHAIRWOMAN WATSON: Yes. They, I think, work with their interns and their residents.

DR. SHACKS: We are talking about at an entry level --

CHAIRWOMAN WATSON: And then going out from there, you're saying, into the training institutions, the medical schools?

DR. SHACKS: Yes.

CHAIRWOMAN WATSON: As well as the high schools?

DR. SHACKS: We'd love that, but we particularly would like for it to go medical students and students involved in the allied health areas.

CHAIRWOMAN WATSON: Yes.

In fact, I worked with a program -- where is UCLA; it's somewhere out west there -- I worked at UCLA, directing a program to be able to motivate high school students in the allied health occupations and professions. And we started with them when they entered high school and then when they got to the 12th grade, many of them were taking courses at the universities and the colleges in this regard, getting credit.

And I think through a program like that -- we don't have too many of them left, but I think that some of the vocational programs have them -- this might be a way, too; reaching the potential health care specialist earlier.

DR. SHACKS: Certainly if the mechanism is in place to provide for training at a place like our Center, where we've got a medical magnet school, the first one in the country, we would be able to involve those students and other students who are coming in taking specific science-related courses.

I will make available, if you wish, in fact a project that three high school students did on AIDS that I think is probably as up-to-date as anything that you will read. They've got the ability to assimilate this information now.

The problem with most of the disease-oriented activities is nomenclature. It becomes more and more specialized to eliminate participation by other people over time. And I think if we allow this problem to become so highly technical in the way it's spoken about and described, without our students having early involvement, we'll be cut off from a need that is specific and unique to us in a disproportionate way.

CHAIRWOMAN WATSON: I appreciate your testimony, Doctor. Thank you very much.

DR. SHACKS: Thank you very much.

CHAIRWOMAN WATSON: Levi Kingston, Los Angeles Community Consortium. Mr. Kingston?

Sally Jue, the Asian Pacific AIDS Task Force. Ms. Jue?

Luis Mata, Multicultural Area Health Education Center. Mr. Mata?

MR. MATA: Good afternoon. I want to thank the Panel for giving me the opportunity to provide this testimony for you this afternoon.

My name is Luis Mata. I am the Executive Director of the Multicultural Area Health Education Center, located in East Los Angeles. It is a nonprofit agency whose purpose is to promote family-oriented primary health care in the medically under-served areas of the Latino community through education interventions.

Since its inception, the Multicultural Area Health Education center and its Board of Directors has viewed AIDS as a serious and vastly underestimated threat to the Latino community. Consequently, we have engaged in cooperative networking with other groups and organizations whose primary task is to address AIDS through the provision of direct services, education, and/or resources. Our work with these organizations , together with our ongoing health needs assessments and health education efforts in the Latino community, have reinforced our view that the future of the Latino community is seriously jeopardized by the fact that

its members are at significantly greater risk for contracting AIDS.

There are a variety of factors which contribute to placing the Los Angeles Latino community at greater risk for AIDS. During the last 15 years, Los Angeles County has seen a tremendous growth in the Latino population to its present figure of 3.2 million of a total population of 8.1 million. This influx of people has occurred concurrent with a political moment which has seen a dramatic decrease in health care funding. Obviously, this has resulted in a steadily diminishing capacity to even begin to address the health needs of the Latino community.

This large, medically under-served group is also heterogenous and very little culturally relevant material is available to prevent new HIV infection. The majority of currently available materials are translations of tools originally developed for use in the English speaking community. As such, these tools, while good in themselves as originally developed, are not effective when placed out of context in a community whose literacy and culture are different.

What must occur prior to any significant reduction in AIDS risk factors to the Latino community is the development of original and culturally sensitive materials. Also, due to the literacy and education variances, there should be a heavier reliance on non-print education materials. For example, why not run Latino-oriented announcements regarding AIDS before screening of movies in the Spanish language theaters?

A survey of medical professionals and health service providers conducted by the MAHEC in 1987 revealed that many of the respondents would be willing to engage in more vigorous AIDS prevention education; however, they have neither the funding to send staff to training nor for the purchase of materials. This is a clear example of a segment of the community which is in place to address the health needs of Latinos and is being under-utilized.

While helping existing medical personnel and viable Latino organizations to maximize their effectiveness in AIDS prevention is desirable and practical, it is not a replacement for the recreation of programs which can specifically impact and monitor the presence of HIV infection in the Latino population.

We recommend that any AIDS prevention legislation which earmarks funding for minority communities be devised with safeguards for ensuring that this funding actually reaches the community in proportion to the incidence of new cases for minority group population size. A Latino commission could be established to monitor AIDS funding and programming in the Latino community.

In sum, it is not possible to overstate the danger AIDS presents to our community, nor to overstate the need for immediate action.

Thank you.

CHAIRWOMAN WATSON: One of the points I raised with Dr. Shacks is that we should have some direct funding into minority programs, minority hospitals, or hospitals that deal with a large minority population, those who already have some experience.

Your recommendation for non-print educational materials is exactly what we had in mind. Public service announcements that precede musical selections. In our community, music is a part of life, and every young person has a cassette tape or a loud-playing radio in his or her car. Music is at their side at all times. Maybe announcements there on the radio, t.v. spots, those that are public service-oriented, certainly would be one way of getting this information out.

Somebody earlier in the day mentioned that we do better in our community learning through visual --

MR. MATA: That's correct.

CHAIRWOMAN WATSON: -- and through auditory means than we do through the written message.

MR. MATA: That's correct.

CHAIRWOMAN WATSON: And much of it is told to a higher level of reading, or educational level, than most of the poorer people of our communities have obtained.

MR. MATA: That's correct.

I have witnesses pamphlets on however -- I mean, people are given pamphlets, and I see them out in the streets because they will not take the time to read them because they can't read them.

I also wanted to echo Mr. Lara's testimony where he testified that we have organizations in place in our community that, if trained, can be of help, you know, in curtailing AIDS, the spread of AIDS, but one of the things is that we're lacking funds to train these folks. We have people that are working with

drug abuse, alcohol abuse, you name it, but they are not specifically trained in combatting AIDS.

So, I echo his testimony because I think that, you know, the funds are not available for us to train these people.

CHAIRWOMAN WATSON: Thank you for your remarks, Mr. Mata.

MR. MATA: Thank you.

CHAIRWOMAN WATSON: We'll take a five-minute break.

(Thereupon a brief recess was taken.)

CHAIRWOMAN WATSON: We will resume our hearing now.

Juan Uranga, Cara a Cara. Is he here?

Yolanda Ronquillo.

Wilbert Jordan, Dr. Jordan.

Dr. Jordan, if you'll just wait, we'll take you next.

Yolanda Ronquillo and Henri Norris, the two of you want to go together?

MS. RONQUILLO: Good afternoon, and thank you for adjusting your schedule. We have a flight leaving fairly soon.

Good afternoon, Senator Watson and staff. I'm here to echo a lot of the points that have been made already by my colleagues in this, our struggle to halt the AIDS epidemic, especially as it has focused on people of color.

I gave you a copy of the testimony, but I'm actually going to jump around a little bit because some of the points that I have at the beginning have already been pretty much covered by other folks.

I'd like to talk to you -- one of the questions posed by this Senate Committee was around what works? What is successful? And I've heard people talking a little bit about the video that we produced at the Latino AIDS Project, so I'd like to tell you a little bit about what that process was about, and also to underscore that that process is something that can be duplicated by other folks because, in fact, it is reflecting the needs of the community.

To impact and bring home the fact that AIDS was and is affecting and infecting the Latino communities, and to counteract the strong denial fostered by the lack of culturally relevant AIDS materials available to the Latino community, the Latino AIDS Project has produced a 52-minute AIDS education video in Spanish in the "telenovela" format, or soap opera, "Ojos Que No Ven" -- Eyes That Fail to See.

The story line of this "telenovela" is based on many video taped interviews with Latinos who have AIDS and their families. This last point is of utmost importance to this State Senate Committee that has asked for successful models. This video works because it rings true. It reflects the values and lifestyles of the diversity of what we call the Latino community. The Spanish language spoken in this video reflects the wide spectrum of nationalities and the levels of acculturation that allow the viewers to identify with the information and therefore more readily accept it.

The characters show by role modeling how to talk about AIDS and how to prevent its transmission, and how to become an AIDS educator, whatever your lifestyle.

Some of the themes addressed are: the coming out process that is done within the context of a single mother with two young adult children.

Bisexuality; that theme is developed with a married couple, the man being bisexual, and it's in a dramatic form that shows that the woman is the one who doesn't know that she's at risk.

Disinhibition through drug abuse, and this is developed in the video in the format of an immigrant couple recently arrived; the loss of work; the wife is pregnant; and the man, to forget his troubles, becomes drunk and has sex with a prostitute who's a junkie.

And so we begin to see as the story develops how people, without knowing it, have been exposed to the AIDS virus or potentially exposed.

Within the video we show needle sharing, and a very explicit scene of needle cleaning -- how to clean your works; how to flush them out with both bleach and water. We show pregnant women at risk; sexually active youth; the strength of our Latino culture, familial ties that supersede and carry people through in trying times; and the need for compassion.

This video has been aired on Spanish language television through six Univision stations throughout the State of California and parts of Nevada, and has been a resounding success. I have personally used this video as an education tool with drug addicts, farmworkers, church groups, pregnant teens, recent immigrants.

And also I've taken this video to San Quentin and showed it to administrative staff there, underscoring what Mr. Udin has been talking about, that in fact many people, many men of color in prisons, do have sex with other men, do share needles, and do need very real and concrete educational information that they're not getting. In fact, that presentation to date has been the only unsuccessful presentation that we've had with the video.

CHAIRWOMAN WATSON: Which one was unsuccessful?

MS. RONQUILLO: The one at San Quentin.

CHAIRWOMAN WATSON: With the staff?

MS. RONQUILLO: With the staff.

CHAIRWOMAN WATSON: Because they are rejecting the idea that this is going on?

MS. RONQUILLO: I found a tremendous level of fear among the staff, and I was surprised at that because I would have thought that there would have been more education among the staff around AIDS transmission and noncasual contact, or no transmission through casual contact.

But I felt that there was a tremendous amount of fear and denial in that setting.

CHAIRWOMAN WATSON: I remember a discussion we were having in the Judiciary Committee through testing of inmates, and also the statement that homosexuality runs high in prison populations, and one of my colleagues said, "But it's prohibited. It's illegal."

(Laughter.)

CHAIRWOMAN WATSON: That's the mentality that we have to deal with. This is a Judiciary Committee Member.

And what you're telling me is that it probably runs through the staff in some of our institutions also.

MS. RONQUILLO: Well, you know, Senator Watson, what I have found -- and I've worked maybe four years with the Tecatos with IV drug users, many of whom have spent many years in jail -- and what I have found is that many men who have sex with other men in jail do not consider that to be homosexual activity. They do not consider themselves to be gay, or to be anything other than heterosexual.

Within that culture, it's the bottom, the person who, in Spanish that was dead, turns over, which is considered the different person, or not the mainstream culture in terms of masculine standards. And this is something that I have learned in my work with the Tecatos who shoot heroin, and that this has a very special cultural code and language that I feel, as we've been hearing a lot of testimony, what seems to be coming up over and over again, and what you saw, I think, in New York, is that we have to allow the people who know that language, and who know the idioms, and who know how to reinforce positive behavior, recovery behavior, and certainly in this epidemic, how not to pass the virus, we have to allow them to do their work.

And I heard you say that these drug addicts you saw were volunteers. And I think that's commendable. At the same time, I think it's tragic that people to have to volunteer when we really need to support them economically to do this work, to make a

decent living, and to be able to do what they do well, because we can't afford the time that it's going to take to train people who have been in the business and who have not been effective.

CHAIRWOMAN WATSON: They do not receive a penny from the Alcohol and Drug Department from the State of New York.

MS. RONQUILLO: And that is a crime, given what we know to be true on the East Coast.

Well, I bring this to you because I think that this video that we put together -- and I'm not here to sell this video; I'm here to sell the process -- the video was in fact a reflection of the people we wanted to reach. Even some of the dialogue reflects actual words that were spoken to us in interviews.

And I think that when we're talking about materials that are going to make a difference, and we're talking about interventions that will in fact halt this virus, we need to go to the people that we intend to serve and not have focus groups after the fact, after we develop the materials, but in fact involve these folks that we intend to impact in the conception, in the creation of the ideas and the materials that we are going to make, and to reflect back to only act as instruments. Instruments of education, yes, but instruments that are true to the values and the culture of these people.

The State Office of AIDS has not approved this video for educational purposes, nor has any State money been used in the airing or the distribution of its use. The State regulations have recently become more stringent for all AIDS educational materials in terms of language and explicity.

One of the questions this Committee poses is the concern of how adequate the State AIDS educational efforts are, and how they might be improved. Certainly this policy needs to be reviewed and, I feel, changed.

It's interesting that State monies were available for explicit materials developed when the virus was, in fact, impacting gay White males. And now, we see a backlash, or a change, in the winds of what used to be available, and in fact the virus is now very much in the communities of color.

CHAIRWOMAN WATSON: I think that kind of underscores where we put our resources, we see a change. Where we have not placed our resources, we see the growth of the problem.

I think you're going to see in the coming session of the Legislature increased efforts on the part of Legislators to introduce legislation, programmatic legislation, based on the increasing numbers of pediatric or children with AIDS relative to that breakout at Cedars Sinai Hospital. I think you're going to see increased efforts on the part of the health care community based on some specials that we've seen just recently, involving doctors who have contacted AIDS through the hospital environment in which they've worked. And you're going to have new groups now pushing for change. You're going to have advocates for children, and pediatricians; you're going to have advocates for doctors and doctors themselves pushing. So, I think you're going to see a lot of action in this regard.

The Department, I'm sure, of AIDS -- and Thelma Fraziear has left the room, but I understand somebody from the Department

of Health Services is here -- I think they're going to be working in cooperation with us to get something done.

MS. RONQUILLO: I hope so.

CHAIRWOMAN WATSON: There's going to be hope, is what I'm saying.

MS. RONQUILLO: I'm a hopeful person; I hear you.

I also agree very much with your idea of impacting the doctors, and I want you to know that one of our most effective tools in reaching community people -- and those are church groups, and different family groups -- is that people have requested that we have a doctor with us. And we have tried, whenever possible, to have doctors and lawyers come with us to be there to answer the questions that people have. It gives validity to the presentation, and it gives a security that people need to have the trust to ask the questions they really need to ask.

I'd just like to very briefly touch on two other things that we have found that have worked. One is with Latino men who have sex with other men. And I was talking very briefly during the break to some colleagues here about the fact that when we talk about the AIDS epidemic as having plateaued or leveled off in the gay community, we're not talking about men of color. We know that that's not true, and we know that the educational efforts that have been focused on the gay White community have been effective, and we applaud them. We think that they have really paved the way to make some changes.

But we feel that we need to focus on the particular needs of men who have sex with men who are Latino, who are Black, who are Asian, and who are American Indian.

CHAIRWOMAN WATSON: Let me ask you about Hispanic men.

Different levels of education, different subethnic groups, Indians and so on, do they have a different receptivity to AIDS education? I mean, do we have to even break it down further in these groups?

MS. RONQUILLO: I think what we've been hearing in terms of Latinos and in terms of things being more visual and more spoken is true. And I don't think that necessarily corresponds with lack of education.

We are a people of indigenous roots, many of us, and the spoken tradition is a way of teaching and learning. It's a way that is respected, and it's a tradition that we've been taught in our families. And so, I do think it has to be different.

One of the things that we have used is music, as you have suggested. We've gone into gay bars -- there are four gay bars in San Francisco that cater to primarily Latino men who have sex with other men. And again, we don't use the term "homosexual", because men who go home with each other may be saying to each other, "Well, I'm not gay," and the other will say, "I'm not gay either," and off they go, both very convinced that they're not gay. And that's fine, because they are who they know they are.

But in fact, the behavior is what puts them at risk. So we have had what we call creative performance events, where men

who have sex with men, Latin men, have put together dances in drag to music, have put on performances, have created poetry. And they've been benefits for stopping AIDS through the Latino AIDS Project. They've been, I think, a buying-in mechanism where people feel they're actually helping to stop the epidemic, and they are.

Out of that, we began to solicit and encourage people to invite us into their homes, and that's really made a difference in terms of safe sex practice and behavior change; is having people invite us into their homes. They cook for us. They invite their friends and invite their family members, and we have a series of three educational interventions with them, three different evenings, where we go to their home and teach and talk and answer personal questions.

Now, this is something that works, and yet it takes person power. It's going to take more than what we have now. And I think that's what we're hearing in this Committee hearing, that in fact we need to dedicate more dollars to this effort.

I'd like to share one more issue before I close, and that is my personal vision. And I've heard Sala Udin talk about it; I've heard Daniel Lara talk about it, and that is statewide networking. We have to help each other and fill in the gaps. Daniel's project has created a project for women, Entre Nos, which is excellent. We have the video up north, and we've been meeting through the Red Cross effort to strategize and to fill in the gaps.

And I think the State needs to be involved in helping us network at a statewide level, and to create what you have heard here today repeatedly, a training of trainers; a training that would train community-based organizations to incorporate in the work they already do AIDS training; to make AIDS experts out of substance abuse counselors, out of perinatal intake workers, out of youth workers, out of all the people that have already the trust of the people on the street. They need to be the ones empowered with this AIDS education. And we can do it. We just need to have the funds and the support to do that. We're in place.

Thank you very much for your time.

CHAIRWOMAN WATSON: Thank you. We appreciate it.

MS. NORRIS: Hi. My name's Henri Norris.

I want to start by saying, before I get into my testimony, that I'm really pleased and honored to be here. I've been impressed with your astuteness in your questioning and your awareness of the issues that really matter in terms of the minority community, and that's heartening for someone who's out in the trenches doing the work.

In my zeal to hand you a written document, I note I neglected to put my name on the document. My title is in there, and I'm sure you'll be able to decipher.

Since I prepared the testimony, and in the interests of time, I'm just going to breeze right through it.

My testimony this afternoon focuses on what I see as the first step in an effective education and prevention effort in

communities of color: to personalize the issue sufficiently so that the denial of the problem can be broken.

You know the statistics. My colleagues have expressed to you data about the rise in sexually transmitted diseases in communities of color; a clear sign that AIDS education and prevention efforts have not sufficiently reached our communities.

The State has funded, however inadequately, minority outreach projects, including the MAPA project, which stands for Multicultural Alliance for the Prevention of AIDS, which is why we say "MAPA", which I direct. We have reached more than a thousand people with some information about AIDS in communities of color, transmission methods, and behaviors that put one at risk. The overwhelming majority in our communities remain in denial about the problem and the myriad ways it will affect them personally, politically and economically.

Fifteen minutes is a woefully inadequate --

CHAIRWOMAN WATSON: How about socially?

MS. NORRIS: And socially.

CHAIRWOMAN WATSON: I think one of the biggest reasons for denial in our community is social, a negative social aspect.

MS. NORRIS: I think you're right, absolutely. I regret that I don't have it on the paper.

Fifteen minutes is a woefully inadequate amount of time to express all the programmatic insights I have gleaned in my year as MAPA Director and in my 39 years of struggle as a Black female in a racist patriarchy. I therefore respectfully request that I be allowed to prepare detailed written testimony to be

submitted within the next 30-45 days so that you might adequately benefit from my experience.

CHAIRWOMAN WATSON: Please do.

MS. NORRIS: In the time I have left, I want to share the remarks I presented at a recent National Conference on AIDS, sponsored by the San Francisco Department of Public Health. I feel my remarks bear repeating because what must precede massive behavior change is a personalization of the problem.

I began those remarks with a short presentation delivered to the San Francisco Health Commission June 16th, 1987, during hearings on women's health.

In three minutes I cannot begin to do justice to the plight of women who suffer with AIDS and ARC. As Project Director of the Multicultural Alliance for the Prevention of AIDS at Bayview Hunter's Point Foundation, I work with women, primarily women of color, who engage in high risk behavior: IV drug use or sex with IV drug users.

I chose with my precious minutes to paint a picture for you of one woman's story, so that you might feel, as I have, something of what it's like for an IV drug using woman of color to confront her destiny with this disease.

I met her in November of 1986. She saw me as someone she could trust, so she stopped by my office when she could. At that time she only knew she was seropositive. This was the first sign for me of her denial, because she had been in the hospital twice with abscesses on her legs.

Each visit began with tears. She had to confront her disease each time she saw me, because I was one of two people who knew of her positive status. I became one of two opportunities for her to feel her grief, her loss. I would hold her as I confronted my helplessness to do anything for her except be there. I offered her attendance in a women's seropositive support group, but she declined; feared someone would see her and know, and tell she had it. In December, she had to go to court on drug charges. Her man was going to jail, and she feared she would, too.

She had been back in the hospital, and oh, the pain. The pain for which the doctor refused her medication. She was an addict; she just wanted drugs, he said. As I looked at the open wounds on her legs, I wondered how the doctor could make so callous a judgment.

A month passed. Jail seemed more likely, but she needed to talk today. She cried as she told me she had ARC. It was diagnosed the previous week. But how? She thought it was a yeast infection. At the hospital, that's what they told her each time she asked what she had. They said it was a yeast infection. She didn't know her yeast was the same as thrush, and thrush was the same as ARC.

As she cried in my arms, I wondered whose denial kept her from knowing she was dying -- hers or her health care worker's. I wondered why she had to die alone.

This is one story. There are others and many more will follow. Women have special needs and require special programs.

Next I want to express my profound concern about the response to the AIDS epidemic by communities of color. I, too, was guilty of not paying attention to AIDS. I thought it was a gay White male disease, as the media led us all to believe.

Last year, I became employed as an AIDS educator. Even then I was substantially unaware of the devastating impact this disease had already had in our communities. I was in denial.

For those of you who are unfamiliar with denial, it is a protective mechanism that God gave humans to keep us from overdosing on bad or harmful news. It sets in more completely when the news is very bad and is often concretized by the use and abuse of a variety of substances, from alcohol to heroin. Though it can be protective, it can be destructive as well. It can blind us from the need to act in our own interests for our own safety.

The third day on my AIDS job, after getting both statistical information about AIDS in my community and medical, transmission and risk information, I decided the responsible thing for me to do was to get the antibody test. It took me a full four months to actually get the nerve to be tested, even at the anonymous test site. Though I, by my behaviors, was at almost no risk for exposure to the virus, over those four months I realized that nine years ago, when I was 30, I had no idea whether the few people with whom I had slept had ever gotten a blood transfusion or slept with someone who had. I was even less likely to be told whether a partner was bisexual or an IV drug user, whether addicted or not.

I tell you this because denial in the face of the AIDS statistics in communities of color can be fatal. And in my opinion, many in our communities are at some risk, particularly our youth. A recent San Francisco study found that 36-44 percent of the Black community was at some increased risk from unsafe sex and needle sharing practices.

And yes, I want to scare you because I'm scared. I'm scared that AIDS will be the final tool in the right wing's arsenal that will truly wipe us out. If our young people who experiment with sex and drugs show widespread HIV infection, where will our future generations come from?

I want to get back to the HIV antibody test. This is another issue that raises fear around this epidemic. When this disease was viewed as a gay White male disease, San Francisco developed an anonymous testing program. The Black and Latino Coalitions on AIDS took a strong stand against changing to confidential testing. The different between the two is very significant.

With confidential testing, someone knows your name and your test result, but they promise not to tell anyone. With anonymous testing, no one knows your name. You decide when, how, or whether to tell anyone else. There are lawsuits in the courts around the country because the person who promised not to tell, told.

The legal and social policy implications become apparent. In an atmosphere where Senator Jessie Helms has called for the quarantining of people who test positive, it is dangerous

for us to remain ignorant. Mandatory or routine testing has already been accepted for Job Corps applicants, immigrants, army recruits, and prisoners as they enter and leave prisons. Who are these people? What will happen with the information if they are positive? Already, discrimination lawsuits have been filed in the areas of employment, housing, insurance benefits, and even perceived AIDS.

We must come out of the closet about this disease. It is no secret that homophobia -- hatred and fear of homosexuality -- has been a major factor in our denial and continued ignorance about AIDS. I pray that we will end our denial and join forces with others, who are protecting their interests, to protect ours. I hope we do this before our families and friends are in jail or camps for people who have AIDS, ARC or HIV positive status.

Laws are the result of legislation. Senator Doolittle is making progress in changing California's progressive laws to repressive ones. Some of the proposed laws are reasonable, most are not, but all require that someone else make decisions about our lives. I would hate for the person who told to be the person who decides.

There have been times in history, Nazi Germany comes to mind, when seemingly innocent laws were enforced in oppressive and unintended ways. Taking responsibility for ourselves and educating ourselves about this epidemic is our best protection.

So what can we do? What works?

This disease must first be personalized to communities of color. T.V. commercials must show people of color talking

about AIDS. Important local and national leaders must risk their political fortunes to save their constituencies. Educators must speak frankly and often about the personal risks we all face.

The myth the most people are consistently monogamous must be confronted, and the real behaviors in which people engage must become permissible subjects so that behavior change can be put into motion. Until one admits it, one is not likely to change it.

Judgmental name-calling does not work. The IV drug abuser, as opposed to user, turns the listener off. Implying that if gay men were not so promiscuous, AIDS would not be a problem does not validate and honor a human being's choices sufficiently to be heard by him.

Billboards and bus advertisements are very effective for communities of color. We ride buses and read what's on them. Elaborate and intellectual brochures do not work. Comic books do work.

Eighteen women were reportedly infected by the same man in Atlanta, Georgia's Black university community. The chilling reality that it could hit our family next must overtake us all, and we must act now.

CHAIRWOMAN WATSON: I want to thank you for this very dramatic presentation. You bring many points home.

I share with you the frustration when I sit with my colleagues and preside over piece after piece of legislation that is tended to be punitive rather than positive. The whole series of testing of the various categories that you mentioned here, the whole series of bills.

The one simple question that I have raised: For what reason? If you're going to test prisoners going into a lockup facility, for what reason do you test? Do you test, then, to isolate them or to quarantine them? If so, where do you put them? "Oh, we're going to put them in Vacaville." All right, Vacaville is already overloaded 300 percent.

If you are going to test the population and let them continue within the prison population, then what are you going to do in terms of the treatment? Is the treatment going to improve?

There's some people who choose to differ with me, but I think the worst form of health care is in our prisons. That is my own informal observation. But I also have had that verified by the inmates themselves who write me stacks and stacks of letters. My staff here can attest to it.

Yes, we've got some real problems. We're dealing with some attitudes that prevail in the legislative place. We've got to get beyond those attitudes. We're dealing with name-calling, and we had a recent bill that said if somebody has had sex with somebody else, and that person knew he or she had AIDS, then they're criminally liable. What we're doing there, we're penalizing the victims and we're making crimes out of being ill. That's the danger that we're facing.

However, I think every day we become a little more educated. We, as policy makers, are becoming a little better educated.

Everybody rushed about three years ago to have the first piece of AIDS legislation, and we were trying to enhance the

confidentiality; we were trying to set up the testing programs, et cetera. I think each year, as we do this, we have a little more knowledge than the year before. So I think when we come back, as I said before today, you're going to see more attempts at education, prevention and education. You're going to see more attempts to educate those who have direct contact with sick people, health providers. You're going to see an attempt to educate educators.

So, I think we're going to have a better opportunity. But the points that you make, and the vignette that you give us, the scenario that you give us, is very pertinent to what we have to do: to tell the story of a very real person. And if we could get a baby to speak, that would do it.

If you want to see some change, we're going to get medical doctors, and that, too, is going to get it for us, and I think we're going to see them coming in. I wish I could get the young man that was on "20/20", a young doctor immigrant who came here to this country, and through some accident in the surgical suite, he contacted AIDS. If he could come and testify, with the power of CMA behind him, you're going to see some raid changes for the positive.

So, thank you for your testimony. I know the two of you must catch a plane.

MS. NORRIS: Thank you, and I will be in touch.

CHAIRWOMAN WATSON: Great.

Dr. Wilbert Jordan, with the Minority AIDS Project.

DR. JORDAN: Thank you, Senator Watson. I am Dr. Wilbert Jordan. I am really here as a private physician. I treat most of the AIDS patients of Black physicians in this city who have private patients. They refer their patients to me.

I also am associated with the Minority AIDS Project, and I am also the Director of the AIDS Clinic at Community Hospital and share the co-chair with Dr. Creary of the AIDS Coordinating Council at the King/Drew Medical Center.

CHAIRWOMAN WATSON: Before you go on, would you get in touch with Dr. Clavreul -- raise your hand. She tells me of her international body of researchers and physicians who are looking at the whole AIDS question; not one of them is Black. I did ask her to get in touch with Dr. Ludlow Creary, but now that you're here, I wish that you'd talk to her and maybe suggest some names of people that might serve in that capacity.

DR. JORDAN: I have treated over 400 patients with AIDS, ARC, and HIV positivity. From my experience in the community, it's very deep.

Recently what I'm seeing more of in terms of categories are, one, married men who are bisexual whose wives do not know it, and that in itself poses a lot of problems in terms of what happens if they tell the spouse, et cetera. And two, a lot of women who are coming in, child bearing age, are HIV positive. Some are pregnant, and many have been found to be positive through testing at military sites or at other instances but not themselves having gone out to voluntarily want to be tested.

I'm sure most of the colleagues who have presented data before have talked the incidence, the danger, et cetera.

The reason I came is twofold. One, the reason the Minority AIDS Project was formed was because at that time I, as a private physician, was not getting support that I felt that I needed and my patients needed from AIDS Project L.A. And I met Reverend Bean, and I have been associated with him. I know there has been a need for the Minority AIDS Project here. I think as we see a diversification of people who are getting AIDS, there'll be more needs of different kinds of agencies.

My concern today, though, is more what needs to be done within the Black community, the Black community institutions, to stop the process. More funding is needed to service those persons who are infected, but we also need to do something to prevent this large group of people from becoming infected in the first place so they won't need those services.

If you take a walk down Santa Monica Boulevard, or through Castro District in San Francisco, you will see many signs and many businesses that are gay-oriented about AIDS. In fact, if you were to have wakened up from a 20-year sleep, just walking down the street you would see all these signs; you'd wonder what is going on, what is AIDS.

If you were to listen to the gay radio programs or stations in any of these cities, you would hear every night something about AIDS. If you read the gay newspapers or periodicals, you would see something on the front page, back page, in the middle of the paper, every time it comes out, something about AIDS.

And if you stop someone in their community and ask him, "What is AIDS," he would have some degree of knowledge of what it is. And more importantly, if you asked him, "Has any of your friends died of this," he would say, "Yes," and would know who they are. And he may tell you that at this point in time, the big problem is in the Black community or the minority community.

And if you then drive over to Watts, or Compton, or any other Black community and took a walk down the street where the Black businesses are, you would have to search long and hard to find one poster, one anything, about AIDS.

If you listen to Black radio stations, or the Black-oriented stations, the music is very seductive. It says how sex -- it says, "Sex is great." But nothing is said about, "Hey, you kids, be careful." You may hear a program once every four or five months on Sunday nights or in the morning, but nothing is intertwined with all of this "Go-out-and-have-sex" music to make these kids responsible.

If you go and pick up the Black-oriented news periodicals, nothing about AIDS. You will see what church went where, who raised money for the building fund, but nothing about AIDS.

And if you can stop someone in the community and ask them, "What is AIDS," he wouldn't know. And if you ask him, "Have any of your friends died of AIDS," he wouldn't know. If you say, "Well, have any died of pneumonia or something?" They may say, "Yeah, I had a friend die of pneumonia; somebody had meningitis; somebody else has these things on his neck." But it hasn't clicked that these persons have AIDS.

So what has happened in the community, first, that first person, the fact that your fiends have it, you've seen it, doesn't exist in the minds of the community, the people of the Black community. The day-to-day reinforcement that is here in the community, "Be careful," does not exist in those institutions that those persons who are at risk rely on to give them validity and to make them think.

One thing I'm hoping, and I'll leave it up to you, is that some kind of nonlegislative act can come from Sacramento to Black leaders to get them to become more responsive to their communities. The problem we have in this community is the Black leadership has not addressed the issue. And until the institutions -- the churches, the Alphas, the Omegas, the businesses, all those things, radio stations -- until those institutions address this on a day-to-day basis, no more seminars but on a day-to-day basis, this group of people, this large group, will end up over here needing services. And I hope we can devote some time and attention to try to prevent this group form ever needing these services in the first place.

Thank you.

CHAIRWOMAN WATSON: I think you make a very graphic description of what the case really is.

All you have to do is walk through the streets, and I guess everybody in this room can say the same thing, there's just no information out there.

I noticed that in San Francisco, and so on, they had the bulletins where they show the back of a male with a condom in the pocket, a very provocative advertisement.

You're absolutely right. As you were speaking, I was mentioning to Jane that maybe we'd better go talk to Golden State Medical Association, Charles Drew, maybe Golden State Mutual Life Insurance, and some of those groups as they have their meetings. We need to inform them. They got excited about drug usage and what they could do, and now we've got to get them excited about what they could do in regards to trying to curtail the spread of AIDS.

There are many, many things that need to be done. We're just scratching the surface now. We're holding this hearing, the first one, on minority AIDS. We used to hold hearings on AIDS, period, but we felt the need to do something different in terms of the minority community, and this is the first hearing of this sort.

I'm asked to ask you, what is the current status of Minority AIDS Project?

DR. JORDAN: In terms of what?

CHAIRWOMAN WATSON: You were saying that you were having difficulty. You have been in touch with Reverend Bean.

DR. JORDAN: No, Minority AIDS Project has for me been a blessing because initially my patients, who were Hispanic and Black, mostly Black, were not getting serviced by AIDS Project L.A.

AIDS Project has done an outstanding job in servicing the gay community, but to me it has been AIDS Project by gay L.A. And that's what it is. It did not meet the needs of the Black patients.

When Minority AIDS Project came along, he was able to provide those services. At this point they're doing more and providing more services. It has filled a tremendous gap in terms of providing social services that are needed as well as providing some emotional services.

One other problem that we have as a people is the fact that this is a disease that requires sociological, anthropological, political science input also. It isn't just a medical problem. And those agencies really aren't directing it.

Quite often, particularly the gay patients and also drug users, you need something to help the families talk. Black people, per se, are not used to going to see psychiatrists when most have Medi-Cal, and psychiatrists won't take Medi-Cal anyway.

So, you have a problem. My typical scenario of a gay Black male, now, is one who -- that's sort of out of the closet gay Black male -- whose mother has, quote, he's thought "accepted" him all these years; never had a problem. His friends have been over. When in reality, she has taken a deep breath and tolerated it. Now he gets sick, and she has to deal with all of her anger with his friends. She won't allow them into see him. He doesn't understand what's going on. I can't get her to see a psychiatrist because the psychiatrist is a foreign thing to her. The one person whom she's used to talking to is her minister, whom I can't get him to come see the patient or her.

I have this family also who is pulling me, now. I'm ending up playing psychiatrist for the family because there's no one else out there that they can go to. These kind of issues are

difficult. And to bring in, quote, "a psychiatrist" to this family, when that person is really foreign to them, it's quite difficult. I can't get the ministers to do it. There's no one else out there.

CHAIRWOMAN WATSON: I'm going to need you to testify when I reintroduce my bill that would set up counseling services for the family and the loved ones.

DR. JORDAN: It's needed.

CHAIRWOMAN WATSON: That's exactly the problem that we knew we were going to run into: the denial, the rejection, especially in our community where we have not ever confronted these problems before like this.

DR. JORDAN: That's right.

CHAIRWOMAN WATSON: If somebody has a problem, you talk to the people closest around you. We have not sought out the medical community for professional counseling. This is new. And it's going to be necessary, as we have more instances of people with AIDS.

So, we'll call on you when that time comes.

DR. JORDAN: Thank you.

CHAIRWOMAN WATSON: Thank you so very much, Doctor, for your testimony.

CHAIRWOMAN WATSON: I understand Sally Jue is here with the Asian Pacific AIDS Task Force. Ms. Jue.

MS. JUE: Senator Watson and Members of the Committee, my name is Sally Jue. I am a licensed clinical social worker, and I'm also the Mental Health Program Manger for the AIDS

Project Los Angeles. But I'm here today primarily as a representative of the Asian Pacific AIDS Task Force of the Los Angeles Asian Pacific Planning Council, a consortium of Asian community service providers.

I'm very happy that we have the opportunity to represent our communities here, because we have seen very little about the Asian community and AIDS in terms of programs, funding, media coverage, pretty much any arena.

In Los Angeles County, according to the 1980 U.S. Census Bureau, there are roughly 435,000 Asian and Pacific people. And those are only the ones whom the Census Bureau has been able to find. And we represent about 14 languages and dialects.

California's proximity to the Asian continent and political instability in many Asian countries has led to the growth of sizeable specific Asian and Pacific ethnic communities here. Linguistic differences, along with cultures that emphasize conformity to group homes and reverence for family and tradition, have contributed to influencing [sic] many Asian and Pacific communities from outside influence and information, and they also really limit one's ability to function independently outside their own community.

High risk behaviors, such as unprotected hetero and homosexual contact and IV drug use, do exist in Asian and Pacific communities, but with the exception of sex in a marital relationship, are unacceptable behaviors. Cultural values that prohibit bringing shame and ostracism to one's family has forced those who engage in these behaviors to do so outside the community or within the community with great discretion.

And in terms of AIDS, for example, most gay Asians that we know of who are tied to their community for linguistic, familial and economic reasons, will seek multiple relatively anonymous sexual contacts, far from the community, in order to keep their behaviors secret. Many of our Asian clients at APLA, and we number roughly over 30 at this point, fit this profile.

How often risk behaviors occur and the extent to which they have led to HIV infection within Asian Pacific communities raises four critical issues we'd like to address.

The first is the lack of information about Asian and Pacific people with AIDS. We are classified as "other," so we often don't even know how many of us in California are diagnosed, much less their risk factors, sex, age, generation, and specific ethnic group. Without this information, it's virtually impossible to convince our community that AIDS is not just a gay White American disease, and that high risk behaviors do exist in our communities and could lead to tragic consequences.

Lack of information also makes it difficult to decide which Asian and Pacific communities, and groups within those communities, are most affected. And as anyone who has worked with Asian and Pacific communities know, Koreans don't care how many Filipinos have AIDS; Chinese don't care how many Japanese have AIDS; Samoans are only interested in how many Samoans here or in Samoa have AIDS. And often that information is just not available to any of us.

Secondly, there is virtually no AIDS information available in Asian and Pacific languages, and with the exception

of what's gone on in San Francisco, what little there is is often presented in a culturally insensitive or unacceptable fashion.

The other thing is a lot of concepts related to AIDS transmission are concepts that linguistically and culturally don't exist in many of our communities. We're having to find translators that can deal with that as another problem, and without appropriate materials, we cannot educate our communities.

Third, most research on AIDS does not include Asian and Pacific populations for study, and what few projects we know of are so culturally insensitive or linguistically inappropriate that they are doomed to fail. And without this research data, the task of breaking through our own community denial becomes impossible, especially since early reports of a nonfatal HTLV virus in Japan has led some researchers to publicly postulate that Asians have some sort of genetic immunity to AIDS. And I feel that our Asian and Pacific clients at APLA are tragic proof that we are no more immune than anyone else.

Fourth, there are no AIDS programs in Southern California Asian and Pacific communities, and the majority of health and social service providers in our communities either know little about AIDS or tend to be very homophobic. Agencies outside our communities are often linguistically inaccessible, culturally insensitive, or Asian and Pacific people just don't know that these services exist outside their communities.

And to further illustrate the need to address these issues, I'd like to use Los Angeles County as an example. In order to obtain the following information, I had to put in a

special request to the County Public Health Department, and I feel I got the information only because I happened to know somebody who goes about collecting it.

As of December 14th, 1987, there are 41 Asian and Pacific AIDS cases in Los Angeles County that we know of; 31 were gay and bisexual men, and 7 men and 3 women were transfusion and blood product recipients. There are currently no reported cases of IV drug, heterosexual contract, or pediatric cases, but as with other communities, it is only a matter of time.

What is of particular interest to the Asian Pacific AIDS Task Force is that 20 of the cases are first generation immigrants, not American-born Asian and Pacific people as we had originally thought, and most of these cases are gay or bisexual men. Out of 8 unknown birthplace cases, some are undoubtedly also foreign born.

This information is a strong indicator that not only do high risk behaviors exist in Asian Pacific communities, but also that American-born Asians are significantly less affected, probably because they have access to AIDS information, and foreign-born Asian and Pacific people do not because of language and cultural constraints, and more importantly, the lack of culturally sensitive materials in their own languages.

In order to resolve these issues, we would like to make the following recommendations.

First, that the State and County Public Health departments discontinue classifying us as "other" in their AIDS statistical reports, and that they document age, risk factors,

and sex as they do with other ethnic groups. In addition, we'd like to see them provide information on the incidence in specific Asian and specific Pacific groups, and how many cases are first generation immigrants as opposed to American-born. Such information would be meaningful to the different communities, useful in planning education and prevention programs, and targeting communities that are most impacted by HIV infection.

Secondly, that funding be made available for Asian and Pacific AIDS education programs and the development of appropriate AIDS information in Asian and Pacific languages.

And thirdly, that research funds be made available to study Asian and Pacific people and AIDS, or that their inclusion be mandatory in larger research projects.

And one thing I neglected to put in my statement is also that funding be made available to train those that are already working in Asian community-based programs. I mean, the people are there; their relationships with their community are there. It's just a matter of giving them the AIDS information, enabling them to form networks with service providers outside their communities and to make more culturally sensitive service providers outside our communities.

Currently the incidence of AIDS in Asian and Pacific communities appears to be relatively low. We would very much like to keep it that way, but we cannot do that unless we act now, and we cannot succeed without your help.

CHAIRWOMAN WATSON: We appreciate this statement. I know it must be very dehumanizing to be referred to as "other".

We're now on most of our forms, State forms, governmental forms, using Asian Pacific Islanders, which takes in pretty much the ethnic groups in Southeast Asia and down the islands. And for other, I guess, research purposes, "others" are used. But through the school system, through the government programs, we are specifying the group.

Any help that you can give us in further breaking that down will be very helpful.

MS. JUE: I think it's difficult for us because our access to that information really --

CHAIRWOMAN WATSON: I don't mean the information, but how best to identify.

MS. JUE: Okay. If you'd like, we could probably come up with a document that would detail some of these things, and we would be happy to send that along to you.

CHAIRWOMAN WATSON: We certainly would appreciate that. Thank you very much.

Phil Wilson. Mr. Wilson, would you sit in the first row, please, and I'll get to you after Levi Kingston, with the Los Angeles Community Consortium.

MR. KINGSTON: Hi again. Sorry I'm late today. I've been under a lot of pressure with respect to a number of things that the Consortium's doing, but we did produce a piece that I'd like to read from. I rarely do that, but in this situation I'd like to do it, with your permission, and then come back and answer any questions that you might have.

First of all, from the perspective of a community-based organization operating in one section of South Central Los Angeles, we would like to address the questions your Committee has raised regarding the relative higher risk of AIDS in the Black and Hispanic community as follows:

(A) The ethnic population within the boundaries of our catchment area is primarily Black with an increasing Hispanic presence, specifically with an influx of Central Americans.

(B) The quality of life that we experience in our community obviously has a relationship to the high risk behaviors referred to by your Committee. The citizens of the neighborhoods that we are concerned with here today generally need empowerment in specific terms of their political, economic, educational and psychological development.

(C) The strategy and purpose of the Community Consortium is to achieve and maintain the highest possible quality of life in the Hoover/Exposition area of Los Angeles through cooperation and communication among its citizens and community organizations or institutions working together for the common good as neighbors. This purpose is based on the conviction that people of this area need to provide mutual assistance and enablement so that they can more fully control the assistance and enablement -- that they may fully control the destiny of this section of Los Angeles.

The goals of the Consortium are to more fully realize the unique potential of this important neighborhood and to confront such issues as: cultural and recreational activities;

economic development; special events; education; crime prevention; public services; and health care.

Secondly, based on the need to provide AIDS information and resource information targeted to Black and Hispanic communities, the Consortium held an "AIDS: A Multi-Ethnic Perspective: Your Community at Risk" conference on June the 27th of 1987 at the Davidson Conference Center of the University of Southern California. This conference was co-sponsored by the Black Agenda, the California State Health and Human Services Committee, the Community Consortium, Incorporated, and the Spanish Language AIDS Hotline of the East L.A. Rape Hotline, Incorporated.

Thirdly, the Consortium's Health Care Task Force recommended, prior to the June 27th conference, the need for creating a coalition to develop and implement AIDS education/information targeted to the Black and Hispanic community. Based on these recommendations, a coalition has been established.

The Consortium's Health Care Task Force Coalition is chaired by Adrienne Goodloe-Duar, who is also the Project Director of a State funded Office of Family Planning Information and Education Project entitled the Parent Adolescent Communications Project. This project is affiliated with the JWCH Institute -- John Wesley for those of you who may remember -- slash, H. Claude Hudson Comprehensive Health Center which provides health care services and community health education programs within the catchment area of the Consortium.

The primary interest of the PAC Project is to facilitate and provide coordinated family education programs for parents and youth, especially in the areas of teen pregnancy prevention, sexually transmitted diseases and AIDS.

As a follow-up to the June 27th conference, we organized a Community AIDS Rally for Education -- we called it CARE -- event in conjunction with the October AIDS Education Month sponsored by the City and County AIDS Education Committee, of which we were a member. Please see Attachment 1. Okay, you have that. Due to poor weather, the CARE Day Rally was cancelled. The Health Task Force Coalition recommended that we pursue another course of action.

We are currently exploring the feasibility of conducting a community-wide AIDS education/information needs assessment survey with the assistance of Councilman Robert Farrell of the 8th District.

In summary, we recommend the following:

One, minority AIDS education/prevention programs currently providing education and information on AIDS are limited in terms of outreach capability to impact a change in the high risk behaviors of the Black and Hispanic community. Therefore, there is a need for the Senate Health and Human Services Committee to sponsor regional meetings, conferences involving these organizations within Northern and Southern California areas.

Two, focal points for community AIDS education, information and testing should include prisons in the listing of formal institutions.

Three, and finally, educational materials, both audiovisual and print, be developed in a culturally sensitive manner for dissemination to Black and Hispanic populations. All materials should be pretested prior to final production and distribution.

CHAIRWOMAN WATSON: Thank you.

Mr. Kingston, as you will remember, we were down at Quincy Auditorium when you were at Davidson.

MR. KINGSTON: Right.

CHAIRWOMAN WATSON: And we had the experts in the field. We didn't have anyone to hear them except we talking to each other.

Your recommendation is that we sponsor regional meetings with groups that are already working on AIDS prevention or with the community? I'm not quite sure of the target groups in that recommendation.

MR. KINGSTON: Okay. I think -- I was talking a little earlier today, and we don't really have any problem with you moving in both directions, formal organizations and/or informal organizations as the kind of organizations that you referred to, like churches and so on, and incidentally, Senator, Reverend Kilgore had to be out of town this week, so I didn't even pursue the alternative of getting him to speak to you here today.

I am not impressed, and I have to be candid, with the cooperation, you know, that I think is necessary in the minority AIDS community. Our organization obviously, and one of the reasons I wrote this thing the way I did today, is not just

concerned with AIDS education. We're concerned with the number of variables, things that we as people, Blacks, Hispanics, have to live with every day. I think that I have not seen a lot of the, quote-unquote, "experts" work with the -- I think the vision that they ought to be working with with respect to actually building a coalition. And I'm not just talking Black, you know. I'm talking Brown as well as well as Asian.

And I was very impressed with the last speaker's point of view, because I think that the way to deal with the health problem on the level and magnitude that AIDS currently exists is to pull these forces together. I think the State can play a role in that.

I think when I say "conferences" here in this, in the piece that we wrote here, we have been conferenced to death on one level. However, I think that a Committee like yours can bring -- put together workshops, maybe is a better way of describing what I'm saying, what we're saying, workshops with the information necessary to deal with this. Because I don't hold my breath, you know, very frankly with respect to waiting to hear form somebody in the Black community who's working on AIDS. It obviously has potentially, you know, disastrous impacts on the community that I've lived in most of my life, in all kinds of situations, incidentally. And I believe that there's a need for us to come together.

I think that the State, your Committee, can act certainly as a catalyst to bring that about. This hearing today is the kind of thing, I think, that can happen. Also I think

that this Committee can also meet in different venues throughout South Central, East L.A., where ever. We live in a horizontal place, so we don't have quite the same problems that exist in a vertical city like San Francisco.

I therefore think that your presence is absolutely essential with respect to keeping this dialogue alive and for real, you know. I think that we're in a leadership crisis here.

I'm very excited, incidentally -- and I don't want to be the prophet of gloom today -- we more recently did have a good experience here with Councilman Farrell's office actually coming out and saying something. That may not sound significant to a lot of people here today, but one of the concerns that I personally have had in this pursuit is the lack of leadership on a local level happening, and especially as that relates to local elected officials.

I think there here again, this isn't spelled out in this piece here today, but I think that your Committee, you know, certainly, I think it's appropriate coming from a Committee like this, that you make whatever you learn here today known to local officials who have said very little. You know, when you go back to Sacramento, we have to deal with City Hall, to make a long story short. And the ignorance that is pervasive, in my opinion, just on that level alone, not to mention community leadership, and a lot of people have referred to that today, I think that it's imperative that information be gotten out to these bodies.

The other thing I'd like to underscore, because if I don't Bill Rogers will have my neck -- he's out here in the

audience; he works for the Youth Authority -- is the, in our opinion, the next-to-no-policy, evidently, status of what's happening with -- and you underscored this in some of your own statements -- with the prison populations. Not just adults, but Youth Authority, you know. I feel that when people like Dr. Neal Schramm are put on the spot and asked about what the future is of AIDS, what Dr. Schramm comes back with these days is that the adolescents, as it relates to their behavior, will determine what the future will be.

Very little, again, and I'm most fortunate to have a person like Ms. Duar -- who's recently come back to the fold after leaving on a maternity leave. She's sitting in the audience to my left -- working with us again, chairing our Health Committee, because -- and especially with the focus on youth.

We do, incidentally, at the Consortium have such an entity within our ranks run by peers, youth, incidentally, what we call high-risk youth, ex-gang members, who have formed an organization called Youth Outreach. Youth Outreach people have been contacted by people, health professionals, who work with AIDS projects, and there's been no follow through, you know, by some of those people. We are very much concerned about that.

I think everybody here in the room understands that the future is the youth, you know, and that certainly can't be looked at as though it has no relationship to any of the discussion that you've had here today. Other people may have made this point. I'm here to put my two cents in, as it were.

We will continue, you know, to work. We're very hopeful, and anything you can do, Senator Watson, to do a survey through Council Farrell's office where, incidentally, our approach is going to be a little bit different. What we want to do is to get the people themselves to say what they want, you know.

Everybody here, at least since I've been here today and I haven't been here that long, I would feel, maybe, the consensus is that we all understand the element of fear is pervasive in the community. Maybe that's because we haven't asked the people themselves what they want to -- what they want, you know. We're busy providing -- my office is literally stacked with AIDS information from the floor to the ceiling. People are very apprehensive; we know this.

I think that -- we believe that it's possible to elicit cooperation on a broader scale than what we've been pursuing in the past by involving some of the leadership here. Elected officials, obviously, have the mailing lists, you know. We have from the very communities that we're concerned with here today, there is political leadership. And a committee, again, like yours could play a very significant part, I believe, in both providing, again, the information that you've been able to pull together today, and also coming back, hopefully -- hopefully coming back with a forum like this. Don't leave us.

CHAIRWOMAN WATSON: We're not going. We're trying to figure out the best way to package it and put it together.

Let me thank you for your testimony.

MR. KINGSTON: All right, thank you..

CHAIRWOMAN WATSON: Mr. Phil Wilson.

MR. WILSON: As Chairman of the National Black Gay and Lesbian Conference, which we held here in February, I want to personally thank you for your kind letter and endorsement of that conference.

My name is Phil Wilson. I am the Outreach Director of Stop AIDS Los Angeles. I'm also the Director of the Speaker's Bureau for Minority AIDS Project. I'm a member of the National Minority AIDS Council, the Kaiser Permanente AIDS Prevention Board, the AIDS Hospice Foundation, and then I'm the current Co-Chair of Black and White Men Together of Los Angeles.

I'm here today as a part to speak of our experiences in the various organizations that I represent, but also I'm here today because I'm a person who's been exposed to the HIV virus, and in October of this year I was diagnosed with Aids Related Complex.

I speak about my experience, and I speak about the organizations that I currently work with, to begin to paint the landscape that I'm sure, at this point, you're very familiar with, and to address the issues of the complexities and the diversities that exist when you speak about AIDS in the context of a Black, or Latino, or an Asian community.

We have gay men who are fighting the battle of racism in a non-Black or non-Latino or non-Asian gay community, and who are also fighting the battle of homophobia in their ethnic communities.

We have the issue of Black women who are dealing with poverty, and child care, and underemployment and unemployment.

We have the issue of young Black adults who, as all young adults, are immortal and don't believe in such a thing as death, and who are struggling with the issues of drug use and drug abuse, inadequate education, peer pressure.

I spend a lot of my time talking to young adults, and I tell them, as I hope you've heard today, that 25 percent of all the AIDS cases in this country are Black, and Channel 7 tells them you have to be White to get AIDS. I tell them that 52 percent of the women in this country with AIDS are Black, and Channel 4 tells them that you have to be gay to get AIDS. I tell them that 60 percent of the children in this country with AIDS are Black, and Channel 2 tells them that you have to be male to get AIDS.

We spend a lot of time dealing with the myths and using language that is totally inappropriate. We need to abandon the language that speaks to high risk groups and begin to address the realities of high risk behavior.

Mr. Helms may understand what digital manipulation means and may appreciate the language of copulation, but it doesn't work when I'm speaking to a 15-year-old Black young man that lives in South Central.

I find it humorous when we have debates about mandatory testing, and I'm confused about what is routine about routine testing. When I speak to a group of young people in the Job Corps, and I know that testing is already taking place at the Job Corps, and to them it's mandatory and it's not ordinary.

It bothers me when, after I speak to this particular audience, a young Black woman comes up and says, "They told me that I have AIDS. They told me that six months ago, and they didn't tell me that it's transmitted sexually. And I've been sexually active with my boyfriend all that time." That bothers me.

If we are going to test, yes, I have to know what are we going to do with that information? But more importantly, I want to know what are we going to do to address those issues with those persons we test?

I think it is criminal that this particular case -- and it duplicates itself over and over again -- that they have the audacity to test her and then not tell her what she can do with that information.

I think that it's interesting when the military and the prison populations are already doing testing. Who are these audiences? Who are the persons that are overwhelmingly a part of the military and who are overwhelmingly the prisoners in this country?

It's time that we begin to make our choices. We must deal with the denial that exists in our community, and some other people have addressed the issue of denial. There's such a thing as adaptive denial and there's maladaptive denial. Adaptive denial is when we use our denial to protect ourselves.

Maladaptive denial is when we, as Black people and Latinos and Asians, begin to say that there's no such thing as AIDS in our community. It happens when parts of our community

begin to deny the reality that there are gay people in our community. It happens when we begin to adapt a policy or a philosophy of "Just Say No". When there are 34,000 teenage pregnancies a week in this country, somebody's saying "yes" somewhere.

It's important that we deal with language, that we deal with provocative language. I am troubled when the audience is White and gay, and with some financial power, it's all right to talk in the language that they understand. But when we begin to talk about a disempowered group -- like Black youth, like Black women, like IV drug users -- then we have to play games with language; then we can't address the issue in a language that they can deal with. And I think that is a problem.

As we talk about programming legislation, quite frankly I think it's time to stop being polite and start being effective.

Recently the Red Cross did a survey, and they discovered in this survey, when they talked to Anglos -- men who had sex with other men -- that only 10 percent identified themselves as being heterosexual. You take that same population and you paint them Brown, you call them Latino, and 70 identify as being heterosexual. You take that same population and you paint them Black, and 90 percent of them do not identify with being gay or bisexual.

Again, I point that out to speak to the issue of high risk behavior. The phrase of high risk group is only used to separate us.

I'm nervous when I know that this government has not been adequately responsive to the AIDS -- the issue of AIDS when it was perceived to impact non-Blacks and non-Latinos. It bothers me when a gay community can say that we have solved the problem, or we have adequately addressed the problem in the gay context.

I wrote a workshop called, "Hot, Horny and Health: A Close Encounter of the Safer Kind." And it was desirous to be a safer sex workshop, targeting Black and Latino men. And one of the questions that I asked, and I specifically phrased the question in the following manner: "Why is it that Black men are not interested in safer sex practices?"

Clearly, there are a lot of problems with that question. There's lots of assumptions that are made that I don't want to own and that I do not accept. But to date, I've never been challenged on that question; not once have I ever been challenged on that question.

That tells me something. That tells me that today, 10 years into the epidemic, that the persons who die of AIDS are not Black, and that's a problem when I see the statistics. When the message is White, and the messengers are White, that those of us who do not identify with that message or that messenger do not get the message.

Thank you.

CHAIRWOMAN WATSON: Wow! I would have to agree with you on much of all that you've said.

One of the reasons we're holding this hearing grew out of the fact that we've had other hearings like this, and we have talked about the threat to the gay community. And we're now realizing that babies and -- you know, we haven't even talked about seniors here. I've mentioned it once or twice. But the older a person gets, the more susceptible to illness and the more times they will go to the hospital, and the more days they will spend there. And the more accessible medical workers and health care workers are to them, the more injections and transfusions and so on. So they are at a high risk, too. The Black woman, the pregnant Black mother who comes in and has no prenatal care, delivers and finds out somewhere along the way she contacted AIDS.

These are all groups that have been under-represented in the populations we have talked about. We're just now getting to the point of who should even deliver the message. You know, how do we put together?

I was just asking Levi, how do we put together a successful group so that we can at least have people hearing the message who have never heard it before?

MR. WILSON: Well, you know, I think that I concur with Levi, that we have been seminared to death. And as a health educator, it is disheartening and, quite frankly, I'm not willing to continue in the process of going to seminar after seminar and speaking to nobody.

We need to redefine the strategies that we use to reach those populations. One of the issues is that we're still working

on the models that work with the White gay male population: a population that can afford to take a day off work; a population that has adequate transportation to get to where you're going to hold the seminar, and all of those issues; and clearly, a population that already identifies themselves as being at risk. So, that's one of the issues in the technique.

We need to take the message to the people who are being impacted in ways -- now, Reverend Bean has said that we know how to sell Black people Cadillacs and hamburgers. And if we can do that, and we seem to be able to do that effectively, surely there's a way that we can educate them on how to protect themselves.

I suggest that we use some of the same techniques that are used to sell us hamburgers and Cadillacs and what have you to save our lives.

CHAIRWOMAN WATSON: The macho-looking male who you'll see on the "20/20" segment on this program, "New York in Depth," said, when she talked about condoms, "Oh, I don't fool around with those things." Well, when she left there, at least he was thinking about the relationship between his sexual activity and the contacting of AIDS; probably would never have fooled around with those things if somebody hadn't gone to the shooting gallery and given him the information verbally.

They tell them the risks that they're at in the terms that they can understand. People go who look like them, who've come through those same experiences. They would never have been able to get to that third floor in that abandoned building if

there hadn't been someone with them who could open the door for them; I mean, figuratively open the door for them.

And when they left there, you see, they left something with them in their hands: they left those bottles of bleach; they left condoms; they left very graphic materials. Because those guys, as they are high, and their alertness is diminished, are not going to sit down and read a six-page brochure. What they might do if the thing is thrown at them in graphic designs, you know, and figures and so on, they might look at that as they sit there getting high and coming down. They might see that. They certainly see the bottles, and they see the condoms.

MR. WILSON: Actually, I have a specific request to make.

One of the issues that we're dealing with is communications. And I know you're part of a program that's coming up on KCT, and I, too, am a part of that program. And I did one of my workshops.

In my workshop, one of the things we do is, we talk about condom use. And the number one reason why condoms fail is that people don't use them.

The number two reason why condoms fail is that people use them improperly. And for those of us who are State funded or county funded, it is problematic in how you demonstrate proper condom usage. And in fact, when I wrote the "Hot, Horny and Health" program, I deliberately did it outside of government funding, because I think it's important to show people who condoms are used. And people don't understand the difference

between -- people do not get the message of how to use a condom when you sue a pencil, or when you use your fingers. They need anatomically visual ways to do that.

That type of graphic -- that type of challenge is the type of challenge we need to take on.

CHAIRWOMAN WATSON: I agree.

Thank you so very much for your testimony.

We just have a couple more witnesses. I do have a couple of people that asked to speak if there was time.

Dr. Lewandowski, would you come up, please.

Is Teresa Garay here? Yes, do you want to come up to the first row, and would you come up also to the first row.

Did Juan Uranga come in from Cara a Cara?

Was there anyone else who was scheduled to speak here? All right, fine.

MR. OCHOA: Senator, we're together for ICN. I'm going to identify myself as Ralph Ochoa, of counsel to ICN Pharmaceuticals, headquartered in Costa Mesa, California.

With me, as you've already mentioned, is Dr. Leon Lewandowski, who is the Vice President of Medical Affairs for ICN.

In the interest of time, our remarks shouldn't go beyond about six or seven minutes. After Dr. Lewandowski makes his remarks, perhaps I'll have a moment to mention something about the two things that you and I had a moment to visit on, the issue of the manufacturing of Ribavirin, which is ICN's drug in Mexico, and how that impacts the Hispanic and Black communities of

California. And also the issue of Assembly Bill 1952, which was passed by the Legislature last session, and how those possible clinical studies may affect Blacks and Hispanics.

At this moment, I would like to give the microphone to Dr. Lewandowski, the Medical Director at ICN.

DR. LEWANDOWSKI: Senator Watson, thank you very much for the opportunity to attend and, in fact, participate. Given the late hour, I'll be brief.

I am a recent emigree to California from New York. I'm currently the V.P. of Medical Affairs at ICN, as Mr. Ochoa stated.

Previously, I had served as Director of Laboratory Medicine Institute of the New York Department -- New York State Department of Health. In that capacity, I served as a member of the AIDS Technical Review Group of the National Institute of Drug Abuse. So, I do have some experience that probably goes back to the early 1980s.

We have heard a goodly amount about existing and planned programs for those at high risk in the minority community, in particular the IV drug abusers.

I am here -- and let me stress this -- to learn about these programs, and then to determine if and how a local California company, such as ICN, might effectively participate in the efforts of this Committee.

Today has been very educational for me. You have gotten your message across successfully.

The second reason I am here is to try to complement all of the previous inputs from the particular perspective as chief medical officer of a small, local pharmaceutical company. Unlike many of the previous speakers, we at ICN are not educators; we're not social workers by training.

What we do at ICN is drug discovery and drug clinical testing. I think we do it well. This process has successfully led to the first broad-based, broad spectrum antiviral drug called Ribavirin, currently marketed in the U.S., as you know, for RSV, respiratory syncytial virus, one of the most common oral pathogens of infants.

In 1984, a Dr. McCormick at the CDC discovered in the laboratory that Ribavirin proved effective against the AIDS virus. Based on the CDC finding, the company designed some of the earliest medical trials targeting the earlier stages of AIDS; that is, LAV and ARC. These trials have been financially expensive, time consuming, given the constraints of our being a relatively small company.

I won't discuss these trials here today, since the interpretation of our findings are currently under discussion with the FDA. The FDA has recently considered, however, that under the test conditions used, the drug Ribavirin is safe. Based on this ruling, ICN has reinitiated clinical trials to determine the maximum tolerable dose to be used in future clinical trials to be sponsored by ICN.

In addition, the recent findings of the Boston Clinical Group under an independent investigator, Dr. Claude Crumpacker, concluded that, quote:

"Ribavirin therapy merits extensive evaluation."

Unquote. And this will serve as the basis for an NIH-sponsored multi-censored control trial, independent of company-sponsored trials.

I'll leave a copy of this publication for inclusion into the record.

Why are these and all other private company, government, and academically-sponsored clinical trials important to this Committee? Will we discover a drug or a vaccine that targets the minority population exclusively? Probably not. There will be no magic bullet that discriminates on the basis of skin color, just as the virus does not discriminate on the basis of skin color.

Clinical trials are important because anything we learn about AIDS infection, regardless of the population examined, will have just as much direct benefit to the minority population suffering from AIDS as it will, for example, to gays suffering from AIDS.

Over and above this, however, there is the issue of who in fact are being examined in most clinical trials. Most clinical trials today have examined gays because: one, gays have been the most organized; two, the gay community has been most successful in educating how to minimize risky sexual contacts; and three, the homosexual community has been very supportive in ensuring compliance with medication taking.

The scientific and medical staff at ICN has been struggling with this question of how do we include, for example, IV drug abusers in our research efforts.

CHAIRWOMAN WATSON: Okay. Glad you asked that question.

Where are the people that were in here just a few minutes before testifying? Let's get you in contact with some of those people who run community-based programs.

DR. LEWANDOWSKI: If you give me just about another half a minute --

CHAIRWOMAN WATSON: I'm not finished. I'm just saying I want to stop you right there, because you're raising the question, and I want to strike while the iron is hot.

I'm sure that many of the witnesses -- let's start with Dr. Chase; let's start with Dr. Shacks; let's start with Levi Kingston; let's start with Mr. Wilson -- I'm sure they can identify for you people at high risk to complete your sample, to generalize your sample to the entire community.

DR. LEWANDOWSKI: Well, as Dr. Clavreul pointed out, IV drug abusers -- and I'm trying to take her words directly -- particularly in the minority community are -- I think it was something to the effect, "not in a favorable position" to avail themselves to clinical trial.

CHAIRWOMAN WATSON: Wait a minute.

Come on up, Doctor.

Do you want to explain what you just said? Since she's here, let's open the discussion up her to clarify that.

DR. LEWANDOWSKI: By the way, I'm not taking her to task for it.

CHAIRWOMAN WATSON: No.

DR. CLAVREUL: I just mentioned that we needed -- we did have to keep track of all the clinical trials available in the country or internationally so it could be available to everybody concerned, especially the gays and minorities who, up to now, had very little access to it.

And I just wanted to make the point earlier why most of the gays were involved in the earlier protocol, because most of the earlier protocol and clinical trial testing specified that a person involved in a clinical trial had to be gay -- I mean male, and homosexual in the first clinical trial in this country. And the reason I know so well is because I had some very heterosexual patients who could not qualify for the clinical trial.

CHAIRWOMAN WATSON: I'm sure they've been much enlightened since that time, however.

Go ahead, would you continue.

DR. LEWANDOWSKI: Thank you.

Successful participation in a clinical trials program would require, for example with the IV drug abusers: number one, that all drug abuse cease; and two, that the medication schedule, laboratory testing program, et cetera, et cetera, be rigidly maintained.

These two conditions have all but eliminated successful clinical trials geared expressly to the IV drug abusers.

Let me leave the Committee with a sense of our concerns and frustrations at not being able early on to do more for the IV drug abusers as part of our research and development efforts.

CHAIRWOMAN WATSON: I don't believe that. It's really hard for me to accept your testimony. I really is, because I cannot believe that a pharmaceutical company of your magnitude would not have the sophistication to get in touch with us before and say, "Who can I go out and talk to?" There are any number.

Mr. Wilson, are you getting this down so that you can get in touch with him?

I mean, there are any number of people that you work with every day that would love to go under testing who are minorities, and so on.

This drug does not discriminate. That's what we're talking about. It does not discriminate. I'm not asking you to produce a drug in this state addressed just to the minority population.

I am asking you to produce in this state a drug that can used with anybody who is at risk, with anyone, period.

I can't believe your testimony.

MR. OCHOA: Senator, if I may, it was important for us, at ICN, to have a moment with this Committee to be able to put this issue on the table, if you will.

And that is that persons in decision-making positions, as yourself and your colleagues, even during the end of the last session when things were going very quickly with Dr. Filante's AB 1952, there was the pressure of a number of drugs that had some promise in fighting the progression of AIDS, but had run into bureaucratic tape at FDA. And you know that AB 1952 utilizes a Health and Safety Code which was enacted in about 1970

and has never been utilized by the Department of Health Services in the State of California. It was only until you and your colleagues last session said to the Department of Health Services, "Go back and utilize that older statute so that we can expand clinical studies today."

We're not here to make excuses. We're here to say we have learned so much sitting here today.

CHAIRWOMAN WATSON: I hope.

MR. OCHOA: We have, but it's important, I suggest, to work together.

Let me mention briefly also something you and I had a chance to visit on. As you know, Ribavirin is not indicated for AIDS. However, it is licensed in about 29 countries for different indications, including pneumonia, herpes, et cetera. One of those 29 countries is Mexico.

There are a number of persons who are affected -- infected with the AIDS virus who have both the financial wherewithal to travel either from Northern California or Southern California across the border to Mexico to buy one month's personal supply -- that's condoned by the U.S. FDA -- and then come back.

One of the problems with that that we wanted to present today, just so that you're aware of how it impacts even more those of the have-nots financially, and we as --

CHAIRWOMAN WATSON: Are you saying that this is a drug that you're not intending to use with AIDS victims?

MR. OCHOA: No, no, quite the contrary.

We're trying to, and working with FDA, to expand the clinical studies, the treatment IND. And that is moving, I think, fairly well at the moment.

However, one of the problems -- and we think at ICN that it impacts the Black and Brown community in a special way, especially in California -- is that those who are using Ribavirin because it is available in Mexico, come back and use it at indifferent doses, et cetera. Some of it is monitored by some physicians, and most of them are not. And it's just information that we thought persons who are in leadership positions with the Black and Brown community who have testified here today should be aware of, those kinds of things. Most people are not.

The gay community, because of what the Doctor's just mentioned, they are more organized; they know much about Ribavirin, et cetera -- the company itself, as we've already indicated, is trying to move forward with the treatment IND. But I think that -- well, we think at ICN that -- and I'm being repetitive -- but persons from community groups who have been here today should know that others in the general community, the AIDS-affected community, are utilizing Ribavirin.

So we're trying to work with the kinds of persons that you've had here in a successful hearing. And I think also, as we've visited with your staff, AB 1952, I think, will be implemented, and it's a matter of what companies submit; which applications are working with the Department of Health Services with their protocol. The question is: what types of persons will be the patients? And we're struggling with that.

CHAIRWOMAN WATSON: Can we give you some information?

DR. LEWANDOWSKI: Yes, in fact, I think, Senator, the contacts we've made today are much appreciated.

The concept, is there a network of physicians such as Dr. Jordan? I have never met Dr. Jordan -- and mind you, I'm a recent emigree to California -- but I've never met him, but now knowing him, he primarily services a minority community population who could guide us into incorporating his patients into a successful clinical trials program.

The success of a clinical trials program rests not with the drug company, but rather with the physicians in the field and their ability to enlist, to advise, and to monitor the target population. In this case it would be minority AIDS patients.

I invite the representatives of the health care and community organizations in attendance at today's session to contact me, and in fact I would say the drug companies involved with any and all suggestions.

I'm delighted to hear today that the minority committees [sic] are beginning to network. We heard the word "network" several times. That they're beginning to network on the issue of AIDS, much like the gay community has successfully done for some time now.

I welcome the Committee's input, and once again, thank you for the chance to present these few considerations.

CHAIRWOMAN WATSON: As you establish your clinical drug trials, if I hear you correctly, you are going to reach out to try to find various segments of the population to include in those trials; is that correct?

DR. LEWANDOWSKI: I think if you look not only at our clinical trials, but the clinical trials done in general, they were targeted to that population who one could ensure was not going to be at risk for continued exposure to the virus. And the gay community has, in fact, done their homework and have been done a relatively good job in minimizing risky sexual contacts.

The second point is that you have to have a population that's going to be very clearly capable of following the instructions for the medication, for coming in. And I think when you're dealing with IV drug abusers, I think that there's a certain problem with compliance.

We would love to get around this issue of compliance.

CHAIRWOMAN WATSON: You are getting into some very deep water with me.

Maybe you had better explain to me what the purpose of your drug will be and what population you intend it to be used with.

DR. LEWANDOWSKI: We intend to treat all AIDS patients.

CHAIRWOMAN WATSON: Then I would suggest to you, Doctor, that you reach out and you, then, find those people who are in the high risk categories.

I think you heard today that the instances of AIDS and ARC are spreading among Black IV drug users.

DR. LEWANDOWSKI: Absolutely.

CHAIRWOMAN WATSON: Now, regardless -- and you've been hearing us and the witnesses also tell you what would be the best method to reach these various populations. They have been

suggesting that we write literature in their language; it has been suggested that we verbally give instructions; it has been suggested that we reach out and go to places where they are; it has been suggested that we make a concerted effort to find those populations that were not included in the White male gay population. Because we're finding that the spread among women, pregnant women in particular, the loved ones of homosexual and bisexual men, or the loved ones of men who have sex with men as Hispanic witnesses have preferred to have them referred to, we are finding, the more hearings I hold, that it's spreading across. It's moving beyond that one category.

We'd better get about recognizing that. I will personally --

DR. LEWANDOWSKI: Absolutely. I agree.

CHAIRWOMAN WATSON: I will personally provide you with a list of people, contact people.

There are two or three in this room right now who could run up and give a card to the Doctor so that he will know that you're able to -- Mr. Wilson, I'm sure, can supply him with names of people that I'm sure will consent to being part of your clinical trials.

What I understand is that the persons with AIDS are volunteering now. They feel that something is better than nothing, so they're putting themselves at risk in terms of the testing to hope that the risk they're under can be minimized in some way.

So, we will be happy to serve in that capacity, to supply you with what you need.

If I were you, I would not worry so much as to the various educational levels. I found that went over like a ton of bricks when I raised it earlier. You heard me raise it, and the witness said to me, you know, irregardless, this is existing. So I wouldn't hold that out as an obstacle.

What I think you need to do is try to be sure your population that you use in the testing is representative of the population and those who are at risk.

Now, what you did last week and last month and last year probably served the information you had at the current time. What you do from here on ought to relate to the information as we are currently receiving it. And it doesn't look good out there for heterosexuals; it doesn't look good out there for the newborns of mothers who use drugs and have drug users as their lovers; it doesn't look good for seniors.

DR. LEWANDOWSKI: This, in fact, is the challenge to all companies, all pharmaceutical companies, that are doing drug testing for AIDS.

CHAIRWOMAN WATSON: That's right.

I understand it's your drug that was the subject of 1952, and that was what was in the minds of most of the Legislators.

MR. OCHOA: No, it was just one of about half a dozen, Senator.

CHAIRWOMAN WATSON: Let me repeat what I said.

On the inside, on the inside, it was this drug that we had in mind.

MR. OCHOA: That's accurate.

CHAIRWOMAN WATSON: So, apparently you're going to be way out there ahead of a lot of the others, is what I'm saying to you, from what I understand. And if so, you're going to have to know who it affects.

I am not quite sure, and somebody just said something to me earlier today that was startling to me, that there is a possibility that Black people, Africans, have a predisposition to ARC. Now, you don't even need to respond. I don't know anything about it, but I'm just saying that we might find that that might be true about people who live in certain areas of Africa, because of their immunological system and its development of a period of time.

MR. OCHOA: Or nutrition or lack of it also.

CHAIRWOMAN WATSON: Yes, and so you might find out as you test that this drug might react differently to people who eat certain foods or who are from certain kinds of climates.

So, I think we are going to find out a lot. As I said before, I think this is an opportunity to really become knowledgeable.

DR. LEWANDOWSKI: I told you, my first basis for coming here was learning, and that I did.

CHAIRWOMAN WATSON: Yes. We are going to continue to educate you.

But I would be real happy to provide you with the contact people that I think can identify for you willing people who will come in and be part of your testing population.

DR. LEWANDOWSKI: We welcome these contacts.

The greatest problem will be in finding physicians in the community to, in fact, oversee the trials. And I see that as a generic issue. In any clinical testing program, the greatest need, I think, is to have physicians out in the field who are capable and able to have that population and willing to take the time to monitor, et cetera, et cetera.

CHAIRWOMAN WATSON: And I think you heard Dr. Jordan say how difficult it is to find physicians who want to treat AIDS patients, and so we know that's a problem.

But that should not stop you from making that contact. Dr. Jordan's name is going to be on your list that we give you.

DR. LEWANDOWSKI: I've written it down already.

CHAIRWOMAN WATSON: And we will contact him and see if he can identify the other two doctors in the Black community -- I don't know how many there are -- but the number of doctors that would be willing to monitor these.

And I understand how these empirical testing situations have to be structured. If the results are going to be worth their salt, it's got to be set up scientifically.

MR. OCHOA: It's my own personal experience in growing up in East Los Angeles and still working there that we have as few physicians willing to work with AIDS patients as you just mentioned in the Black community, but that's one reason, Senator. And we didn't mean to take up this much of your hearing time.

But I feel that ICN does have a social conscience and made the move to come here to learn, and we really do want to work with the persons who represent the Hispanic and the Black communities, as you've mentioned, so we'll be working very closely with your staff.

CHAIRWOMAN WATSON: This is instructive, what I'm just getting ready to say to you.

As you go out to make your presentation, let me caution you, because people will have -- my reaction was toned down. We're talking about very sensitive areas. We're talking about a lot of denial. We're talking about the health profession personnel who don't even want to deal with this. We're talking about parents of children, parents of adults who have AIDS, who reject their children being homosexual, or men having sex with men and women having sex with women; who, as it was said to us, who then take out their hostility on the friends that come. You know, we're dealing with a lot of sensitive feelings and a lot of hidden feelings.

And the way you approach people has to be very careful. You have to choose what you say and how you say it, because then you'll lose them.

I wish that we could get the "20/20" tape and show it, because Yolanda Herrero, who goes in, takes people who speak the language and is able to make contact with them and communicate with them in terms that they understand. I don't even understand the language myself. I'm not of that culture.

But you see, to be able to have results, you have to be able to speak the language. So I caution you, as you go about trying to find your clinical subjects, that your approach to describing the problem is done in words that are well-chosen, because the population that we're trying to get to, in many instances, are already turned off, dropped out. And if we're talking about the IV drug users, they're going to be high most of the time and with a very warped sense of reality. And they're looking for people who don't understand them, you know, to do them in.

So, just be real careful how you make your presentation and what you say.

I can understand it because I hear this kind of thing all the time. And my response was subdued today, because we are a resource for you: myself as Committee Chair; my Committee. They receive telephone calls all the time and letters and so on. We can give you the information.

So in an instructive and constructive way, I would say to you that what you've done in the past you are able to justify and verify, and now we're talking about the new populations that are coming into risk simply because we didn't know too much about the disease and who it is spread, and who then become the next persons with AIDS.

I've been told and trained not to use victims. The first time I did, they jumped all over me, and I was on their side. It's just that I did not know the current vernacular or the terminology, and it changes, too. Just like with my own

group, you know. We were Negroes; we were colored; we were Afro-Americans; African Americans; and now we're Blacks. "What do we call you?" I said, "I don't know. You just have to call me what I'm calling myself at the current moment." That might change next week. And if we do change, you're going to have to call us by the changed name.

So, I understand it. And anytime I go somewhere to a hearing, I learn how to address the audience that I'm talking to. And that's a sensitivity that one has to be sensitive to to be effective with this.

MR. OCHOA: Thank you, Senator.

DR. LEWANDOWSKI: Thank you.

CHAIRWOMAN WATSON: Thank you so much. I appreciate you staying here -- it's already 5:00 o'clock -- and waiting for your turn to almost be lost on the agenda. And I know how important and valuable your time is.

I thank you for that, and I thank you for listening to my preachings, and I hope that we all can benefit from what you're trying to do.

Teresa Garay.

MS. GARAY: Thank you, Senator, and thank you and your staff. I'm privileged to be here, and my name is Teresa Garay.

Noticing that I was the last person on the agenda, I did want to say that I hope that this one occasion when the best was not saved for last. Instead, I hope you've been given a good complement of the many factors that influence the issue of AIDS in the Black and Hispanic community.

I've come here to enter into the record some observations and recommendations on a vital element to any modern-day education campaign. That is the role of the media. I will be concentrating my remarks on the broadcast media, primarily television, which is my particular area of expertise.

I feel I bring a unique and qualified perspective to this discussion for four reasons: Number one, as the Public Service and Broadcast Standards Administrator for KCOP Television, Channel 13 here in Los Angeles, I am a working member of the media. I've been involved in the area of community relations for close to five years, and in that time the issue of AIDS has entered into the scope of my work.

Number two, as a complement to my work, I serve on the Board of Directors of AIDS Project Los Angeles, which is certainly is one of the more recognizable AIDS servicing agencies in this town.

Number three, as an active member of the gay community, I've been aware of AIDS since the onset of this crisis situation, and I have carried this awareness by necessity into my work setting. I bring a historical perspective on AIDS and the media because our station has been at the forefront on this issue with various forms of programming. We were the first station to carry public service announcements targeted to the gay community on this issue.

Number four, and no less significant, I am a member of the Hispanic community. A native, born and raised in East Los Angeles, I am particularly keen on the needs of the minority communities as respects the media.

In my discussion today, I will be focusing on three main points: the key component to a successful education campaign targeted to the minority community; the need for cooperative relationships between members of the media, and also between AIDS servicing agencies, and how Legislators can assist with this process; and finally, the need for a regional approach to funding a media campaign on AIDS.

I will draw many of my remarks from my recent experience with KCOP's October/AIDS Education Month campaign. I do so in the hope that this campaign will be used as a model for information going into the Black and Hispanic communities.

Let me being my presentation with the key element to successfully educating the Black and Hispanic communities on AIDS: and that is identification. In order for target groups to identify with a message, effective representation is essential. With forethought, this does not have to be done at the expense of one group over another.

KCOP, working in collaboration with KNX Newsradio, orchestrated the broadcast media campaign for October/AIDS Education Month here in the Southern California area. Our primary goal when producing the public service announcements was to reach a broad base audience with the message. We settled on a format that featured Rabbi Allen Freehling, the Chair of the County Commission on AIDS, on screen with Reverend Carl Bean of Minority AIDS Project.

AIDS is a disease that has the potential for separating people and groups. With this simple presentation, we were

effectively uniting the White and minority community on this issue. Further, by choosing men of the cloth, we were addressing other prejudice issues that still surround AIDS. It's compelling to see religious leaders talking about AIDS. The spots also paid attention to the significant role the church plays in the minority community.

By all indications the campaign was a success. Minority AIDS Project reported a record number of calls during the month. Reverend Bean was recognized wherever he went. Whether it was standing in the line at the supermarket, or eating at the local Sizzler, he tells me that people were responding to the message and approaching him for information on AIDS. Rabbi Freehling reported a similar response in the communities where he travels.

Another notable use of effective representation can now be found in the public service announcements produced by the Centers for Disease Control. These spots feature minority people from all across the country giving their personal stories on how they've responded to AIDS. I believe that in fact the speaker that is following me is one of the people featured in the public service announcement.

Of course, how a campaign is marketed is also crucial to its success. This brings me to the need for cooperative relationships between members of the media and between AIDS serving agencies.

One of our first objectives with the October/AIDS Education Month campaign was to enlist the support of the other television stations in the market. We had similarly made the outreach to radio by uniting with KNX Newsradio.

It is true that television stations are competitive with one another. However, it's equally true that we share a responsibility to serve the public. My experience is that this second truism can sometimes override the first with effective marketing.

To kick-off the October/AIDS Education Month campaign, KCOP hosted a working luncheon for decision-makers from the various radio and television stations. I should point out, this included Spanish language stations.

As a rule, a good broadcast media campaign will incorporate news, editorial, public affairs, and public service time. At the luncheon, we asked that our station counterparts support the campaign using these various forms of programming. The response was favorable. Presented with a specific need, KMEX, one of the Spanish-language stations here in Los Angeles, offered on the spot to produce the Spanish PSAs for the campaign.

Some of the strongest public service campaigns I have seen have united the television stations in a similar way. A recent water conservation campaign, featuring television weather personalities, is a notable example. These same principles can and should be applied to presenting the message on AIDS to the minority community.

Legislators can assist in this process by using their influence to bridge such unions. An example of this would be the letter sent out by County Supervisor Ed Edelman to the General Managers of the television stations, asking for their support of our campaign. The effort worked. I was pleased to see the KCOP-

produced spots airing on network affiliate stations in excellent time periods, and that includes some of the stations that Mr. Wilson earlier said were conveying incorrect information about who the target audience is.

As the State begins structuring its media campaign on AIDS, this Committee or the Senate Select Committee on AIDS might consider forming a media panel to assist with the effort. I believe the State would be well-served by enlisting the support of decision-makers from the media, or on-line people like myself who have experience with outreach to the minority community. Such a panel could be invaluable as a resource for providing oversight on how funds are used.

I think it's also key to point out here that people have to be sensitized to our particular programming needs. It's true, we had some controversial issues, like how to show how to correctly use a condom on television. I think by bringing these minds together, we might be able to some ways to creatively do it.

From the point of view of someone involved with an AIDS servicing agency, I can also see the value of cooperative relationships between agencies. AIDS is too large an issue to segregate services. The burden must be shared. A coalition of agencies bound together by Legislators is one way to do it.

My final point today deals with the need for a regional approach to funding over a county-by-county approach. Simply put, a county-by-county approach could severely inhibit broadcast media efforts for one fundamental reason: the broadcast media

crosses county lines. When speaking about the Los Angeles television market, for example, I am actually talking about a five-county area. From my vantage point, I can see a county-by-county approach creating unnecessary competition for television air time. Presented with public service campaigns from, say, Riverside, Orange, Ventura, San Bernardino, not to mention Los Angeles County, whose would I choose?

I will close by admitting that KCOP's October/AIDS Education Month was only one step, and much remains to be done in the media to effectively reach the minority community with the message on AIDS. Still, the campaign did succeed on two levels: firstly, it included the vital component of identification for minority people; secondly, it demonstrated that the broadcast media can work together in a cooperative spirit.

One of the most effective ways to education is by using existing channels of communication. I respectfully ask that the State learn from KCOP's experience.

Similarly, the State can lend its assistance by creating a mechanism so that not only the broadcast media learns to work together, but the AIDS servicing agencies as well. A regional approach to funding is also essential to the education process.

Of course, I am asking for assistance with the understanding that you have my offer to help you accomplish all of this. I'd be happy to meet with you or your staff to expound on any or all of my points.

And I thank you for your time. That concludes my presentation.

CHAIRWOMAN WATSON: Thank you.

I was wondering, since KCOP has taken the lead, do you think that the other networks and channels would be willing to run a public service announcement, like on a daily basis, in prime time? You know, you can see these kinds of advertisements late at night, but what's your feeling about prime time, preceding major programming?

MS. GARAY: I think that if you were able to put together a panel, as I suggested, of decision-makers, it might be done. It might not be done on a weekly basis; perhaps it would be done once a month. But even once a month, if you were to have the same public service announcement -- and I'm reminded when, during the political campaigns, frequently the candidates will buy commercial time, and it doesn't matter what station you turn on, the same commercial was going on on every one. The same thing might be done with a public service announcement on AIDS. It doesn't matter what time you turn it on, say, at 7:58 P.M., when you have very high audience levels, there is going to be that public service announcement with some kind of identifying components for the minority community.

I think that could be done. But again, you have to be able to find some way to get the decision-makers to buy into the process. And I think that is where Legislators can assist, because the decision-makers in our business certainly are influenced by the people with power.

CHAIRWOMAN WATSON: I was hoping that the industry would take it upon themselves. Of course, we need some kind of

advisory panel. And I would hope that you would do it without expecting any kind of financial reimbursement.

I would hope, as you do your public service announcements, that this will become part of the public service.

MS. GARAY: Yes, I wasn't talking about anything that would be financed. I'm talking simply about something where people from the different stations would contribute as part of their donation to the public good.

CHAIRWOMAN WATSON: Yes.

MS. GARAY: The spots that we produced, we did pro bono. We wrote them; we brought in the Reverend and the Rabbi to do them. We then distributed them to the stations at this luncheon that we hosted. And I was very pleased to see how many of the network affiliates did carry them.

If you got a network affiliate to do the same thing, the budget could even higher.

As the Committee starts organizing its panel, or its media campaign, one of the things is, too, to see if the television stations could possibly support some of these projects on their own, again, as part of the public service requirement. And it's done. I mean, the fact of that matter is that in order for us to maintain our FCC licenses, we have to act responsibly.

CHAIRWOMAN WATSON: Yes, we need to put together, and I think your recommendation was a fine one, maybe a statewide advisory panel to come up with some guidance for the networks.

MS. GARAY: And for purposes of this discussion, that should include, obviously, people with some experience in minority outreach.

CHAIRWOMAN WATSON: Of course.

Thank you so much. We appreciate your testimony.

MS. GARAY: Thank you.

We are going to have to rush to our cars because they'll lock us in if we're not there at 5:30, so I'm going to give you just about three minutes apiece. I'm sorry.

You can just talk. I know you have a lot of information, so talk from your head and you don't have to read your statement, and we'll let Ms. Jacques close it out.

MS. REYES: Thank you, Senator, for allowing me to appear in front of you.

My name is Jennie Reyes, and I just lost my son to AIDS on November 11th.

As Teresa said, I was part of the public service announcement for the Hispanic community, and it's airing on the Hispanic channels, 52 and 34, and I understand it's a remarkable job.

I also feel it should be done on the elderly on Channel 5. I agree with Teresa on that.

But the reason I'm here is because of my experience as a mother, a single mother, raising three children, trying to be mother and father to three children. My oldest boy, Eddie, was diagnosed with AIDS in November of '85.

It was very difficult for me, because I was trying really to be such a mom and dad to my children. But anyway, from a very private person, I came out publicly and started talking about my own pain and suffering. It has been remarkable what it

has done to my life. And I continue doing so, and the thing that I'm really -- what I really want to focus on, it is so crucial, is the fact that many family members are not able to cope with this crisis of the AIDS epidemic. And I speak by personal experience because my other family members, even up to now, are not able to cope, have not been able to cope.

My personal feelings are that once a person's diagnosed being HIV positive, or with ARC, or with AIDS, they should definitely, definitely have psychiatric help immediately, counseling right there and then, and have follow-up counseling throughout the whole time of their life span.

In addition to that, I also feel family members need to have counseling as soon as they find out, complete counseling, so they can be able to learn to cope. Because what happens with families, it's too devastating. Some family members, like I say, are not able to cope, and others are able to cope.

And I thank God that He gave me the strength to be able to reach out there and to get educated. And I wish that I could say that for the rest of my family members, because even though my grief is as bad as it is, theirs is worse because they don't understand the AIDS crisis.

Thank you so much.

CHAIRWOMAN WATSON: Thank you for expressing that sentiment.

MS. REYES: Thank you.

CHAIRWOMAN WATSON: Ms. Jacques.

MS. JACQUES: Thank you, Senator Watson, and thank your staff.

My name's Colette Jacques, and I'm the Executive Director of SOAP, which stands for the Support Organization for AIDS Prevention, an organization that was created to target Haitians and also the Caribbean.

As you well know, the Haitians were first accused of bringing AIDS to the United States, and that has created a great impact. That closed them to cause themselves to education. And I'm brave enough to go to them and say, "Hey, look, this is an issue here, and everyone needs to know about AIDS, and everyone needs to protect themselves," and they are listening and they are ready to be educated.

We have done a great deal of projects. We have participated in giving out information, thanks to the Red Cross and also to the APLA, who profiled some information on AIDS. We have participated in Caribbean parades, where we pass out AIDS information wrapped with candies. We go to parties and give them information.

I would like to make this brief, respectfully requesting that the Haitian group be educated and the only way we can do that is if funding is available to us. We need your support, Senator Watson, and without that we cannot succeed.

Thank you so much for allowing me to speak this afternoon.

CHAIRWOMAN WATSON: Thank you.

I really appreciate all of you who have come down, those who are not here and those who are still here. We appreciate your input.

Rest assured that this will get back to my colleagues in Sacramento. I think you can expect to see any number of pieces of legislation as it relates to AIDS as a result of this hearing.

I feel we're far more educated now than when we started this morning. We will have a lot of input, a lot to do.

Thank you very much, and this hearing is adjourned.

(Thereupon this hearing of the Senate Committee on Health and Human Services was adjourned at approximately 5:20 P.M.)

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CERTIFICATE OF REPORTER

I, EVELYN MIZAK, a Shorthand Reporter of the State of California, do hereby certify:

That I am a disinterested person herein; that the foregoing Interim Hearing of the Senate Committee on Health and Human Services on "AIDS in Minority Communities," held on Monday, December 14, 1987 at the State Building in Los Angeles, California, was reported in shorthand by me, Evelyn Mizak, and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties to said hearing, nor in any way interested in the outcome of said hearing.

IN WITNESS WHEREOF, I have hereunto set my hand this 12th day of January, 1988.

EVELYN MIZAK
Shorthand Reporter