COUNCIL OF THE CITY OF PHILADELPHIA
PUBLIC HEARING AND PUBLIC MEETING BEFORE
COUNCIL COMMITTEE ON HEALTH AND HUMAN SERVICES

- - -

Room 400, City Hall
Philadelphia, Pennsylvania
Tuesday, 5/01/01
10:30 a.m.

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RES. NO. 010116 - Authorizing the City Council Committee on Health and Human Services to hold hearings to assess the impact of HIV/AIDS on the citizens of Philadelphia and to evaluate the direction, the cost, the effectiveness, and the priorities of City-funded and City-administered HIV/AIDS prevention and treatment programs.

PRESENT: COUNCILMAN ANGEL L. ORTIZ, Chair
COUNCILWOMAN BLONDELL REYNOLDS BROWN
COUNCILMAN DAVID COHEN
COUNCILMAN W. WILSON GOODE, JR.
COUNCILWOMAN DONNA REED MILLER
COUNCILMAN FRANK RIZZO
COUNCILWOMAN MARIAN B. TASCO

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P R O C E E D I N G S

COUNCILMAN ORTIZ: To all of my colleagues in their offices, we're ready to begin. Please make your way down to the fourth floor.

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COUNCILWOMAN TASCO: Good morning. Good morning.

AUDIENCE MEMBERS: Good morning.

COUNCILWOMAN TASCO: We'd like to welcome you here this morning to the Committee on Public Health and Human Services hearing on the AIDS epidemic in the City of Philadelphia. I'd like to say that we have a quorum in the presence of Councilman Angel Ortiz, who is the sponsor of the resolution; Councilwoman Blondell Reynolds Brown; Councilwoman Donna Reed Miller; and I chair the committee, Councilwoman Marian Tasco.

Before we get started, we'd like to have the clerk read the bill into the record.

THE CLERK: Resolution No. 010116, authorizing the City Council Committee on Health and Human Services to hold hearings to assess the impact of HIV/AIDS on the citizens of Philadelphia

and to evaluate the direction, the cost, the effectiveness, and the priorities of City-funded and City-administered HIV/AIDS prevention and treatment programs.

COUNCILWOMAN TASCO: Thank you very much.

Before we call our first panel, I'd like to recognize Councilman Angel Ortiz for a statement, and then we will recognize other members of the committee who might want to say something if they'd like to. And then we'll proceed with the first panel.

Councilman Ortiz.

COUNCILMAN ORTIZ: Thank you.

AIDS has been a problem that began being identified with one community. It has now become the scourge of the Third World, as we have seen in Africa and in other places. But it also has kept on growing in urban areas such as Philadelphia. The gay and lesbian community have suffered from it, African-Americans and Latinos, specifically women, have begun to increase dramatically.

The last time this Council held

hearings on AIDS was in 1987, I think. And we went through a time period in which new drugs came into the market. People really began listening to the educational process that was taking place. And it seemed that people got comfortable with the disease. And then you began hearing reports and you began seeing things and programs such as "60 Minutes," that people were out there beginning the same bad habits that led to the increase and the growth. AIDS could be stabilized, AIDS could be handled, you really -- you know, it's really not that bad, it's really not a disease that is totally fatal, and this and that.

And in our high schools, in our young people the issues about safe sex really started going over their heads, the issue about using needles and exchanging needles and sharing them in our communities, and we saw again the curve to start going up.

I think it's time that we brought everybody together -- the advocates, the Department, the City, the individuals that are out in the street doing the work -- and see where we're at, see what needs to be done so that we can

take this process to the next level so that we really can begin to handle it and we can really begin to put pressure in also the powers that be that AIDS continues to be a problem, and it continues to be a problem more so in poor communities than anywhere else, and that we need to be able to begin putting programs, bringing in money, and putting the instruments and the process together so that it becomes less of a problem until we find a final cure.

Thank you, Madam Chair.

COUNCILWOMAN TASCO: Thank you.

Would there be any comments from any other members of the committee?

(No other comments from committee members.)

COUNCILWOMAN TASCO: I'd also like to recognize that we have been joined by Councilman Wilson Goode Jr. and Councilman Frank Rizzo.

First we'll have our Health Commissioner, Dr. Walter Tsou come forth.

(Witnesses come forward.)

DR. TSOU: Good morning, Councilwoman Tasco and members of Council's Committee on Public

Health and Human Services. I'm Dr. Walter Tsou, Health Commissioner. I'm joined by our co-directors of the AIDS Activities Coordinating Office, Pat Bass and Joe Cronauer. And thank you for the opportunity to discuss the impact of AIDS on Philadelphia and the City's approach to combatting this epidemic.

It's been over twenty years since the first AIDS cases were reported in Philadelphia, and the epidemic continues to grow and disproportionately our impact most vulnerable citizens. Today, there are over 13,989 cases of AIDS in Philadelphia. Of those cases, 6,905, or 49 percent, are known to have died; and 7,084, or 51 percent, are presumed to be living with the disease. In addition, while HIV is not yet reportable in Philadelphia, the CDC conservatively estimates that 16,000 City residents are living with HIV, many of whom who have not yet developed full-blown AIDS.

It has been said that AIDS is an equal-opportunity virus. However, in Philadelphia, those most affected tend to be our city's most vulnerable residents, as Councilman

Ortiz pointed out, poor people and particularly people of color. AIDS surveillance data shows that 74 percent of Philadelphians living with AIDS are African-American, 14 percent are Hispanic. Moreover, every section of the City is vulnerable to AIDS, and AIDS cases are not evenly distributed across the City. Rather, AIDS cases disproportionately impact low-income communities, including Kensington, Northwest and Southwest Philadelphia. In fact, 14.8 percent of all cases within the City are from three zip codes in Kensington and North Philadelphia: 19132, 19133 and 19134.

Seventy-five percent of those living with the disease are male, and the two major risk factors for AIDS are injection-drug users and men who have sex with men. However, trends show a 17 percent rise in heterosexuals with AIDS from 1995 through 1999.

On a positive note, the number of deaths related to AIDS has steadily declined since 1994 due to the effectiveness of antiretroviral therapies. Additionally, as a result of these therapies, fewer of those affected with the virus

are making the tradition to full-blow AIDS.

Unfortunately, this decline in AIDS does not necessarily indicate a slowing of the epidemic. The CDC estimates that 16,000 Philadelphians are infected with HIV and that 25 percent are unaware of their status and likely infecting others. Moreover, a host of national studies have noted a rise in unsafe behavior and a growing complacency about HIV among those most at risk, conditions, which if not addressed, could lead to an exploding rate of HIV within the next few years. Thus, the need for concentrated and effective prevention services has never been greater.

In the face of this growing complacency, the City has waged a full assault on the epidemic, and we support a full range of prevention and care activities designed to ensure that every citizen has the knowledge and skills to protect him or herself and others, and that those who are infected receive the care and services that they need to build healthier, longer lives.

In Philadelphia, the vast majority of publicly-funded HIV/AIDS services are coordinated

through the AIDS Activities Coordinating Office in our department. HIV/AIDS services provided through AACO have an annual budget of about $34 million, the vast majority of which is federal funding. Additional service are also provided and paid for through the City's health centers, Behavioral Health Services, as well as through individuals' private and public insurance.

HIV prevention services are primarily supported by $5.5 million in federal funds through the Centers for Disease Control and Prevention. We are one of only six cities across the nation to be directly funded by the CDC. However, we are also the only one of those CDCs that does not receive any of our state's CDC dollars despite the fact that more than 50 percent Pennsylvania's AIDS cases reside in Philadelphia. We continue to advocate for our fair share of those resources from the State which they receive from the federal government.

AACO does receive a small amount from the State's own AIDS resources as well as $4 million in city general funds that are used to fill gaps in HIV/AIDS care, prevention, and

surveillance activities.

The City's HIV care services are, in large part, provided through the Ryan White Title 1 dollars appropriated by Congress, and they're awarded to Philadelphia through a competitive process. Ryan White funds provide the vast majority of care services through AACO, which is $22 million, and they cover a nine-county service area in southeastern Pennsylvania and southern New Jersey. Philadelphia has competed extremely well for these Ryan White resources, earning a $2 million increase last year and a $4 million increase this year.

AIDS surveillance is also conducted through AACO, which receives a $1 million grant annually from the CDC to conduct these activities.

Fortunately, due in large part to our innovative planning and programming, AACO has been extremely successful in its efforts to procure increased federal support in a highly competitive funding environment.

AIDS funding is used to conduct a comprehensive continuum of prevention and care

services. The priorities for these service are determined by two planning bodies: one for care and one for prevention. It should be noted that Philadelphia is responsible for planning direct-care services for the entire nine-county region, which in addition to Philadelphia County, includes Bucks, Camden, Delaware, and Montgomery Counties in Pennsylvania (actually, where did you get Camden in there?), and Gloucester and Salem Counties in southern New Jersey. Decisions made by these planning bodies are based on where the epidemic is most prevalent and what services are needed and the availability of resources to support those services.

Throughout the nation, Philadelphia's considered a leader in HIV planning. Our HIV planning efforts have been recognized by both the City's primary HIV service funders, and much of the work conducted by our planning bodies has been cited as a model for replication nationwide. Our planning bodies, which determine which services are provided and where these services are provided, base their decisions on science, community needs assessments, and the availability

of other resources. Our planning bodies are composed of communities memories who reflect the demographics of the epidemic, and they include a majority of people who are infected with HIV themselves.

The care services center around medical care and an array of service sites across the City, including the City health centers, local hospitals, federally-qualified community health centers, HIV specialty clinics, etc. Federally-approved standard of care are required to be filed at out of these sites. We fund an extensive array of services to those living with HIV/AIDS to help in maintaining medical care. And in light of the large number of speakers today, I'm going to just simply list them. We provide:

Medications;

Case management services;

Housing services;

Emergency financial assistance;

Home health care;

Dental care for those who are underinsured or uninsured;

Care outreach, which links HIV testing

sites with primary care services; psychosocial services, including drug and alcohol services; peer counseling;

Food;

Nutritional counseling;

Transportation;

Complementary therapies;

Information and referrals;

Day and respite care;

Translation and interpretation services;

Client advocacy; and

A buddy companion service.

In an effort to stem the tide of infection, AACO provides a multi-pronged approach to HIV prevention. All prevention services focus on assisting high-risk individuals and those living with HIV to understand their risk, access counseling and testing, and learn safer sexual and injection behaviors and maintain safer behaviors for the protection of themselves and others. Our prevention efforts target those communities most at risk, particularly low-income people of color, those who have traditionally been disenfranchised

and hardest to reach.

To ensure that our programs are accessible as well as culturally and language-appropriate, AACO has contracted with over 90 community-based providers, many of which are small and minority-controlled nonprofit organizations. These organizations deliver a vast array of care and prevention services directly to the neighborhoods where the epidemic has had the greatest impact.

And recognizing that not all individuals respond to the same approach, AACO supports a variety of prevention services, which I will now list. We provide:

HIV counseling testing;

Prevention and case management;

Outreach services;

Interventions at the group level; and

Health communications, including PSAs and using the mass media.

All of these strategies funded by AACO are recognized by the CDC as effective interventions. Most have been scientifically studied and proven to have a positive outcome. In

the few cases where little documented evaluation exists, AACO is conducting its own outcome evaluation to assess the effectiveness of the intervention in question.

Finally, I want to talk about special programs that the City also supports, innovative initiatives designed to ensure that those most affected by the epidemic have access to services that they need.

We have, for example, a special program called the "Storefront Model," which has been developed by AACO and brings care and prevention service directly into high-impact neighborhoods where quality medical and social services are scarce. Literally located in storefronts, the program is operated by neighborhood organizations with ties to the community. Each storefront offers a variety of services, including medical evaluation and referral, HIV counseling and testing, care and prevention outreach, food, support groups, laundry, and clothing banks. This comprehensive range of services helps the program attract many consumers who might otherwise avoid HIV services because of the associated stigma or

because of the pressures of meeting more basic needs. Currently, these storefronts are located in the Kensington, Germantown, and West Philadelphia, cities working with neighborhood-based providers to provide additional storefronts in North and South Philadelphia.

An array of services is also available to inmates of City's prisons, many of whom are infected or are at extremely high risk for infection. We have ten AACO employees who are stationed within the prisons and that conduct HIV prevention, education, voluntary confidential HIV testing, and condom distribution. Working with the Philadelphia prison systems, we have also implemented a system that assures that HIV-positive inmates receive uninterrupted medications upon their release. Additionally, a newly funded community-based care outreach program assists those who are released in accessing HIV care and other services.

In an effort to harness the power and the influence of the City's many religious and civic organizations in the battle against AIDS, AACO has forged several innovative

collaborations. The City funds numerous faith-based organizations, including the Women's Christian Alliance, Catholic Social Services, and Positive Effect Outreach Ministry, which are an integral component of service delivery in highly impacted communities.

Additionally, the City has recently contracted with a longtime community advocate to develop a network of influential organizations, including the Black Clergy of Philadelphia, the NAACP, and other religious and civic organizations to fight HIV across the City.

And, finally, to protect the City's youth, AACO funds a variety of school-based programs conducted by community organizations throughout the City. The Family Planning Council operates health resource centers in numerous schools that provide counseling for HIV, STDs, pregnancy, and reproductive health, as well as referrals for services. YO-ACAP and PHMC conduct theater presentations in schools to demonstrate the impact of HIV on young people and to teach prevention skills. We also have COLOURS, Congreso, ODAAT, and many others who provide

classroom trainings.

AACO also funds a variety of programs to ensure that hundreds of out-of-school youth, who frequently are at a greater risk, do not fall through the cracks. The Youth Health Empowerment Project and YO-ACAP and conduct street outreach in venues where out-of-school youth congregate. The Attic and COLOURS provide a host of programs targeted to young gay, lesbian, questioning, and transsexual youth.

Finally, to ensure that HIV counseling testing is accessible to everyone at risk, AACO funds a network of 40 different test cites across the City that last year provided over 30,000 free anonymous or confidential tests.

As important as the quantity of programs, however, is their quality and effectiveness. AACO has developed nationally-recognized evaluation models for both care and prevention. The City also conducts a rigorous quality-assurance program. The agency regularly monitors staff competencies and ensures that all programs comply with standards of care and confidentiality.

As far as the future of fighting this epidemic, this testimony provides only a brief glimpse to the extent of the epidemic, its impact on our residents, and the many ongoing activities to halt its spread. Despite our best efforts and the efforts of countless experts, researchers, advocates and tireless AIDS workers throughout the City and nation, we have yet to eradicate this virus. Thus, I applaud and appreciate Council for providing -- for its continued ongoing support for Philadelphia programs to not only fight the epidemic but to provide quality care and support for thousands of City residents living with the virus.

As the AIDS epidemic grows into its third decade and the number of new infections in Philadelphia continues to grow, especial among ethnic, racial, and sexual minorities, the City is moving forward in expanding services by and for those most impacted by this epidemic. The City is committed to moving forward with increased coordination of HIV/AIDS prevention and care services among the City's various departments, including AACO, DHS and the Behavioral Health

System. This coordination and collaboration will ensure a broader continuum of HIV/AIDS prevention and care services, reduce the duplication of services, and facilitate a system that can better meet the HIV/AIDS prevention and needs of Philadelphia citizens.

Given the important role that the church plays in the life of many of those impacted by AIDS, the City is planning an HIV/AIDS summit to expand the collaboration and participation of churches and community-based institutions in removing the stigma associated with AIDS and to bring additional services to those most at need.

In recognizing the need for renewed awareness of the continuing threat of the epidemic on the City and so many of its citizens at risk, the City is currently planning the introduction this year of a large public-health media campaign to bring the message of HIV awareness and prevention to every neighborhood. This message must include information about HIV prevention, testing, care services, and the need to protect yourself and exhibit responsible behavior.

Terms of funding. The City continues

to recognize the need for additional resources to meet the increase in demand and cost for services, particularly care services. This problem is compounded by the fact that this year, our president proposed a federal budget that has level funded all Ryan White Care Act resources, which is a primary source of funding for HIV/AIDS services in Philadelphia.

In order to address the growing need, we must continue to advocate with the State, which has thus far refused to provide Philadelphia with any of its federal prevention dollars. The State has awarded this funding based on its total number of AIDS cases and, as I previously mentioned, Philadelphia accounts for more than 50 percent of all AIDS cases in the State.

And, finally, as we move forward, we must continue to dedicate available resources to the expansion of services to the neighborhoods most impacted by the epidemic and provide those services through neighborhood-based community organizations, which both science and common sense have demonstrated to be the most effective method of delivering services to those most in need.

Thank you for your time.

COUNCILWOMAN TASCO: Thank you very much for your testimony.

Are there comments from members of the panel?

Councilman Ortiz.

COUNCILMAN ORTIZ: Yeah, Councilwoman Tasco just leaned over to me and said, "Why don't we get any money from the State?" I mean, what's the rationale, you know? They do it to us in the school system and with children, and so it is part of a pattern.

But tell us the rationale for the record.

MR. CRONAUER: I am Joe Cronauer, Co-director of AACO.

Philadelphia is the only one of the six directly-funded cities that receives no CDC dollars from the State, from its accompanying state. The State's rationale has been because we receive our own direct funding. We have appealed to the CDC to intervene on our behalf, but because they don't have a clear policy on the relationship between cities and states around HIV funding and

the State is not required at this time to give us funding, they have not intervened. So we remain the only city that does not have --

COUNCILMAN ORTIZ: How much money does the State receive?

MR. CRONAUER: About $5 million.

COUNCILMAN ORTIZ: About $5 million. And they distribute that? Do we have a breakdown on how they distribute that? How much does Beaver County get, for example?

MR. CRONAUER: Actually, I don't know that. I know they distribute it across all of their counties, with the exception of Philadelphia.

COUNCILMAN ORTIZ: Well, I would imagine that there are not that many cases in places such as Beaver County and areas like that.

MR. CRONAUER: Right, yeah. Fifty percent of the cases are in Philadelphia itself, and if you include the surrounding counties in Pennsylvania or suburbs, that accounts for 70 percent of the State's entire caseload.

COUNCILMAN ORTIZ: Commissioner, you said that the growth in Philadelphia in poor

minority communities overall has grown by 17 percent?

DR. TSOU: I said -- I spoke about -- the 17 percent I spoke about is the increase among heterosexuals with AIDS.

COUNCILMAN ORTIZ: In the microphone, you got to --

DR. TSOU: I'm sorry. I spoke about how there's been an increase among heterosexuals with AIDS, which has grown about 17 percent in Philadelphia. And it turns out to be an important new area that perhaps part of our public-health media campaign will be focusing on.

COUNCILMAN ORTIZ: But that's during the last few years.

DR. TSOU: That's right, from '95 through '99.

COUNCILMAN ORTIZ: And we can project that in 2002 and 2001, that has kept on growing.

DR. TSOU: That's right.

COUNCILMAN ORTIZ: Okay. And most of those heterosexual males that you're talking about, they reside in two zip codes, you said? Or three zip codes? That's the African-American and

the Latino community in Kensington and North Philadelphia.

DR. TSOU: The majority of our cases are in those zip codes, as you mentioned before, Kensington and North Philadelphia.

COUNCILMAN ORTIZ: If you have AIDS in North Philadelphia, where do you go for treatment?

DR. TSOU: I'm going to let either Pat or Joe -- we have many places go for treatment.

MS. BASS: Good morning. My name is Pat Bass. I'm the other co-director of AACO.

We actually fund many of the programs in the North Philadelphia and Kensington and West Philadelphia area. For primary care, we fund the North Philadelphia Health System, APM. And, Joe, help me, are there others for primary care?

MR. CRONAUER: There are and the health centers.

MS. BASS: And the health centers.

We have Congreso and APM, who provide case management. So that we've tried the make sure that the dollars are in those communities where the services are needed.

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Additionally, those providers like BEBASHI and Action AIDS, who are two of our larger case-management providers, also provide services in those areas. So that we are clear that we try to target the areas where the services are needed.

COUNCILMAN ORTIZ: You estimate that at least 25 percent of our population doesn't know that it has AIDS or HIV?

MS. BASS: That's correct.

COUNCILMAN ORTIZ: And they are now going out and propagating it and spreading it in a sense?

MS. BASS: That's correct.

COUNCILMAN ORTIZ: How did you reach that number?

MS. BASS: Well, it's something that we struggle with. We have looked at prevention, and I think that one of the things that's been very innovative with AACO is that we have now tried to look at primary and secondary prevention.

COUNCILMAN ORTIZ: But how do you reach the number to estimate that 25 percent -- that there are 25 percent of our population out there with AIDS that really don't know they have it?

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MS. BASS: Okay. That is a CDC number that we get from Atlanta; is that correct, Joseph?

MR. CRONAUER: Yes.

MS. BASS: Okay.

DR. TSOU: I think it's based on other national (indiscernible) prevalent studies. They can do blinded (indiscernible) prevalent studies about how often they detect someone with HIV. They also know it's sort of something about how much they would estimate the number of people with HIV in Philadelphia and they know how many tests have been done. That's how they can come up with an approximation about how many people do not know their HIV status, because if they know how much has been done, they know how many have been done in blinded (indiscernible) prevalent studies. And from that, they can actually make an estimate.

COUNCILMAN ORTIZ: We've come a long way since 1986. And when I had a meeting here with the then-Commissioner of Health, and we talked about supplying condoms in the prisons, and at that point, that was not done and it was not even thought about it.

But in terms of AIDS in the prison, how has that -- what type -- do we know the population numbers that have AIDS? How is the distribution of prevention devices such as condoms and other aspects done? And how is the treatment within the prison happening?

DR. TSOU: You want to speak on that?

MR. CRONAUER: Yeah, I can speak on that.

Well, the primary medical care services is provided by PHS, Prison Health Services.

COUNCILMAN ORTIZ: And we've had many complaints from advocates and other individuals about those services.

MR. CRONAUER: Yeah. I mean, what I can personally address are the services provided by the City Health Department, if Walter wants to talk about PHS.

But we have ten employees that are AACO employees that work within the prisons, and they do two major tasks: One is education and skills building amongst inmates that are within the prisons; secondly, we provide all of the HIV testing in the prisons on a confidential basis so

that we encourage people that are at high risk for HIV to get tested, and we distribute condoms to prisoners who ask for condoms.

COUNCILMAN ORTIZ: And I know that there's this issue of confidentiality, but do we have any idea of individuals within the prison system and those individuals that come out of the prison systems that are infected with AIDS and how do we monitor that situation?

MR. CRONAUER: Oh, people who are released from prisons who have HIV?

COUNCILMAN ORTIZ: If we know about it.

MR. CRONAUER: Yeah, that is a real challenge. We have a few programs that are specifically addressing that issue. One is a program that we developed with the prison system so that when people with HIV are released, they receive a supply of medications when they get released. And we ask them for where they would like to go for medical care once they are out in the community.

We have a medical summary that's provided by the prisons, and the Health Department will send that, after the person signs a release,

to the medical-care provider that they intend to go to, to ensure that there won't be any interruption in the medications or in primary medical care.

The challenge is working with individuals that are released to encourage them to actually access that care. That in all of the priorities the individual has upon their release, maintaining primary medical care and maintaining their medications is something that is very important that we have to focus on.

COUNCILMAN ORTIZ: Commissioner, we've had experience now since, I would imagine, '86, '87 with AIDS funding and AIDS programs and HIV prevention. Do we have any data, does the Department have data in terms as to the effectiveness of the programs that we have, the effectiveness of the funding that we do? And if that data is available, can you make it available to us so that we can see it and study it.

Do we have that type of ongoing evaluation of programs taking place?

DR. TSOU: Well, the short answer is, yes, we could have that data available.

MS. BASS: Yes.

DR. TSOU: I think it's fair to say that in terms of HIV prevention dollars, we follow CDC best practices in terms of programs that have been shown to be effective. And those are the program that we actually implement in Philadelphia.

In terms of HIV treatment dollars, I think the truth is that we have done a remarkable job in trying to make sure that we can provide HIV primary care services to individuals, including an extensive case management program, what we call "Care Outreach," to try to get people into care.

COUNCILMAN ORTIZ: How do you measure effectiveness?

DR. TSOU: But we realize that we need to do a lot more.

COUNCILMAN ORTIZ: How do you measure effectiveness? You fund a program, that program comes back to you for re-funding or more funding. How do you measure whether the goals that they put forward and the objectives were achieved are being achieved and the dollars that you are giving and that we're dispensing are being used to the best

of our ability and getting the most use for it?

MS. BASS: Okay, we have quite an extensive continuous quality improvement program where we have set standards for all of the service categories that are identified through the Planning Council. And we have a system where we go -- we have outcomes for each of those service categories. And annually, we collect data primarily in the case management and primary care areas and the dental as well as nutritional counseling. But we monitor all of our agencies for their service goals as well as the quality of the services they are providing.

Our outcomes are primary care-focussed, and so whatever the service category is that we're funding, the goal is that folks will be connected through primary care, understanding that the clients will have to be connected when they are ready to be connected -- sometimes that takes a little more time that we would like. But, certainly, we spend a great deal of time and effort looking at continuous quality improvement.

Any program that does not meet our standards is given a report with the corrective

action that they work with their program analyst to make sure that they are correcting their services, and then they get reports back. Additionally, I give a report to all of providers to let them know where they stand in terms of how their quality of care is being rendered.

So I think that in general, we do a very good job of that.

Annually, we require that the agencies, as part of our procurement, file a continuation application. And their continuation application, in addition to looking at what they've done in terms of meeting their goals, we also consider their quality of services, and that determines the level of funding that they will receive for the next year.

COUNCILMAN ORTIZ: Could we get some of that data?

MS. BASS: I can absolutely send that report to you.

COUNCILWOMAN TASCO: Councilwoman Reynolds Brown.

COUNCILWOMAN BROWN: Thank you.

Good morning, panel. I'd like to go

back to the conversation and discussion regarding the State's involvement or lack thereof. Did I hear you say that 50 percent of the cases for the entire state are in the City of Philadelphia?

MR. CRONAUER: Yeah, that's correct.

COUNCILWOMAN BROWN: And in recent years, the City has received no support from the State for AIDS prevention service medical activities?

MR. CRONAUER: We receive from State-supported tax dollars about $970,000 that has been level funded since the early '80s.

COUNCILWOMAN BROWN: Since when?

MR. CRONAUER: Since the late '80s, actually, excuse me.

COUNCILWOMAN BROWN: And that continues to today?

MR. CRONAUER: Yeah, that continues to today. And that is disproportionately low in terms of the actual State dollars that go to HIV prevention and care.

Our main issue is around the federal dollars that have come to the State.

COUNCILWOMAN BROWN: Okay.

MR. CRONAUER: Which are the federal CDC dollars that every state gets and every territory to do HIV prevention across the state. And are the only -- we have 50 percent of the cases, and out of all of the -- there are six cities directly funded; we are the ones that receive no State federal funding, in Philadelphia.

COUNCILWOMAN BROWN: And did I hear you say that that was partly because the CDC has no clear policy across the board for how cities should receive dollars from the state? Did I hear that correctly?

MR. CRONAUER: That's correct.

COUNCILWOMAN BROWN: Have you had an opportunity or thought about having conversations with the leadership of the Philadelphia delegation and/or the legislative Black Caucus to probably enlighten them and inform them and then ask them for their help as it relates to this, given the harsh reality that 50 percent of the cases are in our city? Have you had an opportunity to do that yet?

MR. CRONAUER: No, and I think that it's something that we should definitely do.

COUNCILWOMAN BROWN: I would -- we would encourage that, because granted, there's a lot on their plate, but they respond to issues that are brought to their attention, and they can be helpful.

Since you say that these dollars come through the State from the feds, the same might apply with regards to the Philadelphia delegation on the federal level. Congressman Bob Brady and Congressman Chakka Fattah and Congressman Bob Borski -- a conversation with them might be helpful.

And I read with interest the green booklet that you provided to us, particularly on the prevention side on what's happening. And you say that a lot of the cases are in the North Kensington section of the City. And when we think about prevention and the next generation, of course, for me, the following question is, And what's happening with high schools, if not citywide, in that area?

Is there any relationship conversation, discussion, about informing high school students? Since those areas are highly targeted and there

are high schools in that area to get -- to just to inform them, enlighten them about this reality. Anything happening in that area?

MR. CRONAUER: Yeah. We have a variety of providers that are located either directly in some of the schools.

COUNCILWOMAN BROWN: Okay.

MR. CRONAUER: Through the health resource centers.

COUNCILWOMAN BROWN: Okay.

MR. CRONAUER: Or they are provided ongoing education at the classroom level or at like an assembly level, if it's something like a dramatic presentation, to enforce -- to reinforce with people their individual risk of HIV and to build skills.

COUNCILWOMAN BROWN: So these are tangible, ongoing programs?

MR. CRONAUER: Yes.

COUNCILWOMAN BROWN: Not ad hoc, if you will.

MR. CRONAUER: Yes.

MS. BASS: That's correct.

COUNCILWOMAN BROWN: Is there evidence

-- you mentioned best practice in prevention. So if I hear you saying that there is activity and a presence in area high schools, then there is best-practice evidence that says to the extent that you enlighten and inform high school students, it works with regards to not ultimately ending up with the disease. Is there supporting evidence to support that?

MR. CRONAUER: Yeah. Well, all of the interventions that we do, whether they're group level or individual one-on-one interventions, are all done based on methodologies that have been scientifically proven to be effective. So that we will not fund a provider to do something with a particular community, including youth, unless research has already shown that that is an effective way to create and sustain behavior change with that particular group of people.

COUNCILWOMAN BROWN: And my final question is, these programs are located in schools citywide or only in targeted areas where there's a high presence of the disease?

MR. CRONAUER: I would say nearly all schools have some form of program or another

around HIV. And all schools are also required to have HIV education as part of their curriculum. That's something that happened, I think, in the late '80s or early '90s.

COUNCILWOMAN BROWN: Good to know.

MR. CRONAUER: Middle schools are also required to do that.

COUNCILWOMAN BROWN: Thank you very much.

Thank you, Madam Chairwoman.

COUNCILWOMAN TASCO: Councilman Rizzo.

COUNCILMAN RIZZO: Thank you, Madam Chair.

Good morning. Commissioner, during your testimony, you said something that interests me and I'd like to pursue. You mentioned that there are a number of people in Philadelphia that have AIDS, have HIV, and don't know it. What could we do better to identify that number of people? What can we do to encourage people at risk to come in and identify or test? It seems as though that's an area that really we should be concerned about, the people that have AIDS and don't know it.

MS. BASS: Mm-hmm, mm-hmm.

COUNCILMAN RIZZO: What are we doing to encourage that test? I know early on when AIDS first became --

DR. TSOU: Well, I'll start and then I'll ask Pat Bass to finish.

I mean, clearly, our goal is to try to encourage HIV testing, and it starts really at the school level where we -- it starts at the school level, where we encourage people to learn than more about the risk factors for HIV, and we ask those people who might engage in those factors that they get tested.

And we have, in fact, as we mentioned, 30,000 tests that were done last year. We have over 40 test sites throughout the City. We have both anonymous and confidential test sites.

But I'm going to turn to Pat; maybe she can explain a little bit more about some of the other efforts we do on that.

COUNCILMAN RIZZO: Before you go forward, could you just refresh the numbers. Could you tell me how many people you speculate -- and I guess it's speculation or data that you

receive from Atlanta. How many people in Philadelphia do you believe are infected that don't know it?

DR. TSOU: Well, we estimated that 25 percent of the people who are at risk. Now, what that number calculates to, I wouldn't remember -- I wouldn't know off the top of my head.

MR. CRONAUER: Well, it would be 25 percent of 16,000, which is 4,000.

COUNCILMAN RIZZO: So we have 4,000 people potentially affected that don't know it?

MR. CRONAUER: Correct.

COUNCILMAN RIZZO: So what would you do, or what are we doing to make sure that 4,000 people know that they're sick, that every time they have a contact, that they're -- that to me is one of the most important things I think that we can do at this moment.

MS. BASS: It's certainly one of the things that we've struggled with, and we have looked at outreach from what we do in Philadelphia and also with what's happening nationally.

Additionally, this year, with the

reauthorization of the Care Act, one of the things that Congress has said is that we need to address outreach in such a way that we are identifying the folks who are HIV-positive who are not in care. To that end, we have completely revised our care outreach model, meaning that now our care outreach workers are in the community, they're connecting both primary care and counseling and testing. And so that we actually see this as a continuum, and the continuum being that once folks are tested and there's counseling, that we will stay with them until they become connected with a primary-care provider.

We understand that folks may not be ready the day that they find out that they're positive; there's a time frame. And so we're clear that we have to do the supports that are needed to make sure that folks have the support so that they can then be connected to primary care.

All of our outreach contracts now require that there's collaboration between the testing and counseling centers as well as primary-care providers. Additionally, most of these providers are now either working with case

management agencies, some of them are also case management agencies. Because I think the problem has been that HIV is not just a disease; it's also a social ill. And there are many things that we have not addressed around HIV disease.

COUNCILMAN RIZZO: The 4,000 that we're discussing here, at what point -- and forgive me for not knowing this. At what point once -- and they don't know that they have HIV, at what point do they start to decline or get sick where it becomes then aware to a physician or to the patient that they are HIV-positive.

I understand that there's people that have had it for years and years and years and years that don't know.

MS. BASS: I think certainly the folks who are HIV-positive, who are healthier when they start, probably stay healthier longer. Those folks who have other barriers and who are sick because of co-morbidities are folks who probably will exhibit the symptoms and will then decline more rapidly.

We certainly know in our community that African-Americans and Latinos who come into care

frequently are sicker and that we have to -- and, therefore, they require a more intensive kind of care. And it's not just primary care: They need case management, you know it may be other issues around housing and food. So there are other things that we have to address.

COUNCILMAN RIZZO: The minute a person is identified, what happens with that information? If a person goes to a doctor, they're sick, and the results are that they test positive for HIV, could you tell us what the requirement is of that physician to report that, or is it confidential? I'd be interested to know how that's dealt with.

DR. TSOU: Right now, HIV is not reported, but there is a proposal for doing reporting come January 2002.

The physician, of course, is obligated to know something about HIV, and our hope is that those physicians who know something about HIV would provide initial therapy, counseling on the disease and education, because that's really one of the most important parts. Those who don't know the care for HIV should, in fact, refer patients

to people who do know. And strongly encourage that and we, in fact, fund a variety of very excellent care programs in the City of Philadelphia.

But your whole gist of what you're describing, I think, is the whole purpose of this hearing today, which is, there is a complacency out there that people don't fully understand, and that by raising this awareness today, we hope to reinvigorate the Philadelphia community to realize that HIV still is out there, people need to come in and get tested. You might be one of the 4,000, for example, and that we need them to come in and get tested, and if positive, to get treated.

COUNCILMAN RIZZO: Doctor, could you give us a sampling of some of the diseases that a doctor is required -- I believe some venereal diseases, there's a mandatory reporting requirement.

DR. TSOU: Right. There's like 60 different diseases, so there's quite a lot. But, I mean, it starts from A to Z anthrax to --

COUNCILMAN RIZZO: And HIV is not one of those?

DR. TSOU: Currently, AIDS is reportable; HIV is not reportable. We anticipate that that will change sometime in the next year.

COUNCILMAN RIZZO: And you support that reporting requirement.

DR. TSOU: We support that. We think that HIV should be reportable, yes.

COUNCILMAN RIZZO: Thank you Madam Chair.

COUNCILWOMAN TASCO: Thank you.

You say that you ask people to come in and be tested. Why would -- what would prompt someone to get tested for HIV? I mean, if they believe that they don't have it, what would prompt them to do that? Because they don't feel well? Or maybe they're healthy. Like you say, you have healthy people who may have HIV.

And, of course, I think Councilman Rizzo raised some issues of privacy. How do you assure that the issue of privacy will be addressed? But if I hear a commercial, Well, go get tested for HIV, does that mean that all single people should go get tested or all -- I mean, who would go receive testing, and how do you get that

message to them about why they should be tested? Do you give certain circumstances as to -- under which they should be tested?

DR. TSOU: Do you want to answer.

MR. CRONAUER: Yeah, I mean that really is one of our most major challenges, and we are actually in the process of -- we have one program developed, and we're developing a another one, to specifically address that in addition to all of the outreach and all of the education we do on a group level and on an individual level. You know, the storefront model that we described before, where we have a variety of services, not all of which are HIV-specific, based in neighborhoods so that people can come in and get services and not necessarily be identified or have to even identify themselves as being at risk for HIV, but we can get them a message about their risk for HIV, and if they should be tested and are willing to be tested, that we can provide the testing onsite.

The second effort that we're doing that will be initiated in a competitive process this summer is pairing our community-based providers with mass-media experts to deliver very targeted,

clear messages to those at risk about the value and importance of getting tested for HIV and messages to people who already know they're HIV-positive about the value of staying in medical care, and if they're not in medical care, getting into medical care, and the value of safer sexual and injection drug use behavior, if that is what they're doing, so that they can protect themselves and those around them in their community.

COUNCILWOMAN TASCO: Any other questions?

COUNCILWOMAN BROWN: Just a follow-up on the schools.

COUNCILWOMAN TASCO: Councilwoman Brown.

COUNCILWOMAN BROWN: This is an additional follow-up for clarity with regards to the school. You mentioned that in the late '80s, it became a mandate for the School District to infuse in their curriculum AIDS education, if you will. So it's incumbent upon the School District to make sure that that happens, or is it incumbent upon the Health Department to make sure that happens?

DR. TSOU: They're audited by the Department of Education and so it's incumbent upon the School District.

COUNCILWOMAN BROWN: And how they do that is left up to them, which could include interfacing with agencies funded by the Health Department?

DR. TSOU: That's correct.

COUNCILWOMAN BROWN: Charter schools came later, but do you know if that mandate includes charter schools?

MR. CRONAUER: I don't believe so.

COUNCILWOMAN BROWN: I'm curious.

MR. CRONAUER: I don't believe so.

COUNCILWOMAN BROWN: Okay, then. Thank you again.

COUNCILMAN ORTIZ: One last in the same frame of mind here. In terms of the young people in high school and junior high -- I have a daughter now that's 11 and it really worries me, the things that she is bombarded with and continuously sees. Have we seen any increase in sexual -- or maybe you may have some data on that, on sexual experimentation at that age? Because

it's through sexual intercourse and the sharing of needles that AIDS is transmitted. And do we see any incidence or rise along those lines in the ages of 14 to 18 here in the city?

DR. TSOU: I mean, we're very concerned about young teenagers who might in fact be involved in sex. We strongly support that people should abstain from sex as the only way in which we can guarantee that --

COUNCILMAN ORTIZ: I understand that that's what we do, but do we see -- is there any information coming into the Health Department that says we're going to have to do something in this area in terms education, in terms of condom distribution, in terms of this, you know, in terms of several things that need to be done.

MS. BASS: We have -- our surveillance unit certainly trends all of this information, and we can make sure that -- we are very concerned about the youth population, and certainly this has been a concern for us for a while, and we are seeing this as an area that we need to continue to address.

What I will do for you is to make sure

that we get the information from our surveillance unit to tell you what the incidence is amongst the youth and we can give that you information.

DR. TSOU: Later this week, I'm going to be giving testimony about sexually-transmitted diseases in Philadelphia and the epidemic we have in this city, and I think that it will illustrate some of the points that you are raising here and the importance that we have in the City of trying to be more vigilant about STDs in general.

COUNCILMAN ORTIZ: In the issue of confidentiality, would name-based reporting be seen or could be a cause or a deterrent towards testing?

DR. TSOU: Do you want to answer that.

MR. CRONAUER: Yeah, there have been studies that have had mixed results, and I'm sure there will be a lot of people discussing this issue today. Certainly for some people, we would expect the possibility that it would be a deterrent for that individual getting HIV testing. Right now the regulations that the State is proposing, the State Health Department does include HIV name reporting, and we have 30 days to

respond at this point, and we're taking a look at how --

COUNCILMAN ORTIZ: If you make it mandatory, how would that affect the individuals who want to come forward to test themselves but don't want to really put their names out there in that manner? And would that be a deterrent to testing and would that affect adversely our ability to be able to take a hold and manage the disease?

MR. CRONAUER: One thing that we are definitely doing, no matter what the state of HIV reporting is, is maintaining all of our anonymous HIV-testing sites, which means that anyone can go in and get HIV testing and not give their name. They can do it anonymously, they can do it for free, they can do it in a variety of --

COUNCILMAN ORTIZ: I understand that, but if legislation is passed that says it has to be name-based and your name has to be given, would that act as a deterrent for our citizens going forward and getting tested? Your opinion, your stand.

MR. CRONAUER: My opinion is that the

results are mixed and that we need to take steps such as maintaining anonymous testing to ensure that people with HIV can continue to -- or that people at risk of HIV can continue to get testing without having their names reported.

COUNCILMAN ORTIZ: Okay, thank you, Madam Chair.

COUNCILWOMAN TASCO: Thank you very much.

Councilman Rizzo and then Councilwoman Brown.

COUNCILMAN RIZZO: Thank you. Could you possibly address this, and I truthfully may have missed it. Could you tell me, is there any data on HIV that indicates whether -- and I know that there's been a lot of controversy and discussion many years ago. Is there any way -- is there any knowledge on whether HIV is contracted through heterosexual sex or other -- is there a big difference? Have we been able to identify the community where it is most a big problem? But is there any way -- you know, it's a difficult question to ask, and we're here to learn, at least I am.

Is there a way that we can determine how HIV was contracted?

DR. TSOU: We know that HIV is a virus, that it's found in body fluids, including blood, that the most common methods that have been identified for contracting HIV, including sharing needles and men who have sex with men. We do know that heterosexual activities is also a way in which people can contract HIV.

The way we know this is that we actually, when we get test results that are positive, we do interview individuals about some of their risk factors that they -- and we have a pretty good idea of what are the most common trends in Philadelphia in terms of what are the risk factors that lead toward HIV.

And from that, of course, we use this knowledge to try to direct our prevention programs most effectively.

COUNCILWOMAN TASCO: Councilwoman Brown.

COUNCILWOMAN BROWN: My colleague and sponsor of this resolution raised an important public-policy question for us, and that is around

this notion of legislation as it relates to privacy. And I heard your opinion and, of course, I consider you an expert, but I think implicit in your opinion for me is the question, has the Department as of yet decided a policy with regards to the issue of privacy and the assistance or not that could bring in -- bring forward those who are affected? Have you --

DR. TSOU: Well, I think it's fair to say that the State has a State requirement on HIV confidentiality.

COUNCILWOMAN BROWN: Okay.

DR. TSOU: Which is known as Act 148, which is very, very good, we think, in terms of making sure the only way that HIV information can be released is through the written permission of the person with HIV.

COUNCILWOMAN BROWN: Okay.

DR. TSOU: Or in the case of physicians who are directly involved with the medical care of that individual, they can -- and in that situation, they can talk about it.

There are major, major restrictions on how and who may have access to the HIV

information, and I think that part is good.

In terms of the recommendations in the future, we strongly support -- and we don't believe HIV testing will ever work unless there are strong confidentiality laws that protect that.

COUNCILWOMAN BROWN: Mm-hmm.

DR. TSOU: And we strongly support that, and we anticipate that under the new HIPA regulations, that those confidentiality laws are going to be reinforced again, and we're going to follow those rules -- not just HIV but all test results of patients should be confidential information.

COUNCILWOMAN BROWN: Sure. Very well. Okay, thank you very much.

COUNCILWOMAN TASCO: I have just one final question. I want to go back to the State funding versus issue. You receive funding from the CDC, all right.

MR. CRONAUER: (Nods head.)

COUNCILWOMAN TASCO: And then the State receives funding from CDC. Those are the dollars you're talking about?

MR. CRONAUER: Correct.

COUNCILWOMAN TASCO: So you get money from CDC, then they also give the State funding, and so you want to get funding from CDC as well as from the State's CDC funding.

MR. CRONAUER: Yeah, that's correct. In all other instances, the cities also get the CDC funding that the State has, a portion of that as well, because when the states apply to receive the dollars from the federal government, they do it based on the entire state's number.

COUNCILWOMAN TASCO: They include Philadelphia's number?

MR. CRONAUER: That's correct.

COUNCILWOMAN TASCO: So that's how they receive the dollars.

MR. CRONAUER: That's correct.

COUNCILWOMAN TASCO: But then they don't give you any of the money that they received.

MR. CRONAUER: That's correct.

COUNCILWOMAN TASCO: Okay, thank you.

Any other questions?

(No further questions.)

COUNCILWOMAN TASCO: Next panel. Thank

you very much.

DR. TSOU: Thank you.

COUNCILWOMAN TASCO: One of you may want to stay around in case there are other questions. I know you have busy schedules, so --

MS. BASS: Joe will stay around.

COUNCILWOMAN TASCO: Okay, thank you.

We next call Panel 2: Jane Shull, Executive Director of Philadelphia Fight; Julie Davids, Philadelphia Fight, Project TEACH; Hassan Gibbs, Midnight Cowboy Project.

(Witnesses come forward.)

COUNCILWOMAN TASCO: Good morning. Could the Sergeant-at-Arms get the testimony, please.

(Copies of written testimony distributed by Sergeant-at-Arms.)

COUNCILWOMAN TASCO: Good morning. Would you state your name for the record. We welcome you to City Council one more time -- again and again.

MS. SHULL: Good morning, Councilwoman Tasco and members of the committee, my name is Jane Shull, and I'm the Executive Director of

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Philadelphia Fight.

COUNCILWOMAN TASCO: What we'd like for you all to do, if you possibly could, is summarize your testimony. We have the copies written that will be entered into the records as presented. But in the essence of time -- we have a number of panel presentations -- we would like to have you summarize your testimony.

Thank you.

MS. SHULL: Should I go ahead?

COUNCILWOMAN TASCO: Proceed.

MS. SHULL: I just want to briefly say that Philadelphia Fight is an AIDS service provider in Philadelphia. We have several programs. They include the Jonathon Lax Immune Disorders Treatment Center, and I provided you with our brochure. We care for 1100 people in Center City. We offer HIV primary and specialty care with infectious disease providers, mid-level practitioners. We have other services on site as well.

Our programs are available to everybody, without regard for ability to pay. We see a great many uninsured people. We see many

people who are not only uninsured but uninsurable because of some issue, like they have been convicted of a felony in the state at some point in their lives.

We also have a wide menu of consumer education programs, including:

Project TEACH, which stands for "Treatment Education and Advocates Combatting HIV," which you will hear more about today, has graduated 600 people from an intensive nine-week training program over nearly seven years and provides peer counseling at 45 outreach sites.

The Youth Health Empowerment Project, which was mentioned a couple of times before, is another one of Fight's programs. YHEP has 12 outreach sessions each week in neighborhoods throughout the City. They reach about 20,000 high-risk youth each year. They have a drop-in center that they just started. They have counseling and so on.

We sponsor the AIDS Library, which is a library -- I won't go into it more. About 3500 people use it each year.

We sponsor the Critical Path AIDS

Project, which allows people free dial-up access to the Internet if they are affected by the AIDS epidemic. It sponsors 131 nonprofit Web pages. I should actually say we have free dial-up access in the 215 area code; we are hoping to expand to 610, 856, and maybe 600.

And we also do research, which is probably the least relevant to what we're talking here, so I will skip that part.

I think as look at the AIDS epidemic in our city today, it's important to recognize that not only is it not over, not only is it not nearly over, but recent reports presented at scientific meetings suggest that if anything, the epidemic is about to become unimaginably worse. In order to see what could happen here, we need only look at Sub-Saharan Africa. There are 25 million people with AIDS in Sub-Saharan Africa, of 36 million worldwide. In many countries on that continent, an average 15-year-old has a better than 50 percent chance of dying of AIDS.

There are seven countries where 20 percent or more of the people are infected. Two years ago, for example, 35 percent of the adults

in Botswana were living with HIV, 20 percent of the adults in South Africa were living with HIV, and that number had risen from 12 to 20 percent in just two years.

The economic, social, and human costs are staggering, unacceptable, and --

COUNCILWOMAN TASCO: Can you slow down a little bit.

MS. SHULL: Sorry. I'm just trying to save time.

COUNCILWOMAN TASCO: I can't hear that fast.

MS. SHULL: -- and very possibly unavoidable. That there should be any question whatsoever that we in the so-called developed world should not be doing everything we can to provide to these countries the drugs that will keep people alive at a cost they can afford is reprehensible. Yet, in spite of a huge international effort on behalf of affordable drugs for the less developed world, we have as yet seen only symbolic victories. So as things stand, tens of millions of people will die who didn't have to.

What does this have to do with

Philadelphia? There weren't 25 million affected in Africa 10 years ago, and there are African countries, including countries in Sub-Saharan Africa where, in fact, it didn't happen. So what happened there was not inevitable and it isn't inevitable here either.

The first conference I ever was involved in with AIDS was in 1987, sponsored when I was still at the Institute for the Study of Civic Values. A physician, Dr. Robert Swenson, who is still a physician at Temple University, gave a little presentation, and he said, you know, an epidemic starts with one little group of people and then it expands and then it moves into a second wave and then it moves into a third wave.

Where Africa was at that time is where North Philadelphia, Kensington, West Philadelphia are today. That's what it has to do with Africa.

There was some truly terrifying epidemiology presented at the Eighth Conference on Retroviruses and Opportunistic Infections held in Chicago this past winter. This is the most prestigious American meeting on HIV. There were two studies presented there of young gay men of

color who have sex with men. One of the reasons we use the terminology "men who have sex with men" is that particularly in communities of color, people who do have sex with men do not identify as gay. And if you talk about people who are gay, you're going to miss the overwhelming majority of people who are at risk of contracting and then passing HIV.

Both studies found that one-third of young men of color who have sex with men were infected. Six American cities. One-third of young men of color who have sex with men were infected.

COUNCILMAN ORTIZ: Are we included in that?

MS. SHULL: We were not included, but there is no reason, given everything else that goes on. The cities were cities like New York, Chicago, Los Angeles, Atlanta, Newark. There is no reason to believe it's any different here.

Further, because they saw this statistic, which surprised even them, they had a statistician go back over the data to try to figure out why this might have happened, and this

is the part that I think is the most scary part. They wanted to see if perhaps these young men were infected because their behavior was exceptionally reckless. The young white men who have sex with men had rates way, way lower than this.

So they asked, did they have more unprotected anal sex? No, they had less protected anal sex. Did they have more sexual partners? No, they had fewer. Were they more likely to share needles? No, they were less likely.

So what that means is, when you start to have this kind of infection rate in a community and one out of every three people you encounter may be infected, it doesn't matter if you're more careful; the epidemic is just going to keep growing and growing and growing.

And a second fact, which is not from particular studies but which is well-known, is that there are very high rates among these groups of people of also having heterosexual sex. And we've talked a lot about who are the people who are infected and who don't realize that they are at risk. From our experience in the Lax Center in treating women with HIV, a lot of times it's

because they're having -- they have behaved in ways that are absolutely not outside the standard behavior in their community, simply not outside. And yet, one of the two or three sexual partners they've had in their lifetime, to one of whom they might be married, had HIV and did not tell them.

What can we do about this? First, we really do have to remember that in every country of the world, regardless of how HIV first enters the population, as the epidemic matures and begins to concentrate among the poorest and most disenfranchised people, and the same thing has happened in the United States. In Philadelphia, as the Commissioner did mention, we've seen the epidemic go from an epidemic that appeared to be concentrated among gay white men to an epidemic of the disfranchised, the alienated, and the poor.

If you use street drugs, you are at huge risk. If you are non-white, especially African-American or Latino, you are at huge risk. The highest percentage increase in the second half of the '90s in Philadelphia, over 60 percent, occurred in that kind of Frankford-Kensington area of the Lower Northeast and was actually higher

than the percentage increase which was in North Philadelphia of 48 percent.

COUNCILMAN ORTIZ: Do we have any data, besides that it's a poor community and so on, that can explain that?

MS. SHULL: I don't know that we have data that can explain that, Councilman, but I think that the answer is something that Jonathon Mann, who was the founder of the UN AIDS Program, also the Dean of Public Health at Hahnemann University, used to say: "If you want a man to use a condom, give him a future." And I think that that's really the point, that the reason for what we are seeing now is an epidemic of people who are vulnerable.

The information on how not to get infected has been out there a good long time now. And I would say that I do disagree a little bit with some of the -- one of the things that the Health Department people said. From my understanding of public health, there is not a lot of evidence that simply giving people information is going to change behavior. They have to have another reason to change their behavior.

Two of those reasons that are very important that I think we cannot neglect is that behavior does not change for individuals; it changes when it changes in the community context and in the family, etc. And the second point is, behavior will change when people think there is a reason to change their behavior; there's a reason that they have a future. And, you know, we've been hearing about this great economy in the last presidential election, but as we all know, it kind of passed a lot of our neighborhoods by.

I think the third thing, which is more anecdotal, but I think that, you know, we are all, who treat people with AIDS, seeing far higher percentages of people with mental health diagnoses, with substance-abuse issues and so on, and the issue is that these were people who were vulnerable in the first place, and we don't have adequate services for that, we don't have adequate ways to address it. And so people become reckless, lose control of themselves temporarily. I mean, there's big, big, big correlations that have been found over and over again between ingesting alcohol on the same night that you have

unprotected sex, for instance, many studies. And if you're interested, I can send you studies. And it makes people vulnerable.

My second point is, we need to remember why there are over 20 drugs to treat AIDS, a disease that's been recognized for over twenty years this June -- although it is twenty years this June -- while there are only a handful of drugs to treat, for instance, tuberculosis, a disease recognized since Biblical times.

Unlike any other epidemic or disease in human history, the difference has been consumer involvement at every level of the AIDS epidemic. People with AIDS, beginning in the '80s, continuing to the present day, have refused to see themselves as victims and behave passively. Instead, they saw themselves as consumers, activists, participants in the decisions that would affect their lives, and they demanded their voices be heard.

We in Philadelphia have contributed enormously to this by working hard as a community to racially, ethnically integrate the service system, to train consumers, including many people

of color with limited formal education, to understand the natural history and treatment of HIV, to learn to advocate for themselves, but also to advocate as a community, in doctor's office, the hospital, and collectively influence public-policy decisions. It's not possible to make a decision, including how the federal government spends its science dollars and how local government spends its service dollars, without the involvement of consumers and people representing organizations of people living with AIDS.

And of all the work that Philadelphia Fight has done, I think the most important thing that we have done and what we are proudest of is Project TEACH, because we have contributed, through that, 600 graduates of people who have participated, who have advocated, who have been involved at every level as consumers and policy decisions.

And there's many graduates of Project TEACH here now, and actually the current class is here -- and I'm not going to ask them to stand up because of confidentiality issues, but they are

here participating in this hearing because they've gone through this program and I think they understand now -- they understand how important it is.

This city and this community have done better than most in transforming our local service system, and it's something we really should be proud of as a city and that really needs to be supported.

But, third, we need to remember that the AIDS epidemic has really -- what it's done is exacerbated the problems of an already-overstrained public-health system. We talked a lot in this hearing so far about how prevention dollars don't come to Philadelphia. We should also remember that we live in a state that has historically have very low Medicaid reimbursement rates, little interest in the welfare of poor people or people of color, and a legacy of a series of governors who believe that saving a few tax dollars and generating these enormous budget surpluses was much more important than saving lives -- in any social service program.

As a result, the resources to provide

for people with AIDS are not there, and I don't think we should lay the fault for this with the local AIDS service system or with the Health Department or the AIDS Activities Coordinating Office. In fact, I think it's important to acknowledge that the current co-directors of AACO, Pat Bass and Joe Cronauer, have taken very significant steps to professionalize the AIDS service system, that its history of petty squabbles and warfare is really now a thing of the past, and that there is a service system in place that care for people with HIV, which there really wasn't in the past.

But we don't have enough resources for these service that are really a matter of life and death because we argue over the small -- the ; $22 million in Ryan White dollars, where there are hundreds of millions of dollars in Medicaid dollars -- in Medicaid that are now HealthChoices over which we have no influence.

And one thing that I want to say to members of this committee is, we really need help. In clinical care, the State of Pennsylvania reimburses about $10 per patient per month. We

had occasion recently to do a computer run of all the recent visits entered in our database. We had about 1,000 patients at that time -- we now about 11 or 1200 -- and 7500 visits entered over an 8- or 9-month period less than a year. So we were seeing our patients an average of seven times -- actually, some had twenty visits because a lot of times, these people are really sick people. They can't be taken care of for $10 a month. This is a life-threatening illness.

And the issue is HealthChoices. There has been a coalition of AIDS service providers that's been meeting with Pennsylvania HealthChoices with the support of the current and past commissioners of the health for several years now, and we can make a few small changes, but we really can't get very far, because the real decisions are being made in Harrisburg by a legislature which is unwilling to appropriate sufficient funds to take care of sick people who happen to live disproportionately in the southeastern corner of the State or who are African-American or who are Latino or who are poor. And I think that this is probably the

single biggest issue.

We are at a time now where if get yourself to HIV specialty care, you will live, you will live. But if we don't have the resources to take care of people with the growing epidemic, then people will die, who really will die needlessly.

Another example: In the year 2000, the reason used up its original medications allotment from federal funding in less than three or four months, and it was for the same reason: people need access to HIV medication or for common complications of HIV such as hepatitis C, for other conditions that they might have such as diabetes or high blood pressure or if they are uninsurable. And the problem is, again, the overall lack of funding for these services. Everybody had to scramble to make up the funds, and remembering that this is always a zero-sum gain.

During the eight years of the Clinton administration, there were two huge increases in Ryan White funding, and there were small but steady increases during the intervening years.

The Ryan White funding pays form, among other things, medical care, case management and so on and services for people with AIDS.

So we seem to be in relatively good shape, but we will not be for very long because now George Bush is president, Republicans control Congress. There will not be increases. And unless we as a community and the communities like us all over the country and all over the state can find ways to effectively organize, we will be playing in a zero-sum game, and we will be in a situation where the resources will, in effect, shrink per person because the numbers of people with HIV are rising.

One small thing that I think this city could conceivably do to address it is at the time when then-Mayor Wilson Goode provided City general fund money for the HIV epidemic, he was the first mayor in the United States to do so, and it was the largest allocation for several years. That allocation has apparently not changed at all since whenever that was, which was around like '86 or '87. So if that could happen, if we could see an increase in general funds, it night to some extent

serve to mitigate the problem.

But I think basically, the issue is we really all do need to stand together, we really all need to work particularly in relationship to Harrisburg to get more dollars into this city, and we absolutely -- we really need to remember that we are not going to stop the AIDS epidemic unless we understand that we must concomitantly address all the other problems that are making people vulnerable to HIV.

Thank you very much for your attention.

COUNCILWOMAN TASCO: Thank you.

(Applause.)

COUNCILWOMAN TASCO: Tell me, what is your plan to deal with Harrisburg? They are presently now in the budget phase and what is the advocates' and provider plan for reaching out to Harrisburg and the State representatives from Philadelphia who represent us in Harrisburg?

MS. SHULL: Well, I would say we probably, as a community, don't have anything like the plan that we should have. I think people go and they speak to their individual State legislators as individuals. We have had some

meetings with them but I think that, you know, one of the problems that I think we face is that we have an incredibly over-burdened social services and clinical care system, and we need some guidance in what would be the most effective way to get the attention of Harrisburg. And we need some help.

COUNCILWOMAN TASCO: Well, I think the help can come from meeting with the State legislators from Philadelphia to develop a plan, because they know best how to lobby their colleagues. And certainly, when I first came in Council in 1988, I mean, the community was here in City Council en mass protesting additional dollars for health services for money for AIDS prevention. So I think you have to take that show on the road to Harrisburg collectively.

And so that means that you all have to organize and begin to develop your own strategy to reach out to Harrisburg, because if they don't see any large lobby or any -- I mean, what happened to the marches that we used to have. I mean, you got to go back to those days so people could understand that.

MS. DAVIDS: I could speak to that. My name's Julie Davids, and I'm the Director of the Critical Path AIDS Project, and I've been a member of ACT UP-Philadelphia since 1990. ACT UP-Philadelphia is the nation's largest all-volunteer grassroots AIDS activist group, and many of our members are here today.

We have gone to Harrisburg many times, and are going there actually, in all likelihood, next month because of our concern that this city is not going to the block the names-reporting proposal and that this city abrogates its responsibility to protect the confidentiality and the lives of people with HIV in Pennsylvania. Every small town and every rural place in this city is in jeopardy.

Of course, we always talk about more funds needed. We have fought for access to HIV specialists in the HealthChoices Program and (indiscernible). We have fought for greater inclusion of drugs in the special pharmaceutical benefits program, which is a joint federal- and state-funded program what provides AIDS medications for those who are under- or

uninsured. And we will continue to.

We also believe that it's important, though, to have the backing of the City to stand by the safety of people with HIV and have really great concerns at this point, when our own public health officials will sit at this table and not guarantee that they will oppose calls for names-reporting, even though they have in the past, even though when it's been opposed by every major AIDS organization in Philadelphia and most across the State, and even when it's been clear that people with HIV in this city have said they would not have gotten tested if they thought their names were going to be turned over.

So we see this, as advocates, as a partnership. We see this as a partnership where we work together with our officials, with our legislators to protect lives and to get more money for health care, and that part of that partnership is not taking these easy, shortcut answers that we're kind of handed from the CDC when they say it's better with names, because we don't need names. So we look forward to continue to collaborate in this manner, but we can't split our

forces by jeopardizing lives in this way.

MS. SHULL: Can I just say one thing about that?

COUNCILWOMAN TASCO: Mm-hmm.

MS. SHULL: Because I think it's important that it be on the record. The issue isn't names-reporting or no reporting; the issue is, will people be reported by name, or will we generate what's called "a unique identifier," a number that can only be assigned to a person once to report them. And the way do you that is you do something like their date of birth and part of their Social Security number. There many ways to do it. And there are some -- I think 19 states -- there are people here who know better, but there's something like that 19 states that are doing that.

So we don't have the choice of not reporting HIV or names; we have another choice.

COUNCILWOMAN TASCO: Let me ask a question that may be controversial, and certainly it has crossed my mind a couple times, about contracting AIDS -- I mean HIV. How do women transmit HIV since they are the host in a relationship, other than through the needle? I

mean, sexually, how do they transmit it?

MS. SHULL: The African AIDS epidemic has always been a heterosexual epidemic, meaning it's been transmitted through heterosexual sex, women to men, men to women. And for many years, there's been this question, well, maybe there's some other strain that makes it easier to transmit in Africa.

There was actually just information published in the scientific literature, I think just last week, something like last week, where this question has now essentially been definitively laid to rest. People have thought that the answer to that question was no for a while, but somebody did something, which I don't understand, but they reported that there is no difference in the type of HIV.

What is different in the United States is that the epidemic entered the population, in the beginning, in a group of gay white men who rarely had sex with women. That's the only difference. As time has gone on and now there is more heterosexual sex going on among infected people we are seeing increases an specifically, we

are seeing increases, and specifically, we are seeing significant increases in this city. We actually saw a line crossed about two years ago, I think, with heterosexual sex and men who have sex with men in terms of transmission -- that is heterosexual sex being more common, and that of course includes women. But we are seeing transmission going both ways.

So the only reason it didn't happen was because there weren't enough people who were infected or having heterosexual sex. It's believed to be somewhat harder but not so much harder that it won't happen.

COUNCILWOMAN TASCO: I guess my question is, who's transmitting it? Is the transmitter a male or a female?

MS. SHULL: Either.

AUDIENCE MEMBERS: Both.

MS. SHULL: Either.

COUNCILWOMAN TASCO: So how does a female transmit it? How is it transmitted?

MS. DAVIDS: I can speak to this biologically, which is that, as many of you know, HIV itself on the surface of the skin is harmless

and does not enter the immune system where it latches on to key cells, where it regenerates itself.

What's necessary is that HIV has to enter the blood stream or via mucous membranes. Because of this, this is why adolescent girls, speaking of some of the earlier questions, are actually at greater risk from the same number of acts of unprotected sex than older women, because they have only one thin later of non-immune-system cells between the cervix, that the immune-system cells are right there and it's easier for HIV to latch on. As women age, the cell barrier gets bigger. So actually, women who are young women can pick it up more easily, so to speak, okay?

If men are having sex with women that's unprotected and HIV is in the sexual fluids of women, it can enter their blood stream through a small cut that they may not even know they have, through a sore that may be painless. There's many different ways that it can happen biologically.

I think it's also really important to remember that folks who are heterosexual who are getting HIV or who have all kinds of, you know,

sexual practices or identities, a lot of what's transmitting HIV in this city and in this nation is a needle. And that doesn't have to happen.

COUNCILWOMAN TASCO: You talked about the study earlier in your testimony, you talked about a study where you said that -- I believe, that African-American males were not as careless -- weren't any less careless -- more careless than the other group but the epidemic -- could you explain that a little more to me. How does the epidemic begin, and if their behavior is no worse, then what is their -- how does the epidemic begin?

MS. SHULL: Well, I think you have to see it as happening over time, and I think what's happened is over time, more and more and more people get infected in a community, and then there's a point at which there was so many people infected that it kind of tips over in terms of everybody's risk. And after that, it isn't going to matter whether you think you're being careful or not because so many people who you might come across are actually infected.

It's as if -- you know, in a group of

100 people and it's 1990 and they walk around shaking hands with each other, whether they're going to get a cold or something. In 1990, ten of them have a cold. So if they only shake hands for a couple of minutes, by the time you're done, maybe twenty will have a cold. But if what happens is that thirty people have a cold, that is one-third, and they walk around shaking hands even with one person, at the end, sixty are going to have a cold. And if they shake hands with two people, probably everybody will have a cold. And it is analogous. I mean, those are exercises we used to do to try to show transmission in the '80s.

So it grows slowly, but there's a point at which it starts to take off. And what I think is extremely frightening -- and I've talked to some of the people at the CDC who did this research, 'cause we actually had one of them visiting us yesterday -- is they think it's extremely frightening too, what this could mean.

And, again, I think it is very important to emphasize that -- I don't remember the percentage, but it was a very high percentage

of the young men in this study also had sex with women. And it's unlikely, from what they found in interviews and so on, that they were disclosing their HIV status. And, of course, as has been said before many times, a lot of them didn't know.

COUNCILWOMAN TASCO: Okay, thank you.

Any other questions? Go ahead.

MS. DAVIDS: I'll just make some brief comments largely based on some of the things that I've heard today.

COUNCILWOMAN TASCO: Sure.

MS. DAVIDS: I'm Julie Davids from Critical Path AIDS Project.

Speaking of the assessments of whether programs work or not, I just wanted to point out that Project TEACH is evaluated extensively through knowledge (indiscernible), and behavioral questionnaires and surveys with participants pre- and post-tests and both quantitative and qualitative research and has been shown to increase people's knowledge about HIV and its treatment, to increase their idea that they can take control of their treatment and stay healthy, and to -- and what they have stated change their

behaviors for healthier practices. So we've been extensively evaluated.

I'd like to point out that across the country, it's estimated that 30 to 35 people -- 30 to 35 percent of all people with HIV have hepatitis C. And we believe it's higher here in Philadelphia since a high percentage of our HIV cases are associated with past injection drug use. So I think it's important that we no longer delink these things. It's very clear that in Philadelphia that hepatitis C is not just for firefighters; it's a vast public health problem.

And if you ask anyone in here today, What's the hotline to call to find out what to do if you may have been at risk of hep. C, where is the practices that your doctor knows if he or she should or shouldn't do if you're diagnosed with hep. C and HIV? How -- who is going to train you to keep your family safe based on possible transmission risks? because it is much easier to transmit hep. C than HIV. No one in this room would know because there's no answer to those questions. So we cannot talk about HIV without talking about hepatitis C.

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I'd like to quickly move away from Center City just for a moment to talk about a place up where to 20 percent of people are HIV-infected. And even though it's known that they're HIV-infected, they are sick and often dying of preventable or treatable infections.

There is a very high rate of stigma where their peers are actually encouraged to stigmatize them and they're further at risk, and they're not told how to protect their families or their partners and kind of left to drift to die.

You may think I'm talking about Sub-Saharan Africa, but I'm not; I'm talking about the Philadelphia County correctional facilities. And these facilities have a for-profit contractor, Prison Health Services, that is supposed to provide health care, that is supposed to be overseen by our health department, not just the prevention services and the transition services are provided by the Health Department; our City government is supposed to oversee Prison Health Services and should be able to tell what's going on here and why people are dying.

There is a Town Meeting happening

tomorrow at Temple University where formerly incarcerated people with HIV, who were fortune enough to come out alive from this system, are going to talk about what they experienced and what they saw in terms of misdiagnosis and mistreatment. We have people who are going in and just waiting for a trial 'cause they can't get bailed out, that are missing their treatment and are becoming incredibly ill or even dying. So I won't go into all of the details now, but it's incredibly important.

COUNCILMAN ORTIZ: You know what bothers me about that? That one of the problems is that we asked for information, and the City Solicitor sat there, and they hired a consultant to come in and evaluate that health system and that company and the services that were provided. And they said to us, even though they paid the consultant, the consultant had the study done, that they could not release that study to us.

And next time around, when they come forward, we will subpoena the study. Because that's information that the public should know. And if we pay for it, the taxpayers pay for it,

the taxpayers have a right to understand what they are paying for. And I do not believe that anything of that sort should be privileged and hidden. So next time around, we will get that report in the next hearing.

MS. DAVIDS: Good. I think it's also really important to remember that what they say they may be doing and they may have stated policies and procedures that absolutely aren't being followed, and we need to go with the overwhelming eyewitness and (indiscernible) evidence in this case.

Last, I will end by talking about the importance of going to the route of, It's time to get to the root of these problems. It's absurd to say we need to collect the names of people that test HIV-positive to know how to deal with this epidemic. We know how it's caused, we know how it's treated, we know what works and what doesn't work in terms of prevention and care.

The US government has proven in nine well-funded studies that needle exchange stops the transmission of HIV without increasing drug use, and there's no one that can tell me that if you

collect the names of people with HIV, we're going to start doing more access to needles. So that's a red herring.

We need to put the information and services where people are. We need to have prison services at the core of our HIV response, not on the periphery. We need to have at-risk youth talked to -- not at schools where they're not, but where they are. We need to use the Internet to get information to people so they can get to it in the privacy of their own home, because people are getting computers and using them at home. And that way, they can get information that they won't feel comfortable getting in their neighborhoods.

We need to go the route of where this is happening and use the innovative things that we've seen work in Philadelphia and elsewhere to do this.

And I applaud City Council for having these hearings and hope that we have the courage to look at some of the facts here and move behind the rhetoric and the blame.

Thank you.

COUNCILMAN ORTIZ: Thank you.

Hassan?

MR. GIBBS: Thank you.

I want to say that I'm extremely nervous. My name is Hassan Gibbs and I am a person that's living with HIV.

Thank you for the members of City Council for allowing all of us to address you with this serious matter that confronts us today. This is going to be reading off so that I could stay focused.

Once again, my name is Hassan Gibbs. I was diagnosed with HIV in 1985, probably infected around '83, and since 1990, after attending my first support group, I have been involved with the HIV and prevention and treatment and education community, working and volunteering in many capacities, from sitting on boards of directors of AIDS organizations to being part of the most innovative outreach primary and secondary prevention programs in Philadelphia.

I need to correct that I am employed by the Philadelphia Fight. And I am the co-lead educator and outreach coordinator at Philadelphia Fight's Project TEACH. I left Midnight Cowboy

Project some years ago, a very great program.

Having been around for a while, I've seen this disease, HIV, devastate individuals and families. I've seen the fights at TPAC over money for program and witnessed agencies fold and programs fail, all while more and people, especially low-income minorities, continue to become infected with HIV and die.

We are entering into a very rough time ahead. The epidemic has not stopped; it has actually gotten worse. And I predict that within the next five years, all of us will really start to see the full impact as if it were the late '80s or early '90s again. Back then, the gay community empowered themselves to do all they could do to get service to their community, and dozens of agencies were born out of that struggle. Many of those leaders, staff, and volunteers have moved on.

Our new clients are people living with HIV that walk through that front door to our agencies today will probably identify as heterosexual, unable to read past 8thgrade level, have mental issues, and may have substance abuse

or be an abused housewife or live-in lover. Unable, scared or not knowing what to do next, the newly infected will probably roam for two years after diagnosis before reaching out for help from an AIDS service organization.

This is the -- they'll probably be infected with multi- drug-resistant, or super virus. This is a mutating HIV virus that is spreading especially in the minority community due to the use and misuse of HIV medications. Due to multi-drug-resistant virus, their first line of therapy will probably fail. Others may fail due to lack of their ability to consume the toxic medications that are required to keep the virus under control.

Because of all of these factors, it will be assumed that the medications for HIV do not work, and that unfounded rumor will spread especially in the minority community. Thus, the first encounter for addressing their HIV issue will probably be at their bedside, in a hospital, after their first opportunistic infection. And I know you talked about at this table earlier about minorities getting infected and only finding out

after they get sick.

Now, opportunistic infections are most times totally preventable these days. And all of this will come after they probably infected their spouse or several casual sex problems whose names they cannot remember.

Needless to say, prevention programs have failed miserably. Relying on tactics from the earlier epidemic that addressed gay men, it just does not work anymore. Let's take African-American men who have sex with men but don't identify as gay and do not want to be seen, nor cannot identify with the agency that has a gay theme. I refer not to a new phenomena but to something that has been around but seldom discussed for many years: and that is "men on the down low," as they call them today, or men who have sex with men. Let us not forget that these men are probably having sex with women also, as has been discussed.

It will take a special type of program and service worker to reach these individuals. After all, coming into a gay theme agency would confirm that they're having sex with men. They

are not gay; you're gay only when you say that you are. Just as we allow transgender to identify as "she" or "miss," we must allow and identify with where a person is. This will take a lot of skills-building and a different approach to prevention outreach and education.

I believe getting into the heads of these individuals in a way that has never been done before will probably be the only way to reach them. And let us not forget reaching out to the women that these men sleep with.

More and more, seasoned staff of AIDS service organizations are moving on due to many reasons. Entry-level folk, who are fresh out of college, are entering the AIDS workforce, many in good faith, just to burn out due to being overwhelmed, or moving on because of limited resources and high caseload. The effect is that the consumer shall suffer because of staff that are overwhelmed and overpaid and made to spend --

COUNCILWOMAN TASCO: Underpaid

underpaid.

MR. GIBBS: Underpaid, sorry.

COUNCILWOMAN TASCO: Don't let the

record show they're overpaid.

(Laughter.)

MR. GIBBS: You're right.

And may have to spend up to 75 percent of their time doing reports or trying to locate services that are virtually at their fingertips.

Now, for many small key agencies, the information age has not reached them, so information gets to them by snail mail instead of e-mail. And by that time, many training opportunities, benefits, monies or opportunity to grow has passed. And the client suffers again.

Ideally, a one-stop-shopping type agency would be nice, but not even in Philadelphia Fight can we offer all of the services that any particular client may need on a given day.

So onwards to some solutions. The need for agencies to collaborate and conduct joint programs. Different agencies are good at providing certain services. Let those agencies join together on projects where they can offer those services to individual clients. Smaller organizations should maybe merge with larger organizations. This will eliminate a lot of

overhead costs. The result will be that money saved will go into services for people living with HIV/AIDS.

And I have a little bit more.

Funders, both government and private, need to be more vigilant about how funds are being spent. Agencies that cannot spend their money wisely or who continually come up with the programs that don't work should be defunded. The money should then go to agencies that have sound fiscal policies, who can prove that their programs have been effective.

The key here is evaluation. All agencies must be held accountable to prove that what they are doing is have an impact on the epidemic. Provide all of the technical assistance that is necessary, but make sure that we are not wasting money on programs that haven't worked and never will work.

I am still appalled that most of the people in the area still do not know the AIDS hotline number. It is a gateway for accessing services in the region. I suspect that this may well be the case in other locales as well. We

have spent good money for this hotline and its design. The problem is that the number has not been properly marketed, so it is unfamiliar. Maybe, just maybe that SEPTA -- and I notice these signs are on SEPTA, but maybe they should post them for free, and that will allow for more postings about AIDS services in the area.

Direct prevention efforts toward people living with HIV. When people are given -- us, people with HIV, are given the adequate training and information, we make the best bang for your buck as far as getting the word out, and there's nothing like a person who's living with HIV going out and letting their status being known to talk to people and convince them about testing and treatment and change behavior.

Also, continue to support needle exchange programs and imbed existing services like case management in needle exchange programs and in harm reduction programs.

Do not stand back and let the disaster in our prisons continue to go unaddressed -- here's that prison issue again. Rates of HIV in many jails and prisons are as high as Sub-Saharan

Africa; yet, medical care is lousy. In Philadelphia, medical care, once again, provided by the prison system PHS, a for-profit HMO, and they know that if they can delay treatment until someone gets out, they can save money. In addition, there are good infectious-disease docs in Philly jails, but people don't get permission to see them, so they are not getting the treatment that they need.

And I'm almost done.

Resources. Put the money and the services where the people are. And I don't mean neighborhoods versus downtown; I mean real funds for real programs for real people, peer educators, prisoners, former prisoners, well-train, funded to help those currently or formerly incarcerated put in resources and staff and to harm reduction programs that are not abstinence only or tough love, and helping people with HIV transition into real staff people and program development roles to be able to amplify and expand good programs.

I heard a lot today and one of the issues that I wanted to address real fast is the testing. Across the board, names reporting is

going to be a disaster.

Another thing is that I think that this city really needs to look into the rapid HIV test that is now being used in some states, and the results come back in twenty minutes. I think a lot of people are lost in coming back for their results. This test can be used on a van or wherever, and it can allow people to remain in one place, look at a video while it comes back. It also has been proven to be as cost-effective. And I have that information, if anyone needs it.

We also felt a look at teens and designer drugs at this point, and that there are many teens that -- it's going to be a whole new wave with the teens and the designer drugs that allow them to practice unsafe sex become -- get other STDs that lead to HIV. And you're going to see that.

So in closing, I just want to say that it's not a really pretty picture, but in my travels all over the country, and I've been all over the country, we're doing a lot better than most cities, a lot better. I pity some of the people who I've talked to from a lot of cities --

not just down south but Detroit and in some other areas. You know, this wouldn't even be allowed in some of those cities, what we're doing today.

So I thank Councilman Ortiz and everyone for this, but we can do better.

Thank you.

COUNCILWOMAN TASCO: Thank you so much.

(Applause.)

COUNCILWOMAN TASCO: Thank you very much.

I just want for the record, so we have a clear statement on the issue of names, could you just kind of put it in testimony that tells us what is happening, who is proposing and -- because I've heard it but I really haven't heard clearly for the record what is happening in terms of trying to have people give their names for HIV testing, what presently exists, what is being proposed, who is proposing it. And that's what I would like to have on the record.

MS. SHULL: What's going on now is --

COUNCILWOMAN TASCO: Where, here?

MS. SHULL: In Philadelphia is at the present time and up to the present time, what has

been reportable is AIDS. AIDS means either your immune system has declined to a certain point of or you have had one of a long list of opportunistic infections and specific complications that means you have AIDS.

HIV has not been reportable up to this time in Pennsylvania. What the State wants is it to be reported. I think that the other pressure that is on the City now, which is probably more to the point, is that the federal Centers for Disease Control are threatening to withhold dollars from states that do not make HIV reportable. Therefore, HIV reporting is moving along in this state.

The controversy, the main controversy in the City now is between whether that should be reportable by a person's name or whether we should find another system that will guarantee that the same person won't get counted twice but will not use their name. And I think it is the feeling of the majority of the AIDS service community, perhaps the overwhelming majority of the AIDS service community, that we want to see unique identifier, not names reporting.

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MS. DAVIDS: I would just add one thing to that, which is that there's now a 30-day comment period began last Friday about the proposed State regulations which emphasizes names reporting. And we know that Philadelphia's comment in this carries extra weight that will set a tone for the rest of the State.

And, unfortunately, we must think not only of our own responsibility to our county and the surrounding counties, but what will happen in rural Pennsylvania if names get reported to the county health department on the way to the State. And, of course, that's your uncle's friend or neighbor works there. I think as scary as it can be for those of us in Philadelphia, it's terrifying for Beaver County, and even if it's two, three, four, of five people, these are people whose lives will be devastated.

So must also in Philadelphia, in our policies, bear the responsibility of what can be so harmful for the rest of the State as well.

COUNCILWOMAN TASCO: Have you recommended a process by which this could take place, an I.D. number that the person can have?

I mean, you know --

MS. DAVIDS: That's unique identifier. Maryland, California, and many other states have used unique identifier systems. CDC does not require names; CDC requires reporting. Maryland came and spoke to many of us here and said anything you can do with names, we can do with the code. People give certain things that are non-duplicative if you use names enough variables like mother's maiden name, year of birth, and other variables.

We have experience with using unique identifier, actually, in Philadelphia through our needle exchange program, which has been extensively evaluated through the University of Pennsylvania to validate its efficacy in wise use of public health dollars. And as you imagine, people who use a needle exchange really don't want to give their names. And it's worked extremely well, it's been extremely effective at getting information we wouldn't be able to get otherwise.

So there's really good models out there. And states as big as California really validates it as being an effective way.

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MR. GIBBS: I'd like to just comment that just recently, I got a letter from the Philadelphia Department of Health, and I hadn't gotten a letter from them in years. And in this letter -- and I hope this never happens if name-reporting comes in -- it stated that we know that you're hepatitis C-positive.

Now, where and how they got that information, I don't know. But just imagine that falling into the hands -- only saying that it was HIV and falling into the hands of some mother whose child has tested positive but doesn't know it and they're not ready to tell.

So that's just another thing.

COUNCILWOMAN TASCO: Have you made your recommendations to the Health Department?

MS. SHULL: We have, we have, repeatedly.

COUNCILWOMAN TASCO: Thank you.

COUNCILWOMAN BROWN: One follow-up. Could you please speck again to this rapid HIV test that you spoke of.

MR. GIBBS: I believe it's Or Shore (ph.) Company, and I don't mean the same test that

they're testing that needs to go away for a week. There is now a rapid HIV test that can test a person's antigens for HIV in twenty minutes.

COUNCILWOMAN BROWN: What city is currently using that?

MR. GIBBS: I am unsure of the exact cities without actually reading it from the document where I got it from, but I can get that information to you. But I know that it's going on expanded -- it's being used a lot and it's become a very good tool in actually keeping people -- getting people into care and --

COUNCILWOMAN BROWN: And that's based on documented research that it is a very good tool because it achieves the goal of holding on to people?

MR. GIBBS: It is in the final research phase now.

COUNCILWOMAN BROWN: Could I please hear from any representative in the Health Department with regards to what you know about the test and whether or not the City has looked at it, why or why not. I would think funs may -- or lack of funds may have something to do with that, where

that might be on the list of priorities.

MS. BASS: Hello. My name a Pat Bass, and I am one of the co-directors of AACO.

We've certainly looked at the rapid testing. And, as has just been stated, it's still in its toasting stages. It has not been approved by the Federal Drug Administration and, therefore, we will not support the use of it until it has finished getting all of the testing. There are some questions around the validity of that test.

And I think that, once again, rather than giving folks misinformation, we would really prefer to be very careful to make sure we're giving people proper information.

COUNCILWOMAN BROWN: Okay, thank you very, very much.

COUNCILWOMAN TASCO: Thank you.

Any further questions?

(No further questions.)

COUNCILWOMAN TASCO: Thank you very much for your testimony.

(Applause.)

COUNCILWOMAN TASCO: The Chair recognizes the next panel: Otha Brown, Director

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of HIV/AIDS Services, One Day At A Time; Reverend Ronald Norris, Pastor, Open Door Baptist Church; and Reverend Wells, Executive Director of One Day At A Time, if he's here.

(Standing ovation.)

COUNCILWOMAN TASCO: While the panel is coming forward, I'd just like to state that I do have to leave as chair. Councilman Ortiz will continue. I have a Finance Committee meeting at 12:30.

Thank you very much.

(Witnesses come forward.)

COUNCILMAN ORTIZ: Please sit down and identify yourself for the record.

REVEREND WELLS: Good morning. Reverend Henry Wells, One Day At A Time.

(Applause.)

COUNCILMAN ORTIZ: Please summarize. We've got like nine groups of people coming, nine panels. So let us begin. Identify yourself for the record.

PASTOR NORRIS: Good morning. My name is Pastor Norris of Open Door Baptist Church, also an on-air personality at WHAT and Chairman of Open

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Door Community Development.

MR. BROWN: My name is Otha Brown. I am the Director of HIV and AIDS Services at One Day At A Time.

(Applause.)

COUNCILMAN ORTIZ: Reverend who begins?

REVEREND WELLS: Yes. I would just like to make a fast comment and let this move along. The one way to get people to understand and to get people to know about this HIV and AIDS is what we're just doing -- and I'm sorry you could not come up with us last Saturday -- is going door-knocking. We canvass the community and we knock on doors, we ring bells, and we take people back into the clinic where we're connected and get people connected, back to services. That's my job. I just want to pass that on.

Thank you.

(Applause.)

MR. BROWN: Councilman, my name is Otha Brown. I have with me today Reverend Wells, who you've just heard from.

One Day At A Time has been in operation

since 1983, providing a wide variety of services to Philadelphians seeking recovery from their addictions to drugs and alcohol. We provide outpatient substance-abuse recovery counseling to approximately 600 individuals per year and transitional housing for approximately 350 unduplicated individuals receiving this counseling and. Also provide HIV testing and counseling to approximately 400 people at high risk every year, as well as AIDS education and outreach service to see thousands more.

Since the early days of the epidemic, One Day At A Time has recognized that poverty and despair that leads so many of our neighbors into addiction also puts them at high risk for HIV infection.

Our primary service area is North Philadelphia, West and Southwest Philadelphia, Germantown, and Kensington. These are the areas where the AIDS epidemic has done its worst. We are proud for over ten years that we've been in the forefront of building concrete practical support services for people living with and at high risk for HIV infection in the places where

fighting AIDS is most difficult.

Over the past decade, under the leadership of Reverend Wells and others, we've established the first neighborhood storefront service centers offering HIV/AIDS education, case management, and access to medical care and other social services to individuals. This approach was the first significant effort to bring HIV and AIDS services to neighborhoods most affected by the AIDS epidemic and has resulted in linkages of thousands of low-income Philadelphians to AIDS education and testing resources, and hundreds of people living with HIV disease to the care and services they need.

Unfortunately, despite the expansion of funding for AIDS education and care services by over 400 percent in the past ten years, neighborhood-based programs such as those operated by One Day At A Time continue to struggle. While we are extremely grateful to the City's AIDS Activities Coordinating Office for its continued support of our efforts, we continue to struggle with the burdensome administrative and funding requirements, which sometimes limit our abilities

to be as flexible and responsive as we need to be for the people we serve.

The City has made enormous strides in its commitment to building the capacity of minority and low-income communities to combat the HIV epidemic. But, unfortunately, we still have a long way to go.

Our comments are not meant as criticisms of the City's AIDS effort, which we believe has set a high standard nationally in their commitment to consumers and neighborhoods, but we must not mistake progress for success. Still many people, especially in poor neighborhoods, get infected with HIV because they are simply unaware of their risk, and we've not provided enough education.

Still many people, especially those who have been victimized by a drug epidemic, get infected with HIV, having been robbed of the hope and the opportunity that we pretend is available to every American, and then we blame them for the result.

Still many people living with HIV disease are forced to obtain their medical care

from a fragmented, sometimes inexperienced, and often too expensive health care system that is much more available to those who have money than those who do not.

And still many people living with and at risk of HIV disease need to obtain their services from AIDS service organizations that are located far from them homes and far from their realities.

We applaud Councilman Ortiz and his colleagues for again raising the public consciousness of the urgency of the AIDS epidemic in Philadelphia. Some of us remember that it was about 15 years ago that Councilman Ortiz led the effort, which eventually resulted in the creation of the City's AIDS Office, and we continue to benefit from his foresight and leadership from that time.

But the battle must still go on. AIDS still kills, despite what the fancy drug companies say. And it's still more likely to kill you if you're poor or black or Latino or a woman or young or gay, or all or part of the above.

We hope that the City will redouble its

commitment to fight HIV. We hope that the City will work harder to ensure that funding for AIDS reaches the communities where the battle really nudes to be fought. We hope that the City will create -- will be creative in finding ways to work through all City departments, not just the Health Department, to provide AIDS services to all of the people who need them.

One Day At A Time stands ready to continue to be a partner in that effort and hopes that it will soon see more and stronger partners in all of Philadelphia's most impacted neighborhoods.

Thank you very much.

COUNCILMAN ORTIZ: Thank you.

(Applause.)

COUNCILMAN ORTIZ: I remember the times long ago, when the only people talking about it at the street corners were Reverend Wells, the casket, and myself. Do you remember that? Yes, Reverend?

REVEREND NORRIS: Yes, sir. Councilman Ortiz, I thank you for the opportunity this morning to speak before you. My name is R.

Jeremiah Norris, and I'm the Pastor of the Open Door Baptist Church, Chairman of the Board of Open Door Community Development, and a concerned member of the community.

And there are some of the things that are occurring in our community that we should claim -- that should claim our attention. The image of HIV- and AIDS-affected persons on billboards send a message that does not reflect the true community. Most persons who are infected have weight loss or some other physical problem that should be recognized. The seriousness is minimized when we look at the image of HIV persons on public display. It's time to deal with the truth and present the right image. A noninfected person looking to the HIV billboard, seeing the healthy and happy person will feel that HIV can't be that bad.

As a pastor who has married more people than I care to count, I will take a stand that I am not willing to perform another marriage where a couple has not had a blood test. How can I in good conscience say to a newlywed before God the vows, "Do you promise to support each other in

sickness and in good health?" when the blood test could at least give the couple a fighting chance in planning a life together.

Motherhood is important in passing the virus on to a baby that was conceived in love is not right. While we are born in sin and shaped in inequity, the curse does not have to continue. According to the AIDS Surveillance Quarterly, the number of AIDS/HIV cases has risen from -- of course we know from 84 to 99. That's the last reporting statistics that I have. And out of the 22,867 cases reported, 12,576 have died, about 55 percent here in Pennsylvania.

In an upward shift of AIDS ages at AIDS diagnosis, the evidence in the cases reported in 1999, the highest age group are those between 30 and 39, which are 4,901. At the next highest group, between 40 and 49, are 2,958. And those at 50 years, those at 50 years or older were 1,174. The population of cases reported in patients over 50 years is now greater than in the 20- to 29-year age group.

With the possibility of better treatment and education, more people are -- will

be living longer. And because of -- because of this, Open Door Community Development is actively seeking support for building a transitional home for women and children who are HIV- and AIDS-active. Training and equipping the residents -- equipping the residents of Open Door Community Development will lead to full employment, health care, education, computer training, and other skills that will give the greater self-worth.

We of the faith-based community need to partnership with non-faith-based groups because of the red tape and other hurdles that were originally put in place for them. We need to release the properties, we need properties released that are held by the City and agencies related to the City government, properties that now are, at best, sites for dumps and have no active use for anything in our communities except an increase of elicit uses.

We need to have the kind of faith-based support that will help all of us develop programs that are needed to address our communities. The need for programs such as Open Door Community Development is recommending is seeking support and

must be a vehicle for other community organizations such as faith-based organizations. The Open Door Community Development mission is:

Develop a strong educational program for those in the Open Door Community Development HIV community, such as computer literacy, GED readiness, test-taking skills, training for a new life;

Provide a place to live for those who are infected and have nowhere to lay down safely;

Provide counseling that will help reshape and focus for living;

Set new dietary guidelines and physical recreation activities;

Provide onsite medical evaluations and treatment.

These are some of the mandates that face our community right now in the area of Open Door Community Development. In that zip code area, there were reported 127 cases, and at the rate of 100,000 per population ratio, that gives us in the community a 2.99 percent of HIV-positive persons.

At present, there are between 182 to

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398 persons who are living with AIDS in Philadelphia. The total of those living with AIDS is 6,220. Open Door Community Development is a faith-based community project that will service as a model for the entire faith-based community. We no longer can preach and teach the wholeness of the relationship with God and not reach out to the HIV community.

There is a time when the religious community regarded those who were sick with leprosy and caused them to wear a sign and cry out, "I yield, I yield." That's in the Old Testament and also in the New Testament. But Jesus gave us an example of how to deal with such problems: to touch them with compassion, prayer, support, and love. It worked for those who received his blessings and they were able to go back to their own communities and earn a living.

Matthew, the 25th chapter, the 45th verse says this: "For I was a hunger and you gave me meat. I was thirsty and you gave me drink. I was a stranger and you took me in naked and you closed me. I was sick and you visited me. I was in prison and you came unto me. Then shall the

righteous answer him saying, Lord when saw we thee in hunger and fed thee, or thirsty and gave thee drink? When saw we thee a stranger and took thee in or naked and clothed thee? Or when saw we thee sick, in prison, and came unto thee? And the king shall answer and say unto them verily, I say unto you. Inasmuch as ye have done it unto one of the least of these, my brethren, you have done it unto me. Then shall he say also unto them, On the left hand, apart from me, ye cursed into everlasting fire, prepared for the devil and his angels, for I was in hunger, and you gave me not to eat. I was thirsty and you gave me no drink. I was a stranger and you took me not in. Naked and you clothed me not. Sick and in prison and you visited me not. Then shall they also answer him, saying, Lord, when saw we thee hunger and thirsty and a stranger or naked or sick in prison and did not administer unto thee. Then he shall answer them, saying, Verily I say unto you inasmuch as ye did it not to one of the least of these, you did it not unto me.

And I say all of that to say this: that we can no longer in the faith-based community

hide behind our churches and just preach on Sunday and go home. Amen.

We need the support of the City, as we step forward by faith, to develop programs that will help in our communities to bring about a wholeness and a healness [sic]. We need the kind of red tape and some of the pressure that is placed on the faith-based churches or faith-based organizations so that we can proceed with progress and become a viable entity in the community for healing.

COUNCILMAN ORTIZ: Thank you.

(Applause.)

REVEREND WELLS: I want to recognize that was good. And we are happy to have you with us, and hope here at One Day At A Time -- I think it's the faith-based organization that you got and with the church and that we can come together closer than we normally come together, because the rubber meets the road out here where we at.

And I want to really thank you for bringing this to City Council because, see, I know who you are. You the man that go where the rubber meet the road, and I know you'll be coming back,

joining up with us to do some more things.

I know this is a little off the record, but Thacher Longstreth was out to see us and I just -- you know, we are praying for him, and we just love City Council people. Mr. Cohen, how you doing, sir?

And we are going to continue to do what we've always done: go where the rubber meet the road.

And as far as faith-based, boy, if we ain't got faith, we couldn't last because we were there when people thought we were out our minds and crazy with a casket, telling people when eleven children got killed that one week that said no to drugs and yes to life, this could be your child. We were knocking on doors then, we will continue to knock on doors.

And we know that you do whatever you can, we know you will pushed whatever you can. And we're planning something really big in North Philadelphia. We want you to come and be a part of that real kickoff.

We love you, God bless. And we all come together. The young man said let the small

organizations join together with the large organizations. Don't be afraid to join. Don't be afraid that you'll lose some money. God's got this, it is all in control.

(Applause.)

REVEREND WELLS: Someone said we need to give our people, and especially our young people, something to hope for, the poor people something to hope for. Well, I can tell you what you can hope for: You can hope to have God in your life, and things will move forward and you will be able to do the will of God.

God bless you, I love.

COUNCILMAN ORTIZ: Thank you, Reverend. Thank you.

(Applause.)

REVEREND NORRIS: Councilman Ortiz, may I just say this. In preparing to hear the questions, that a lot of people question ministers and say, Well, how could you say certain things and how could you be involved and you have no knowledge of it? But I am one who is not ashamed to be transparent, and I have been drug-addicted and was delivered through the power of God. And I

thank God for Reverend Wells and One Day At A Time, for it was Reverend Wells and the One Day At A Time program that helped deliver my son, who was drug-addicted and now three years clean. And I thank God for the program.

(Applause.)

COUNCILMAN ORTIZ: Thank you, Reverend Wells. We have been together for a very long time.

REVEREND WELLS: Yes, sir, we sure have.

COUNCILMAN ORTIZ: And I thank you for your work, I thank you for being here, I thank you for being on the corner.

REVEREND WELLS: And I thank you for coming to the corner with me.

COUNCILMAN ORTIZ: If you had not been on the corner, a lot of kids would have been lost in this city. Thank you very much.

REVEREND WELLS: Thank you, sir.

(Applause.)

COUNCILMAN ORTIZ: Ronda Goldfein, Dorothy Mann, Gary Bell, Anthony Harris, Nurit Shein, Danny Horn, Albert Barrett.

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(Witnesses come forward.)

COUNCILMAN ORTIZ: I'd like to get us -- let me -- so that I can begin putting it together, when we first got this idea to have these hearings, we know what your organizations are doing, so we don't need to really -- what I want to focus on is where do we go. We are here now. We have had some successes, we have had some failures. And what I'd like to hear from the panel as they come up is where is it that we need to be looking at?

There are problems that are confronting us and I'd like to begin so that as we write our report, as we write our report that we can then send to the Mayor and the Health Department and others. We know that after ten years, from 1987, '86 to today, this city has been really much further ahead. We have more organizations doing teaching and prevention. We have some funding -- not enough funding as we would like.

But I would like to see where it is that we need to go to the next level, the next step. And if you can direct to that, I think we will accelerate every panel because we have ten

panels to hear from, and I don't want to be repetitive, every panel saying the same thing, but let us shape our comments as to direction, changes that need to be done, places that we need to be.

Ms. Mann, do you want to begin?

COUNCILMAN ORTIZ: Identify yourself for the record, please.

MS. MANN: I will do that and then sort of summarize my testimony.

My name is Dorothy Mann. I'm the Executive Director of the Family Planning Council here in Philadelphia, and one of our major programs at the Council is the Circle of Care, which assists families affected by HIV and AIDS. The focus is primarily women, children, and their families. For the circle -- last year, the Circle of Care provided services to a thousand families.

But what I really -- in answer to your question, I think -- and what I want to talk about today is prevention, because prevention is the key. First of all, prevention works. And second of all, it's the key to slowing down and stopping this disease, at the same time that we care for people who are infected with HIV.

I'll give you the perfect example of a huge success story in prevention. Pregnant women who are HIV-positive can transmit the disease to their unborn children. This is called "perinatal transmission." In 1994, the National Institute of Health did a study that demonstrated that if HIV-infected pregnant women take the drug AZT during the pregnancy prenatally, it is administered to them during labor and delivery, and the infant is given this medication for six weeks, that you can reduce the transmission from mother to child; in fact, almost eliminate it, which is a huge success story.

Now in the nation, there are probably less than 500 infants born with HIV. And in Philadelphia, since 1998, our records indicate that there were -- from 1998 through August of 2000, there were 31 HIV-positive babies born in the City of Philadelphia. But from what we know now, one infant born with HIV is too many. So in mother-to-infant transmission is almost entirely preventable. But still, babies are being born with this disease.

So we have great science, we know what

to do, and it's not yet entirely working.

Is it better than it used to be? Absolutely. But we still have a way to go.

With funding from AACO, the Circle of Care has a media campaign that I want to show you the posters for. That's the English version; this is the Spanish version. And I've just given you some more materials that you might want to make available to your constituents.

Every pregnant woman in the City of Philadelphia needs to be offered an HIV test when she is in prenatal care -- if she is in prenatal care; and, of course, we have major programs to try to get women into prenatal care. Frankly, that's not happening now. We have to do a much better job in our OBGYN departments and with individual physicians, making sure that every single pregnant woman is offered an HIV test, and explain to her that if she is positive, that there is something now that can be done to prevent her from transmitting this disease to her infant.

I'm a woman, I've had two children, and I think I can generalize to say that the vast majority of women who are pregnant want to have

healthy children. That is their -- it is one of the most important things in their lives. And so when offered this test and when offered this medication, the vast majority of pregnant women will avail themselves of it. My concern is that women who are pregnant in this city are not being offered this test sufficiently and routinely as part of their prenatal care.

Now, moving on in other areas of prevention. This is a perfect example. HIV infection is a disease that is transmitted from an infected person to an uninfected person. That's pretty simple, that's how you get it. Councilwoman Tasco asked, how do women get it? They get it from an infected partner.

Most of all prevention efforts in the City and nationally have been directed at the uninfected. What I am here to talk to you about is my desire and recommendation to change that paradigm to a degree so that prevention and care come together.

Thanks to improved medications, people with HIV are living longer, they are living longer, and they are healthier, and they do look

better and they feel better and they are better. And I think it's a complete misstatement to say that that is not the case. In general, individuals react differently, but in general, people with HIV are living longer and more productive lives.

But, some, because of this success of drug therapy, are, in fact, engaging in risky behaviors. These are infected people. Some believe that because they are taking the medication and their viral load is lower, that they can't transmit the infection. That is completely untrue. A rise in risky behavior by infected individuals can erase the potential benefits of these combination drug therapies by increasing the spread of this disease.

So I am strongly advocating the following in answer to your question, Councilman:

We've got to increase counseling and testing programs. More people need to know of their HIV status. Like these kinds of campaigns and others.

In particular, I wanted to comment on what you were talking about this morning, about

programs in schools. There are a lot of kids that aren't in school, that have dropped out of school, and we can to focus -- and they may be at higher risk than the kids who are in school. So just doing school programs does not address or focus and reach a whole lot of hard-to-reach young people who are out of school.

We need to have greater efforts to get HIV-infected individuals who know their status into medical care, and we need to provide them the support to stay there. Nationally, it's estimated that 50 percent of people who are infected by HIV are not in care. I don't know the statistics for the City; I hope we're better than that. But even if we're better than that, we're nowhere near where we ought to be.

And we must require HIV caregivers to include prevention messages in their care that they give to HIV-infected individuals. Don't misunderstand me, I'm not advocating laws or policies that criminalize or stigmatize HIV; just the opposite. I'm talking about interventions that help HIV-positive people reduce their risk behaviors and protect their partners.

Fully integrating prevention into care is one proven mechanism to prevent the spread of this disease from the infected to the uninfected. Prevention should be a part of every AACO-funded care-provider.

Here's another example -- I mean, part of it is the City. The City has a struggle here. Prevention is funded by CDC, care is funded by another part of the federal government, but at the local level, we have to integrate these things.

Another example of this is that STDs -- science has told us that if you screen and treat STDs, you will presented the spread of HIV and. Yet, STDs and HIV are not integrated in our programs either, the way they should be. And I really, really want to recommend that every care program funded by the City assures that HIV-infected people getting care be screened and treated for other STDs, which I do not believe is happening at this point in time.

I'm not going to tout the fact that the Circle of Care does this, because we do. And I think it's an important part of our program.

Finally, the Center for Disease Control

now indicates that 40,000 Americans will get HIV this year. That is, over 100 people will get HIV in this country today and tomorrow, and 100 people got it yesterday. That's an completely unacceptable level. However, it is much lower than it was when these hearings were held first in 1987.

Unfortunately, in the face of 40,000 new cases a year, the Bush Administration has proposed level funding for care and prevention in its new budget. Somebody has to pay for this tax cut.

So I'm worried about two things. One, that we don't let the administration get away with that, that we pressure our Congressional delegation, both House and Senate that this is unacceptable to the City of Philadelphia because there are no cases. If you have new cases and no more money to treat people, what happens? Either the people that are getting care get less care, or the new people don't get any. You can't do it. When you have new cases all the time, you need more money to care for people. That's all there is to that.

The other thing that worries me is a trade-off between us giving money to take care of AIDS in Africa and in other parts of the world and not in this country, that there is somehow a zero-sum gain regarding AIDS in other parts of world versus AIDS in the United States. And that is exactly what, unfortunately, the Secretary of HHS said the other day. In testimony in front of the United States Senate, he said, We don't need any more money for care. They've had a lot of money. The only thing that's going to save us is a vaccine. And we're giving all this money internationally. To set Americans against Africans or Asians or anyone else is absurd and to set Americans against each other -- i.e., the newly infected versus the person in care -- is outrageous.

So one of things that I think that it behooves this City Council to do is to use its influence and to raise its voice with our Congressional delegation to assure that AIDS prevention funding and AIDS care funding in this country increases -- or the City will bear the burden.

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Thank you.

(Applause.)

COUNCILMAN COHEN: Identify yourself for the record and then go ahead.

MS. GOLDFEIN: Thank you. Good afternoon, Councilman Cohen. My name is Ronda Goldfein, and I'm the Executive Director of the AIDS Law Project of Pennsylvania, an agency in Center City that employs six full-time lawyers, the only independent, nonprofit, public-interest law firm in the United States dedicated soley to the needs of people with HIV. Last year, we received 1800 calls for assistance.

But during my eight years at the AIDS Law Project, I've witnessed a huge transformation in the AIDS epidemic and in the needs of our clients. Eight years ago, our clients were focused on planning for death, but today, they are planning for their futures. Before, they were concerned with shifting from work to disability leave; but now, in the era of (indiscernible) inhibitors and combination therapy, we are advising people who once thought their lives were ending on how to return to work.

We offer two monthly seminars: one on how to leave your job and one on how to go back to work; or for some people, how to work for the first time. And each month, twice as many people show up to hear about planning to work as those who are leaving a job. To help people with HIV plan for their future in this way was unimaginable eight years ago.

But as we all know, the more things change, the more they stay the same. And as we are helping people plan to return to work, we are still receiving complaints from people fired because their employers discovered their HIV status.

In the first four months of this years, 16 people have already lost their jobs simply because they have HIV. Five people have called us this year complaining of denial of health care because they have HIV. That's five different health-care providers, whose job it is to treat the sick, refused care because people with HIV are a little bit too sick, or perhaps they're not the right kind of sick.

Already this year we've heard of 32

breaches of the confidentiality, including a doctor who faxed medical records to the patient's workplace; hospital workers telling friends about a neighbor getting HIV care; a pharmacist who shouted in a store full of customers, "Your HIV medications are ready"; or prisoners forced to stand in medication lines in full view and earshot of other prisoners and staff.

We hear of disclosures in homeless shelters and halfway houses and group counseling sessions, all the places people turn for help, all the places people will not return if they don't feel safe. And in the month of April that has just passed, we've heard of three different complaints of harassment of neighbors once someone's HIV status has become known.

So we must continue to spread the word that discrimination is wrong, not only morally wrong, and ineffective from a public health standpoint, but that it's illegal. We need to be able to fully pursue all of those claims so that doctors dentists and nursing home operators and schools and employers are forced to stop discriminatory practices -- if not by decency

concerns, then perhaps by financial ones.

And we must continue to vigorously remind people of the legal obligation to keep HIV information confidential. A person will get tested and treated for HIV, the sure path to ending the crisis only if it can be done in a confidential setting. That's why the AIDS Law Project, like many other AIDS service-providers, are in support of unique identifiers instead of names-reporting for HIV.

No one in this room would be eager to seek help if our health needs were shared with an unintended audience. Instead, like the 32 people in the Philadelphia area who found that their sources for care not secure or not private, they will wait until it's too late.

And as a unique law firm devoted to people with HIV, the AIDS Law Project has devoted 13 years to fighting discrimination and the illegal disclosure of the information and assure that people get care and treatment. At a time when many people with HIV are contemplating a future instead of an early grave, these services are more crucial than ever.

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Thank you for your attention.

(Applause.)

COUNCILMAN ORTIZ: Who's next?

MS. SHEIN: My name is Nurit Shein. I am the Executive Director of Philadelphia Community Health Alternatives, PCHA, and we have been around for 21 years -- first as a health organization for the gay and lesbian community, and when the AIDS epidemic hit that community, we incorporated the AIDS task force and became the first AIDS organization in the Commonwealth of Pennsylvania and the fourth in the United States. So we've been around for a while. We have a continuum of services from testing to early intervention and triaging into care, to case management, to intensive housing, to regional food bank, to home care to mental health, etc., etc.

I'm going to be very brief today. I would like to speak about two things that I see as service gaps, in answer to your question, Councilman Ortiz. As Dorothy said before, prevention -- and my other colleagues -- prevention works. And in the last five years, we've had level funding from the CDC through the

City of Philadelphia. PCHA has the largest anonymous test site in the City of Philadelphia. We test 10 percent of all people in Philadelphia, over 3,000 every year. We have been level-funded for the last five years, testing more and more people -- and not just testing more people.

COUNCILMAN ORTIZ: But you haven't been level-testing right? I mean --

MS. SHEIN: No. It's level funding; it's not level testing. So we are called to be more and more creative.

Also, the epidemic is changing. We need to create prevention messages that answer the needs of the high-risk population that we want to reach. So today we are, at 1 o'clock in the morning, doing outreach and testing in the bathhouses in Philadelphia, which we didn't do five years ago. But that takes effort, energy dedication, and funding.

We know that the holistic approach of treating an individual as a whole person works as well. The service gap that Dorothy talked about of STD and HIV connection is not there in the City. PCHA is the only AIDS organization in the

City of Philadelphia that also provides STD services. We chose to specifically target the gay, lesbian, transgender, and men who have sex with men population, but we provide STD services to these people, and the crossover is enormous. Most of the people who come to us through what I call "the STD door," we also counsel them and urge them to take an HIV test, and many of them do. Many of the people who come to us for an HIV, because they perceive that they have been at risk for HIV, also choose to take an STD test because the two of them are definitely connected.

Hepatitis. We talked here about hepatitis. We also urge people -- the gay community, for example, is not really aware of their risk for HIV and -- for hepatitis C.

COUNCILMAN ORTIZ: For hepatitis C.

MS. SHEIN: Sorry, hepatitis C, and what is the connection between hep. A, B and HIV and what the meaning of it is.

COUNCILMAN ORTIZ: That's one of the things that came out today that I was not aware of. I'm sure the firefighters of this city are not aware of that.

MS. SHEIN: Right.

COUNCILMAN ORTIZ: And it really -- it is something that we have to begin addressing and publicizing and putting it out the connection between hepatitis C and HIV and how do we handle that, and that's something that came out of the these hearings, that really, if we come out of that with this, I think we've done something.

MS. SHEIN: Well, we're lucky to be a part of collaborative effort of other organizations in the City and the Health Department to do some awareness around hepatitis and HIV, but we need to see more of that collaboration happening at the local level of both the Health Department -- two different hats of HIV and infectious disease. We need to start talking to each other and providing services in a much more holistic way.

COUNCILMAN ORTIZ: Good. Next. Identify yourself for the record.

MR. BELL: My name is Gary Bell, I'm the Executive Director of Blacks Educating Blacks about Sexual Health Issues, otherwise known as BEBASHI. Briefly, BEBASHI offers a continuum of

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prevention and care services --

COUNCILMAN ORTIZ: We know about BEBASHI; you don't have to --

MR. BELL: All right. It has been since 1985.

I don't want to go over the things that have been covered, but I do want to focus again on testing and prevention. One of the statistics I didn't hear mentioned -- and maybe I missed it because I was a little tardy -- is that 40 percent of the people who were diagnosed with AIDS in the last statistics that the AIDS Activities Coordinating Office put out had tested positive six months before that. So essentially, what we're taking about are people who are just testing, getting tested, and probably getting tested because they were already starting to get sick, and then going right into full-blown AIDS.

The efforts to get people testified, we still haven't found enough success in. BEBASHI offers testing -- and I want to disagree with one thing that Nurit said. We do offer some limited testing for STDs, syphilis, and chlamydia. And it is true that there isn't a coordination between

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those units of the Health Department that are doing AIDS and doing STD testing -- at least not enough.

We had a young woman come in who was 12 years old, and she had presented -- this was her third STD she had been infected with. She had been -- at least according to what she said, she started to become sexually active when she was 10 and a half years old. And not with 10 and a half-year-old boys, but with 16-, 17-, and 18-year-old boys.

COUNCILMAN ORTIZ: How old?

MR. BELL: I'm sorry?

COUNCILMAN ORTIZ: How old?

MS. SHEIN: 10.

MR. BELL: She was 10 and a half years old when she first became sexually active, but she was 12 when she came in to get tested. She had never had an HIV test, even though she had been tested three times for STDS.

When I first came to BEBASHI, we had 9 African-American women on our caseload, and at that time, we served about 300 people for case management. Now 45 percent of the cases we serve

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-- we roughly serve about 500 a year -- are women, the majority are African-American women.

And what I'm seeing and what I'm hearing time and time again from the people we're working with, and we're working with -- the majority of them are minorities, African-Americans, Latinos. The main thing we're hearing from many of them is that they don't think they can get HIV. They think there's a cure, they think that Magic Johnson is cured, they think there's some conspiracy. They think everything about except what we know. They still don't think they're at risk.

One of the successful things that we're doing is working in prisons. We're working in the State correctional institutions. Sixty-two percent -- 63 percent of the people who are infected with HIV who are in the State correctional, 24 State correctional institutions, return to the Philadelphia area, and the rate of HIV has been estimated at least 14 times what it is in the general population. We're getting in touch with them six months before they're getting released. Because what do you think the first

thing someone does, especially a man does, when he gets out of prison? So we can't wait for that --

COUNCILMAN ORTIZ: He goes out and has a Coca Cola.

(Laughter.)

MS. SHEIN: That would be good.

MR. BELL: We can't wait for them to get out of prison.

And it works. We're getting people before, we're giving them HIV information. When they get out, we're linking them with a doctor, getting them health insurance, finding them a place to live. That is a system that is working.

And, finally, I just wanted to say two things. One is we vigorously oppose HIV name-reporting. I know we need to know how many people are HIV-positive, but I don't think we have to know their names. We can't keep government secrets, we can't keep secrets about our nuclear technology secret -- and we're going to keep names of people with HIV secret? I just don't believe that.

And, finally, I think this city needs to understand that HIV is not just the Health

Department's problem. You know, we look at the Health Department -- and I think they're doing everything they can with the funds that they have, but it's not just the Health Department.

COUNCILMAN ORTIZ: But the funding has been level since 1980-something, right? I mean the HIV --

MR. BELL: For prevention, it has.

MS. SHEIN: For prevention.

(Unintelligible, parties talking over each other.)

MR. BELL: And we have a pretty good care system. But my fear is that how long -- when we look at the federal government and we look at who's in charge there and we look at who's in charge of the State government, how long are they going to keep paying 12 to $15,000 per person per year for poor minority people to get the state-of-the-art care? I'm afraid that that won't last forever. We have to start preventing this thing.

And the City has to make HIV a priority, not just the Health Department, but every aspect the of City government. Every aspect

of the City government should create a plan. How are they going to ensure that everyone walking in the doors of any City agency, everyone that works for every City agency knows something about HIV, knows how to get it, knows where they can go to get tested? That's something that can't be that hard to do.

June 27th is "National HIV Testing Day." I've been working with a coalition of folks who have been sitting around the table trying to figure out how we're going to raise visibility about that. We have no money to do this. You know, we are basically lending ours to see this initiative. If the City could step in and say, you know, We want to be a national model for -- we want to be a destination city, we want people to come here for tourism, we want people to come here to -- we want people to exercise and drink their water and all that, we want to have great schools. It isn't going to matter if everyone is sick, it isn't going to matter if everyone is doing. None of that is going to make a difference.

June 27th should be the first day that

the City steps forward and becomes the national model for HIV prevention.

(Applause.)

MR. BELL: It starts with having enough money, and we're never going to have enough money. It's the will. We need to have the will to do something about this. Uganda, who has a fraction of the resources we have, have cut their HIV infection rate in half because they made it a national priority, and they're one of the few African countries we're seeing that has really stepped up to the plate to do this. We have, you know, many more resources than they can.

This is something that can be done, but the City of Philadelphia has to decide that this is a priority for us.

COUNCILMAN ORTIZ: Thank you.

(Applause.)

COUNCILMAN ORTIZ: Dorothy, do you have something to add to that?

MS. MANN: Yeah. Well, I would agree, certainly, with Gary.

There were a couple of other things, though, I also wanted to mention. You asked about

the Prison Health. Prison Health is a disaster. In my opinion, it is a scandal.

COUNCILMAN ORTIZ: We pay $25 million to a company to do a disaster.

MS. MANN: Right, and they just re-upped it. What I think is important to understand is that that contract was just renewed.

COUNCILMAN ORTIZ: Mm-hmm.

MS. MANN: And why?

COUNCILMAN ORTIZ: And they refused to give documents that are supposed to be public.

MS. MANN: Exactly.

COUNCILMAN ORTIZ: But we have an administration that likes to keep things hidden, and I don't like that at all.

MS. MANN: Well, somehow it seems to me that somebody has to hold accountable to folks that re-upped that contract and --

COUNCILMAN ORTIZ: We will.

MS. MANN: And to look at that.

I think that the issue that you've heard a lot about today in terms of HIV reporting, I want to clarify a couple of thing about it. First, it is -- the reason we're in this fix is

because the Centers for Disease Control, which gives out the money for HIV prevention, the federal money for HIV prevention, has in fact said, We have to have HIV reporting in the nation. Currently, up until then, about 32 states had voluntarily adopted HIV reporting. And with the reduction in the number of AIDS cases because of the medications that we have and the advances we've had, CDC has said, If we're going to track this disease nationally, we need HIV reporting.

States have a choice, which CDC has let them have, about how to do it, and I think Jane mentioned it earlier. And the problem is that this state is one of the last states to even take on this issue at the threat of losing their CDC funding. CDC said, You have to report to us HIV. The state has made the decision to use name-reporting. I don't think there's an organization that I have seen in Philadelphia that supports it. None of us support it. The Board of Health, I don't think, supports it. Yet the State is sort of inexorably moving in this way.

So it does seem to me that this issue -- there is a way to report HIV without names,

there is a way to report HIV without risking -- we're talking about the fact that 25 percent, if not more, of HIV-infected people don't know their status. Well, how the heck are we going to encourage people to be tested, which we've been talking about, if even -- even if one person says, "I'm not going to be tested because I'd have to give my name," that's one too many.

COUNCILMAN ORTIZ: That's right.

MS. MANN: So, somehow as a city council and as a city, we have to stand up and be counted in dealing with the State Health Department and the Governor that this is something that this city, which has the cases, is totally opposed to. And we have not had a public statement about this, and it seems to me that it's time that City Council in fact took on this issue and stood with the HIV/AIDS community and said no to names-reporting.

(Applause.)

COUNCILMAN ORTIZ: I think since the State is moving in a way that is quicker than we thought moving in that direction, maybe, David, what should come out of these hearings, at least

before the report comes out, is a sense of the Council resolution --

MS. MANN: Yes, yes.

COUNCILMAN ORTIZ: -- as to this issue that says to the Governor and to the State Health Department, This is not the policy that we should follow. And I would like the help of you here in the drafting of that resolution so that perhaps we can submit it next week or the week after that, if we have it at hand.

MS. MANN: That would be great. Thank you.

MS. SHEIN: Thank you.

(Applause.)

MS. SHEIN: If I may, as I said, we test over 3,000 people a year. We did a survey amongst the people that we test. Overwhelming, over 90 percent said, We will not come to get tested if our name was reported.

COUNCILMAN ORTIZ: And we need a statement from our administration that if the State moves toward that, that we will not comply.

MS. MANN: Great.

(Applause.)

COUNCILMAN ORTIZ: Next. Go ahead.

MR. HORN: I'm Danny Horn, the Education Director for Philadelphia Community Health Alternatives.

Nurit Shein, our executive director, spoke a little bit about our agency and about some of the work that we do. I just wanted to talk briefly about our experience in doing some of the outreach to high-risk populations in the bathhouses, men who are having sex with men, or gay and bisexual men.

There are a number of things that I worry about when I go to the bathhouses to do outreach and to link people to HIV testing onsite that are at the bathhouse. I worry about men who, after 20 years, still don't know some of the information, and we're really happen to provide that. I worry about men who are afraid to come to our clinic, even though it's an anonymous clinic. And so it's a great job to kind of link those directly to HIV testing and to care right there, in the bathhouse when we're there.

The thing that worries me the most is when we talk to gay and bisexual men or men who

have sex with men who think that getting AIDS is inevitable for them, who think that that is just a natural part of their lives that will happen, and who really don't plan on living past 30, 35, 40, who don't plan really on living much past the next three to five years. That worries me a lot, and it makes me think that AIDS actually is not really the disease that we need to fight; AIDS is the symptom.

The disease that we need to fight is poverty, it's sexism, the disease is racism, and the disease is homophobia. When we have a community where, as some of the speakers who just spoke talked about, 10-year-old girls are having sex with 18-year-old boys, HIV and sexually-transmitted diseases is only, I think, a small part of what needs to happen to help those girls. What needs to happen is that they need to know that they have a future that doesn't involve being taken advantage of sexually by older boys. And those boys need to know that they have a future and that their community has a future that doesn't involve sexual exploitation of girls.

And I think that gay men and the men

who have sex with men that we work with need to see that they have a future that can be a healthy future and that can be a future that involves them being out of the closet, if that's possible, and staying healthy and staying safe and staying connected to their community.

And I think that the City needs to not just look at HIV as a viral infection that needs to be suppressed but that we need to look at those social ills as well, and to encourage in our schools an din all of our community organizations and in our faith-based organizations to start talking about the future of gay people, the future of bisexual and lesbian and transgender people, the future of women, African-American people, poor people, Latino people, and to look at those issues as social issue and not just as a public-health issue or a viral issue.

So I'm proud that we're doing that work, but I think that that prevention work goes beyond just talking about HIV. We also need to be doing more education about those larger social problems. That is an investment that will ultimately lead to, I think, a future for our

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community -- health people -- both healthy gay people, healthy straight people, healthy people of all races and genders, a healthy future for Philadelphia.

So thank you very much.

COUNCILMAN ORTIZ: Thank you.

(Applause.)

COUNCILMAN ORTIZ: Sir?

MR. BARRETT: Good afternoon. My name is Albert Barrett. I'm an HIV case manager with Philadelphia Community Health Alternatives.

Despite the system or quality of care, there are still many barriers that the people with HIV as an epidemic changes. People with HIV are faced with multiple issues. Through my work over the past three years, all of these individuals that I have encountered are not only dealing with HIV, but they are also dealing with homelessness, mental illness, and drug addiction. Usually these people take priority over the HIV and interface with the HIV care -- interfere with the HIV care.

When I met meet with a individual at Ridge Avenue Shelter, my dilemma is what to do with them first; first find them permanent housing

arrangements or refer them to medical care? And how can they adhere to a regiment of drugs when they don't even have a place to store them? And how can someone who has dual mental health diagnosis and who are found wandering the halls of shelter remember to even take their medication.

As an HIV case manager, I still see the stigma of AIDS when trying to secure services for my clients. I often encounter a lack of knowledge or fear about HIV and a lack of willingness to work with people with HIV.

Over the past few years, there have been an increase of collaborations between the HIV system of care and other systems such as the Office of Emergency Shelter Services and the Office of Mental Health and the Coordinating Office of Drug and Alcohol programs. Yet a better integration of these systems must happen to maximize resources, and much more resources must be earmarked to create holistic treatment strategies that help individuals with all of their needs.

There is one -- when one is homeless and hungry, HIV becomes the least of their

problems. We must create those bridges across the services to better provide for our citizens of Philadelphia who are most vulnerable.

Thank you for giving me this opportunity to speak.

COUNCILMAN ORTIZ: Thank you.

(Applause.)

COUNCILMAN ORTIZ: Could I have the next panel.

Kevin Conare, Greg Goldman, Alfredo Salas, Gustavo Velasquez, Brunilda Reyes.

(Witnesses come forward.)

COUNCILMAN ORTIZ: Susan Higginbotham and Immy Ferrara.

(Witnesses come forward.)

COUNCILMAN ORTIZ: Very good. Thank you for coming and thank you for waiting. I really want to thank everybody who's come and stayed. I believe that you helped shape the direction of the hearing, you helped develop the way we structured it, and I'm very glad that you are here because I believe it's about time that we started putting this back on the priority list.

Who wants to begin?

MR. CONARE: I'm Kevin Conare. I am the Director of Action AIDS. I'm also a person living with AIDS.

COUNCILMAN ORTIZ: And if I may, you know, instead of just reading and giving me about the -- we know your organizations, so let's get into your -- you know, where we're at right now and where we're going to go and what happens with some of the problems, but let's look at solutions to really make this very visible because I think each of the individuals that has come before us -- like Dorothy Mann said, some people think that the AIDS crisis is over, and it isn't, and we have to make that very clear across the whole city.

But go ahead.

MR. CONARE: I will do that. This is all I have to say.

COUNCILMAN ORTIZ: Okay.

MR. CONARE: So I know that anything more than a page is more than five minutes.

COUNCILMAN ORTIZ: Right.

MR. CONARE: So I do want to say a little bit of who we are. We serve 3,000 people living with HIV every year, and 38 percent of them

are women, 76 percent are people of color, and we do that out of 25 locations. That includes the four prisons, our three offices in the Northwest and Center City, and sixteen clinics and hospitals.

I say that not because I'm going to talk about our services, but I think we have experience throughout the City with all of the geographics and demographics of people affected by HIV. And in fact, I would like to really address what I think the City could do that could be very specific. And not actually the Health Department, because I think that's where the conversations gets down to, and some of the issues are bigger.

Most of my peers that work with me know that I don't like to be melodramatic, but I do believe that we have a crisis here, and I think we have a crisis that is brewing that is going to get much, much worse. And one is economic and one is health.

I'm going to start off talking about the economic --

COUNCILMAN ORTIZ: I think Jane said that it's at the level of really exploding so --

MR. CONARE: Right. Well, I just want to do some math with folks just to help, just to -- the economic piece is probably the easiest piece to talk about.

Fortunately today, most people are not dying of AIDS -- today. The medications are working, we're seeing incredible advances in HIV. And as Ronda pointed out, we have people going back to work, we have people in transitional housing. We even had amongst our 1,000 people getting housing counseling, one or two that got mortgages. Even though that's a small amount, that was unthinkable five years ago. So that's great news.

However, people are living at a cost of 10 to $15,000 a year to take care of people. Ninety percent of the people who are getting HIV are low-income, and they are either uninsured or they have Medicaid.

If you do the math, we have about 1,000 people a year that are coming down with AIDS that we know of, probably the same amount coming down with HIV, and 1,000 x $15,000 is $15 million a year. One year. And if we do our jobs right and

they live, that's 30 million, 45 million, 60 million, 75 million. I just really want to impress that this is -- you know, we feel kind of good because -- and I will commend AACO and the Health Department, and they got, along with the Planning Council, a $4 million increase in Ryan White this last year, 2 million the year before.

But we will not be able to keep up with what's happening economically, and I see three areas that we look at. There's the federal, and there's the state, and there's the local. And at the federal level, as people have pointed out, the Bush Administration has not put any additional monies into Title 1, or very little into Ryan White Title 1, where 75 percent of the cases of HIV are still occurring in the cities in this country. And we will not get that $4 million increase next year. I admit that the whole $15 million of care that need isn't all going to come out of Title 1, but 1 to 2 million, 2 or 3 million is, and we will not get that increase.

I believe that the City needs to advocate with other cities to ensure that we get that money. We do it individually as providers,

AACO does it, Pat Bass goes down to Washington, DC, but it would really be good to see the City and the Mayor really pushing for that, as well as us working with our local legislatures.

On the state level, Jane pointed out the hundreds of millions of dollars that are in HealthChoices and we've had an ongoing problem with this. We are spending millions of dollars, increasingly more out of our own City funds to provide people with medications. The State has not yet made a carve-out that's sufficient enough that really says, Let us pay more for these patients. And that's another place where the City push for a change at the State level. Again, I say we're doing a lot of the advocacy ourselves.

And then at the local level --

COUNCILMAN ORTIZ: Could I ask --

MR. CONARE: Yeah.

COUNCILMAN ORTIZ: What is the cost of medication per individual, let's say, for somebody on average?

MR. CONARE: It's $600 to 1,000 a month. If you're like me, which I'm relatively healthy, it's only about 6 or $700 because I don't

have a lot of other secondary things -- a month, only, I'm saying.

COUNCILMAN ORTIZ: And that's if you're insured, you're okay, but if you're not insured --

MR. CONARE: Right. Well, right now, we've been managing between City funds and Title 2 funds, and we've been managing, but this is what I'm saying about the impending economic crisis, because we're talking about what's going to be, you know, tens of millions of dollars increasing every single year, and there has to be a way for us to figure out how to do that. And that has to from a combination of federal and state and local monies. Philadelphia's never going to be able to afford it on their own, so -- but I think some of the advocacy has to from the City to the State and to the federal government.

Then there are places where I think, on the City level -- and I'm not going into detail on this, but because so many people are multiply diagnosed, there's a lot of work we could be doing with DHS, the mental health systems, the shelters, where we are coordinating in a way that we do it more efficiently and really get -- that we're not

only looking at HIV dollars to give care to people that, in fact, have needs that would have been there anyway. So we should be looking at how we can supplement that with some of the other funding that's out there.

The second half of what I wanted to talk about was the health crisis, and I want to -- I really wanted to talk about one issue that really didn't get brought to the table, and that has to do with drug-resistant strains of the virus, and it did get spoken about, so please forgive me if you spoke about it, but I wanted to really make sure that people understand what that means.

Right now, if you take meds, a combination of meds -- well, first of all, HIV's a retrovirus, which basically means it's a very smart virus and it --

COUNCILMAN ORTIZ: It mutates.

MR. CONARE: HIV.

COUNCILMAN ORTIZ: It mutates.

MR. CONARE: It mutates.

COUNCILMAN ORTIZ: Yes.

MR. CONARE: So they found, of course

-- and a lot of people probably know this but I'm still going to go through it. We found, of course, that if you give somebody one med, HIV mutates, figures out how to deal with that med. So now the therapies that people -- that are working are three or four or five combinations of meds. They only work if people get -- consistently take those medications, not if they take every other dose, not if they take a full dose one day and a partial dose the next day.

That will become -- that is going to be our next greatest crisis if we don't deal with it. That will be where we have drug-resistant strains of the virus and we have them spreading. And given that HIV has not declined at all, those strains will be spreading, and we'll be exactly where we were ten years ago, exactly, with nothing offer people. We'll be back in the business that we were in ten years ago of helping people die with dignity.

And, you know, that was a good thing to do when that was the only choice, but it's a terrible, terrible solution now, when there's better things that we can do.

How does that work out practically? I'm going to bring up that old prison issue again. And I think there's some conflict there because there's some doctors in the prison who are really excellent. The Health Department has made sure that all of the health districts will take care of prisons right away, on the spot. AACO's worked to get some medications -- I don't think enough, but some medications that discharge if know when they're being discharged. I'm talking about the county prisons right now.

But there are still a lot of other issues that occur. Lock-downs. Completely understandable; sometimes you have to do lock-downs. In the short term, you might have saved a life; but in the long term, these repeated lock-downs and people not getting access to their meds, or as other people refer to people not even getting to those good doctors aside -- and it's not that I don't care about those lives, it's just those people.

But these are the folks -- this is 10 percent of the prison population that are going to be having drug-resistant strains of the virus.

They're also the folks who are going to be discharged from the system.

And some of the good things is -- you know, I'll say Health Department has funded BEBASHI to help people in the (indiscernible). They're funding us to link people from the prisons. So work is being done.

Where it falls apart is that AACO can don't do so much. They can only work within the systems they control. Even if you get beyond that, the Health Department can only control so much. It has to be a combination of corrections of that subcontractee, of the parole system, of AACO, of the Health Department. And that takes going up another notch.

I'm using the prison as an example, but this is true in the shelter system, this is true when you're talking about DHS and women and children and the growing number of women who now have HIV, all of those issues. It's really true throughout the system, that we have to find ways to start coordinating those services together and not just see it as a nice idea; see it as a way that -- that the integrity of those services is

what's going to make sure that people do not lose contact with their medications, which makes sure that they do not get drug-resistant strains of the virus, which makes sure that we do not have a new epidemic on our hands.

I was going to say something about names-reporting. All I can say is, don't do it.

COUNCILMAN ORTIZ: Good.

MR. CONARE: Thank you.

(Applause.)

COUNCILMAN ORTIZ: Next one. Who's next?

MR. SALAS: Good afternoon. My name is Luis Salas. I'm a prevention case manager for the Legal Aid Project.

I had my notes here with me, but I'll just present a different testimony. From all that I've been hearing today, since the morning, I'm not going to be bringing statistics. Those are another expertise that is not my own.

I believe that as a case manager, I'm in the middle of, you know, a profile within the clients and the system. You know, I'm there, I put my face among the line, trying to provide

services to people, you know, according to the mandates that the system gives me. And, you know, many times, I feel that I'm (indiscernible) out there, that I can do so much, and that so much is not nearly enough to start addressing needs of some populations.

I see -- I feel that the system is -- has been making, you know, huge advances and they've been doing some initiatives that, for some population, has worked with very good rates of -- with very positive outcomes. But there are still some other communities that do not have access to this. I'm talking about communities that are, you know, in poor conditions, drug addicts, sex-industry workers.

And I've been here since almost 10 o'clock, and I don't think I've heard the word "immigrant" being spoken here, and this is something that I wish to bring to your attention. This country has a long history of being formed by immigrants. All of us here present came from another place, either us, our parents, our grandparents, you know.

By working in this system, I've learned

to hate some words, and the word that I perfectly hate the most is the word "eligible," you know, when it basically, you know, has to do with a green card or with a legal identity in this country. I see those clients coming to my office more and more, clients that come here to the country or clients who do not have all of their paperwork together as to have access to regular health-care structures. And it is my job to try to provide them with those services with access to that.

You know, the system has many flaws and also many advantages. One of the flaws that it has is language access, and I believe (indiscernible) for Latino communities but other communities whose language would not be English. You know, even among us, you know, the way we speak Spanish, the way other communities speak Spanish is so totally different, and that prevents the prevention messages to come across when we are trying to help these communities.

I don't feel communities that aim its efforts to immigrants, to Latinos, to Asians, to African-Americans should be considered

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(indiscernible) communities. I believe these are the communities that have the responsibility to provide very comprehensive services to populations that otherwise wouldn't have access to these, you know.

That's basically it.

COUNCILMAN ORTIZ: Thank you.

Just keep going down the line.

MR. GOLDMAN: Thank you and good afternoon, Councilman. Thank you for the opportunity to testify and the leadership that you're providing and your staff as well. My name is Greg Goldman, and I'm the Executive Director of MANNA. The main issue that I would like to address this afternoon is the issue of leadership.

MANNA was founded in 1990, and the first year, we served -- several volunteers served 30,000 meals, about 100 meals a day. Today the organization has more than 1,000 active volunteers, and we serve more than 40,000 meals each month. The number of clients and the number of volunteers that we engage to serve them continues to grow.

These facts indicate two very important

facts for City Council to consider today. The first is that the number of people who need our services continues to rise; and second, that the number of people who are actively engaged in the fight against AIDS, at least from our perspective, also continues to rise.

That the number of those in need is rising reflects the fact that the disease continues to spread rapidly to new populations -- this has been discussed. It also reflects the fact that many of those we serve are living longer and better lives as a result of the new medications. Many are doing well enough to work, volunteer, and otherwise contribute to the community but because of fluctuations in their health, they still require the services that we and our counterparts provide.

But the good news is that we continue to be successful at recruiting volunteers to our efforts. Our corps of volunteers is strong and growing, and they're people that come from every walk of life, including every age group, also their economic stratus, students and teachers, business and retired people, welfare-to-work

volunteers, gays and straights, and even many with physical and mental disabilities.

The issue I think that is present for us today is that in order for us all to continue to advance this fight, members of City Council like yourself and your colleagues and all of us here today who have leadership roles in the community must do two things:

First, we must continue to bring attention to the crisis in whatever ways we have at our disposal. We must inform our constituencies that the epidemic is ongoing and threatens us all. We must call and lobby for and must call for continued concerted action on the part of the public. And, of course, the best way for the public to express concerted action is through broad-based grassroots for ongoing and increased funding.

But, secondly -- and I think this is also very important specifically for members of Council -- we must act, continue to act, to destigmatize AIDS in all of the communities, but particularly among those which are experiencing infection at these high rates and do not have the

community infrastructure to respond effectively. This specifically means the African-American and Latino communities, including their gay and lesbian components.

MANNA still delivers its meals in unmarked vehicles and in plain, brown paper bags to protect the confidentiality of our consumers, and we will continue to do this, but I am convinced, as one in this war, that the stigma that still attaches to AIDS prevents many from actively engaging in the fight by seeking and adhering to the treatment that they need.

So for our part, we're recruiting volunteers and we're seeking out consumers in lots of different ways, but essentially by keeping our voices high and our energy high to express that the crisis is still here and that there is still work to be done to stop it.

The members of City Council, through your words and actions, can also do the same. This hearing is an example of that, and I think that one of the main things that we do is our public leadership to continue to inform the public that we all have a role to play in continuing to

fight this disease.

COUNCILMAN ORTIZ: Thank you.

(Applause.)

COUNCILMAN ORTIZ: You would think that after all of these years, the stigma would not attach, and it does. And you have it in families, you know, that when somebody dies and, well, they don't want to know, they don't want to say that it was AIDS, this, that. It happened in my family and it was very difficult for my aunt and uncles to come to grips with it. And it was a hard time, I had a hard time explaining it and telling them that it was nothing to be ashamed of.

Go ahead.

MR. VELASQUEZ: Thank you for giving me the opportunity to speak today. My name is Gustavo Velasquez, and I am the Division Director for Neighborhood and Family Development at Congreso de Latinos Unidos.

I'm not going to give an explanation of services at Congreso. I would like to mention, though, that since 1987, just among some of the HIV and AIDS services that we provide are linguistically and culturally competent outreach

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media, housing advocacy and rental assistance, prevention education, counseling and testing, case management, translation, interpretation, food services, nutrition counseling --

COUNCILMAN ORTIZ: It was the first bilingual program.

MR. VELASQUEZ: Yes.

COUNCILMAN ORTIZ: Going into bars and so on. I remember in '87 when some people in Congreso started going to nighttime actually to bars to talk about AIDS and the use of condoms and the use of other methodologies. So since 1987, we've had that, and I'm very much acquainted with it because we make sure that Congreso got that money.

MR. VELASQUEZ: Sure. It's the first bilingual program in the City and in the State as well.

I'd like to make two recommendations, but really, before I want to give some striking kind of elements in the relationship between HIV/AIDS and Latinos in the City. Last year, Latinos were 14 percent of AIDS cases in the City; this is just over 1400 cases.

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What is important here to consider is that although we were only 14 percent, we are just 8 percent of the City's population. So in HIV epidemiology, if you look at the HIV incidence per 100,000 people, our incidence was 800 people per 100,000 Latinos versus, for example, 130 Caucasians per 100,000 people. If you look at this incidence, Latinos ranked second in terms of people living with HIV and the relationship with the number of Latinos in the city.

Unfortunately, if we look at this same factors, we ranked first in the case of females. Latinos are 50 percent -- more than 50 percent of Latinos are females and head of households, which means that given the fact that increasing years the HIV epidemics has been growing among heterosexuals, you know, and females, that's how you can see the relationship between the increase also of cases among Latinos in Philadelphia. Not to say that we are also the 14 percent of pediatric cases in the City.

The second point that I want to make is regional concentration. It's really important to know that many, many migrants are rapidly coming

to Philadelphia, not only anymore from Puerto Rico but also from Mexico, Central America, and some areas of the Caribbean rather --

COUNCILMAN ORTIZ: The Dominican Republic.

MR. VELASQUEZ: Right, to Puerto Rico.

It is estimated that 100,000 Latinos living in East or North Philadelphia east of Broad and south of Allegheny when there are 120,000 Latinos overall in the region, which means that for HIV/AIDS, this is a very positive factor because the concentration is really in that area, and we are in a good position to fight, you know, with good prevention and care this situation in that part of the City.

And my third point is really culture. You know, Latinos have a very special culture, and culture is a vital component to help Latinos (indiscernible) becoming infected or living with HIV. A stigma has particularly affected this population and Latinos literally hide from mainstream systems due to, you know, culture barriers. Not to say, you know, the language and extreme poverty. The reality is that we can

become much more effective if we have in place linguistically and culturally competent services.

So, really, my two recommendations will be first to increase the amount of services that are -- you know, bilingual services. We are struggling. I mentioned that we have over 1400 cases of Latinos living with AIDS. Congreso is serving in its case management program 250 people. And that's just not enough. Not to say that within the 250, we have struggled so much in accessing, you know, primary care, that it's provided in a bilingual way. So I think that would be one strong recommendation. And that is also something also that is that the Asian-American communities are struggling.

And, finally, coordination, you know, coordination between City government. We talked before about co-morbidities -- your mental health, drug and alcohol. All the systems need to get together and have a much more coordinated approach. And also coordination between service-providers, you know, that's our responsibility, that's our job, but I feel that also at the City level, it's very needed, the coordination among

different agencies.

One good example is housing. We provide housing, which, you know, funding comes through the Office of Housing and Community Development, and it seems that it's very important to have coordination between the public Health Department and the Office of Housing in the City.

So those are kind of some things that I wanted to highlight.

COUNCILMAN ORTIZ: Thank you. Gracias.

(Applause.)

MS. HIGGINBOTHAM: Good afternoon, Councilman Ortiz. I'm Susan Higginbotham, and I have the honor of serving as the Executive Director for AIDS Fund, a community-based organization whose mission is to raise funds for distribution to AIDS service-providers through a competitive grant process.

In the interest of time and because I have the good sense not to repeat what's already been repeated -- actually Jane Shull from Philadelphia Fight eloquently articulated a number of the funding issues that I wanted to bring up, but there are a couple of points that I really

wanted to touch on.

Because AIDS Fund raises all of the money that we raise through private sources -- individuals, corporate donations, events such as the AIDS Walk and Gay Bingo, and workplace-giving campaigns, we receive no government money. And in that sense, I'm in a unique position really to say that the funding really has to be increased for these AIDS service providers because we are raising money at AIDS Fund every year through these private sources, and it gets harder every year. Since the advent of the new medications around 1996, it has gotten harder to raise that money through private sources.

And one of the things that somebody is inevitably going to say, whether it's City Council or State government, is that whole philosophy of, Well, the government's done enough and now, you know, the private sector has to step up to the plate and, you know, start making the difference. And the reality is because of complacency and because HIV and AIDS is not at the top of the list of the public, that's not going to happen, it's not going to happen. And what I --

COUNCILMAN ORTIZ: It's not going to happen because of the population that it's attacking --

MS. HIGGINBOTHAM: That's right.

COUNCILMAN ORTIZ: -- which is the poor, the black, the brown.

MS. HIGGINBOTHAM: That's exactly right.

And so the best-case scenario is when the AIDS service-providers have diverse sources of income, such as a combination of government money, private giving, private foundations. But the truth is, even of the larger foundations, they are not prioritizing HIV/AIDS services, and so it means that the AIDS service-providers are having to work harder for fewer resources. And so the only place to make up that difference is through the state and federal sources.

And with all due respect to some Councilmembers who have already left for the day, a number of people were suggesting that the providers need to get together and advocate, and they certainly have done that, and I think what it's going to take is City Council, the Mayor,

everybody to pull out all the stops and call in all the favors and talk to everybody that you know, because the power that Council has cannot be underestimated to really make a difference.

COUNCILMAN ORTIZ: It can tell you a lot that we have not had hearings in this Council on AIDS since the last time I had hearings in this Council on AIDS, in 1987, '88.

MS. HIGGINBOTHAM: That's right. Well, thank you for your commitment and your stamina.

COUNCILMAN ORTIZ: Thanks.

MS. HIGGINBOTHAM: To really do something about HIV.

COUNCILMAN ORTIZ: It's a long time between hearings.

MS. HIGGINBOTHAM: Exactly.

One other point I wanted to make -- and thank you to Gary Bell, if he's still here, for bringing up National HIV Test Day, because it is a collaborative effort. AACO, AIDS Fund, and a number of counseling and testing providers are working on promoting events and offering testing during that last week of June. We are working very hard to promote that.

And the truth is, I mean, we could really use help from City Council and from the Mayor's Office. You know, if you could help us get the Mayor to a press conference, we could ensure the fact that we would have the press there to help promote what's going on, because all the providers are doing special events to try to encourage people to get counseling and testing.

And certainly if the State goes to names-reporting, that's really going to harm those efforts.

COUNCILMAN ORTIZ: I think the Mayor should be there. So we definitely --

MS. HIGGINBOTHAM: I'm going to follow up with you about that.

COUNCILMAN ORTIZ: Okay.

MS. HIGGINBOTHAM: Because we need his support and we need to get the media there. And, you know, through television and radio, we can reach millions of households.

COUNCILMAN ORTIZ: Okay.

MS. HIGGINBOTHAM: So we need your support.

And thank you for your time and

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consideration.

COUNCILMAN ORTIZ: No problem.

(Applause.)

COUNCILMAN ORTIZ: Miss Ferrara.

MS. FERRARA: Councilman Ortiz, Mike, I thank you for your continued attention. This has been a very long day for everybody, and I'm going to try to be as brief as I possibly can.

I guess my position's a little bit different than everyone that has spoken before me. I am here primarily today as the mother that lost her only child to AIDS in 1994. Phillip was diagnosed in 1990 and only lived four years with the disease, for two reasons: At the time, the only protocol was massive doses of AZT, and he also had two strains of the virus.

The one thing that I have found in the eleven years that I have been volunteering for the AIDS service organizations and also eleven years that I'm taking care of people hands-on that are HIV-infected or have full-blown AIDS, I found that the families, as soon as the person finds out that they are diagnosed, many of the families also fall apart at the same time. I could speak freely

about this. The gentleman that just flashed my picture, when he found out our son was HIV-positive, for seven and a half years, there was no communication between him and I, and, unfortunately, he had not made peace with his son before he passed away.

The one thing that I hope to do is to bring the humanist to this disease. If I'm able to do this, then my son's life would not have been in vain, or those of my friends.

What I'm going to ask is three things. The most difficult thing that I had to do is to sit down and plan the words and pick them for my obituary. I am going to ask each and every person in this room to take on the responsibility themselves. Mostly everyone in this room is very well versed about how someone becomes HIV-infected. Go home, sit around the table with your family, your friends. Speak to your coworkers. Give them the information that they need to live a life free of HIV.

Is it hard? Yes, it is hard, but we're talking about eradicating this disease. We want the government to do so much, but you want to know

something? The people have the power.

There's nothing special about me, but hopefully, someone that's listening to me today will go home and speak to their family and friends and loved ones and give them that message that they need.

The second thing is, don't stop there. Go to your schools, the schools that your children are attending. Find out what curriculum are they being taught, are they being taught about STDs and everything is sugarcoated? Because if that's what they're being taught -- Mr. Ortiz, your children are in danger just as mine was.

The last thing is, go to your houses of worship. Why is HIV and AIDS not being spoken by our pastors, our deacons, our rabbis. This is unacceptable by any means of the imagination.

When people ask me, am I a good mother? If you had asked me that before 1990, I would have said yeah, but you want to know something? I can't say that anymore, because I gave Phillip good food, I gave him clothes, I gave him a roof over his head, but I didn't give that kid the information that he needed to know how to live in

a world free of HIV. It didn't matter my son's sexual orientation, his age, his race, his religion. Anyone is immune to this disease [sic], anyone can get it. The H in HIV stands for "human."

And the other thing I'm going to ask of each one of us, when we go home, look at ourselves in the mirror. In the last 20, 25 years, could each and every one of us say that our sexual experiences were 100 percent protective? Did each one of us, if we were engaged in risky behavior involving needles, did we use a clean needle? There might be one or two of in us this room that could say yes. I'm not one of them. So, you see, instead of it having been my son that I buried, it could have been myself that my husband and son was burying.

We need to keep the "human" in HIV. When Philip was diagnosed -- and where I live at, I live -- I'm the last street in Philadelphia. It's considered Somerton, right around the Byberry grounds. Absolutely no organizations were available for services. They were so overwhelmed with clients and there was not enough money. Even

till this day, some of the organizations go that far but still not very many. What I hope is that somehow I find out about them and I'm able to transport them. Not everybody in the far Northeast is rich and has cars, I could guarantee you this, and many are HIV-infected.

My husband and I attended a meeting that George Kinney had, State Representative George Kinney, about the grounds on Byberry to be able to house some of the services that are in Center City to come to the far Northeast so that HIV accessibility will be available to those in that region. I could tell you something: Everybody got up off that table and walked out. I wasn't surprised, but guess what, I'm not going away, neither. I lost the most precious thing in my life; there's nothing nobody else could take from me.

Mr. Ortiz, I may not know the faces of your children or those in the room here or their family and friends, but one thing I'm going to guarantee you, I'm going to give it all I got. And if this is what it takes to do it, then I hope there's a lot of other mothers that will join me

along the way, because I'm only one. If I could have the support of others, then together, we could be a force, and hopefully then people will realize that mothers do have a voice and that we do count.

I thank you for your patience and time. And what I'd like to tell you is, the organization that I cofounded, it's called "A Mother's Pledge." We are mothers that have either lost a child or children to HIV and AIDS, or we currently have a child or children suffering with HIV or AIDS. And we are very proud to be a program of the AIDS Fund.

The last thing I'd like to leave everyone with, in the letter that was sent to me, and it was asked to give new approaches on how to stop HIV, and I already explained those. The other thing that it said is, how do you enlist more volunteers? I have one the solutions for you right now: Join with us October the 21st this year for the AIDS Walk. Sponsor a team, help us raise money. This year, the AIDS Fund sponsored over 38 organizations that received money allocated to them, organizations of every race and

religion. Just think, 38 organizations received money. If we could have more people participate in the AIDS Walk this year, hopefully more organizations will receive money and the money that they receive, the amount will be increased also.

Each of us are responsible for each other. And this is the one thing, I know each of you could speak about City and State; I want to talk one-on-one, the human element.

Thank you. And God bless you for allowing all of us to be here and to do this. This is something I dreamed of for 11 years.

Thank you.

(Applause.)

COUNCILMAN ORTIZ: Thank you very much.

(Applause.)

COUNCILMAN ORTIZ: I understand. Like I said, I had someone very close to me who died of AIDS. And the hardest thing was to explain it to a Puerto Rican family and Puerto Rican parents what that disease was and how it happened and its -- and all of the other things that then come with it, and it's very difficult. But it has to be

done.

And thank you for your efforts. Thank you.

(Applause.)

COUNCILMAN ORTIZ: Lisa Jordan, Damon Rosenweig, Laura Lau, David Moore, Ann Cribble (ph.).

(Witnesses come forward.)

COUNCILMAN ORTIZ: Lynn Hacekenberg, is she here? Marty Gillen? No?

Shahiid Robinson and Barry Bush.

(Witnesses come forward.)

MR. ROSENWEIG: My name is Damon Rosenweig, and I'm here today as a public health professional representing an issue, not an organization. The issue is that of HIV among intervenous drug users.

COUNCILMAN ORTIZ: Pull the microphone closer to you, please.

MR. ROSENWEIG: Sure.

My name is Damon Rosenweig. I'm here today as a public health professional representing an issue, not an organization. And that issue is HIV among intervenous drug users.

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Councilmember Ortiz and citizens of Philadelphia, thank you for the opportunity to testify today. And like a lot of people here before you, I'd like to testify about an emergency, something called "a complex emergency." We have a complex emergency here in Philadelphia, and it goes by the name of HIV transmission by sharing syringes.

According to the statistics published quarterly by the Pennsylvania Department of Health, currently, in the Philadelphia region, the Philadelphia planning region, 35 percent of the cases of AIDS have contracted the disease by intervenous drug use and sharing of needles, 35 percent. When you add in the sex partners and the children of those individuals, it goes up to 41 or 42 percent. That represents thousands of people. That is an emergency.

Ten years ago, I finished a master's degree in public health and I've put it to work in public health programs, including HIV and AIDS and a half a dozen states across the United States in a half dozen states across the United States and in a half a dozen -- excuse me, a dozen countries

around the world.

I have worked in Haiti, China, Afghanistan, Pakistan, Turkmenistan, South Sudan, Kenya, Burundi, the Congo, Sri Lanka, and the Ukraine. I have worked for Doctors Without Borders, International Medical Corps, Hospital Albert Schweitzer, Counterpart International, Harvard Institute of International Development.

I have worked in Bush hospitals five miles from the front lines of jungle wars. I have worked on feeding programs and swamps full of starving children, in clinics in desert mountains where women have no rights, in refugee camps full of people driven from their homes by war.

There are a handful of universities that teach courses in the kind of work that we do out there overseas. These courses are called "managing complex emergencies" out in these contemplated places. We didn't know university professors were coming up with this name, but it sure sounds right, managing complex emergencies. And we have a complex emergency here.

Now, I'm not that special. I'm far from the first and I am not alone in recognizing

this complex emergency here in Philadelphia. Several years back, the people who were most affected by the emergency called it to the attention of Philadelphia's leadership. Philadelphia decided to call it an emergency, and Philadelphia quietly supported a few small programs to address this emergency.

Today, the emergency is still here in Philadelphia, and the emergency keeps getting more complex. Pardon my presumption, but here in Philadelphia, we need to do more to manage this complex emergency.

Now, the Pennsylvania Department of Health Statistics say that Philadelphia has an emergency with HIV and AIDS across all modes of transmission. The Pennsylvania Department of Health Statistics say that Philadelphia has an emergency with HIV drug use, both by whites as well as minorities. The Philadelphia Department of Health Statistics say that Philadelphia has an emergency with the whole range of health-care services for minorities. Department of Justice statistics say that Philadelphia has an emergency with the prosecution of drug use among minorities.

Now, all of these emergencies intersect, and that sure seems to me like a very complex emergency.

Now the complex emergency of HIV transmission by sharing syringes calls for a whole toolbox full of solutions, and there is no need to reinvent the wheel here in Philadelphia because 45 of the 50 states in the United States have answered this by a whole range of measures. These measures show measurable results: They work. And it shows that a reduction of HIV transmission is possible. This toolbox of solutions called "harm reduction," and that's a fancy way of saying today, right now, let's limit the damage while we work sincerely to fix the underlying problem.

Sharing syringes is one of the great problems that leads to HIV transmission today. So reducing the chances of people sharing syringes brings a reduction in harm. People stop sharing syringes if have clean, sterile syringes available to them. Most states, most states, have expanded and increased the education and outreach that they support, most states. Most states in the United States have changed their regulations and now

allow pharmacies to sell syringes without prescriptions. Most states in the United States have allowed exchange programs. Many states have removed criminal penalties for the possession of syringes.

Each of these measures helps. Not one is a cure-all, but they each reduce the number of people who share syringes, and that reduces the number of people who transmit and are infected with HIV. Each one of these measures acts as a partial solution to the complex emergency. Together, they make a strong toolbox for managing this complex emergency.

And it sounds like all of this will encourage more drug use, but that's not what happens. It's been shown, it's scientific. In 45 states in the United States, in cities with complex emergencies, just like Philadelphia, real-life experience tells us that drug use does not increase. Real-life experience tells us that more people do seek drug treatment. Real-life experience tells us that less people become infected and other communicable diseases. You can look at the statistics, you can talk to the people

who are involved, and you can see it for yourself as a real-life experience. Harm reduction works.

Now, I understand that these hearings are about bringing forward innovations in dealing with the complex emergencies of HIV and AIDS. Here in Philadelphia what many people would call untried ideas are, in reality, tried and true solutions that other states and cities have adopted. Pardon my presumption, but an innovation in our attitudes seems like a be good place to start.

COUNCILMAN ORTIZ: Thank you.

MR. ROSENWEIG: Thank you.

(Applause.)

COUNCILMAN ORTIZ: Laura Lau.

MS. LAU: Hi. My name is Laura Lau, and I'm the Program Coordinator at AIDS Services in Asian Communities. Our focus is the Asian-Pacific Island of communities, which includes Chinese, Korean, Vietnamese, Laotians, Cambodians, and many, many other Asian ethnic groups, both immigrant and American-born.

The API communities, which encompasses many languages and cultures, is actually, in

reality, ten years behind everybody else. Many Asian Pacific Islanders believe that they are immune to HIV, and there are even non-Asians who believe the same and actually seek them out for that very sole reason.

We do what is financially possible: focusing on some Asian ethnic groups and trying our best with the others. This is probably the most difficult -- these are probably the most difficult meetings that I have with my staff. However, we know that there are some things that work with Asian Pacific Islander communities. They include the media campaigns that we have, which, unfortunately, are sporadic because of the lack of funding; and interpretation and translation programs. We are actually the Health Department's regional provider for interpretation and translation services. Even with those programs, we still must choose.

A couple of months ago, ASIAC received funding for care outreach. Care outreach is our newest challenge. Our target for care outreach is Asian women who work in massage parlors. These women are actually sex workers. Sometimes they

volunteer to do this; many times they do not. Out of all Asian Pacific Islander women, they have the highest risk of contracting HIV. ASIAC is proud to have the nation's first care program focusing on these women.

We hope you understand the value and importance of having an HIV care program that is directed to a population that is overlooked because of its illegal immigration status, limited English proficiency, and nature of their work. We did not receive full funding for this project; we received half. Instead of providing outreach to ten massage parlors, we will only be able to provide to it five. There are 15 or more massage parlors in Center City and many more outside of it. ASIAC will be providing testing, counseling, case management, and referrals to only a fraction of the at-risk women who work in these places. We need more funding to help these women and reach them.

We are proud of our accomplishments, but much more work to do. We admit that we cannot equally reach all of the Asian communities in Philadelphia. We know the needs of our

communities and we have the approaches to reach them. It is limited funding which prevents us from effectively doing our work. With more money, ASIAC would be able to reach groups that need it.

Lastly, the Asian Pacific Islander AIDS agencies in other major cities, including New York, envy the City of Philadelphia because of its continual commitment to funding innovative approaches in reaching Asian Pacific Islanders. We hope this continues.

COUNCILMAN ORTIZ: Thank you.

(Applause.)

MS. JORDAN: Good afternoon. I'm Lisa Jordan, Manager of School and Community Training at the Southeastern Pennsylvania Chapter of the American Red Cross. I would like to thank City Councilman Angel Ortiz for the invitation today and extend our gratitude to the Public Health and Human Services Committee for the opportunity to present testimony on these critical issues.

I have three pages here, which I won't read.

COUNCILMAN ORTIZ: Thank you.

MS. JORDAN: But I think there are

three things that I would like to focus on and also reiterate the growing theme from today's testimony from several AIDS service organizations here and the City Health Department, that prevention does work.

With the American Red Cross since 1985, we've reached over 750,000 men, women, and children with skills and training on HIV and AIDS. Locally, our programs have been innovative. In 1998, our chapter here in Philadelphia was awarded the Elizabeth Dole President Award for our locally-developed HIV/AIDS Teen Peer Training Program.

Since 1998 -- one of the things I would like to highlight specifically -- on a local level, the Red Cross is currently equipping faith-based organizations and communities in Philadelphia with necessary tools to respond and address HIV/AIDS within their respective communities. Through the support of the AIDS Activity Coordinating Office, we've been very fortunate in targeting faith-based programs, targeting a captive audience of women, men, and children, a captive audience of families, people

who are there as one family unit in a place where they are going there for a safe haven to get care, seek guidance, and this is a great opportunity for faith-based organizations to embrace HIV/AIDS prevention education.

But one of the growing concerns I think from today, as you've heard, is that HIV infection has reached a new crescendo recently. And some of the recommendations that we can offer up or maybe some of the challenges that we are all facing is just the fact that there is a growing public perception that HIV and AIDS can be easily managed by drug treatments, and this is definitely undermining prevention education strategies and practices.

Recently, there have been several documented reports in the prevention education field of people lessening their precautions to practice behaviors that will reduce their risk of HIV infection. Let us be clear here: There is no cure for HIV or AIDS, and until there is one, prevention is the most cost-effective and effective means to stopping the spread of HIV infection.

In closing, the Red Cross and other AIDS service organizations could not do what we do without public funding. Without public funds filling the gap, many HIV/AIDS services -- and I think we've heard many of the cases and stories here -- would suffer here or even disappear. Over the recent years, the pool of private-foundation philanthropic funds have become smaller and smaller. The resulting decrease in public awareness has resulted in a correlative reduction in private-foundation funds to support prevention programs.

The need for public funds is more apparent now than ever before. The increasing number of adolescents and women of colors answering the ranks of infected and in the danger of people becoming complacent about practicing safer behaviors only demonstrates the need to continue to fund HIV/AIDS services that work and work effectively.

Thank you, Councilman Ortiz and the members of the Public Health and Human Services Committee.

COUNCILMAN ORTIZ: Thank you.

5/1/01 HEALTH & HUMAN SVCS. - RES. 010116

(Applause.)

COUNCILMAN ORTIZ: Sir?

MR. MOORE: I am David Moore. On July 5th of 1999, I was rushed to the hospital in Boston, Massachusetts, and was diagnosed with non-Hodgkin's lymphoma and HIV, all in those same minutes. Really not HIV -- I had full-blown AIDS. I was a national writer and an advocate for inner-city education, and my life began to unravel.

What I'd like to -- have two words for you today: Triple trouble. Those people who are suffering from HIV, those people who have a mental illness, and those people who are suffering from an addiction. That the focus of these people with triple trouble, myself included, because if you take your mind, your body and spirit, there's a chance that you will not go and relapse, you will not go and lose your sanity, and that you will not go and continue to spread HIV.

And so the focus -- I'm the director of a brand-new organization in Bucks County, along with partner and friend Lamont Bell, who's behind me. We were just funded by AACO. Our salaries

are $2400 for the whole year, and we have over 100 hours where we volunteer each week, searching out those people in Bucks County for recovery and mental illnesses.

And so I'd like to ask you today to really look at that population. I know it's a special-needs population or the population that is at high risk, but I have lost so many people in the last couple of months who have come into recovery houses, only thing to find out that they had HIV and went back to their addiction. And so I'm asking you today, wherever new funding is available, I'd like to be able to take a look at that and see.

I thank you very much for your time. Believe me, 18 months ago, I never thought that I would be speaking in front of you in this beautiful building. And I dedicate my time today to my partner of 11 years who committed suicide on the day that we found out that we had AIDS. Thank you.

COUNCILMAN ORTIZ: Thank you. Appreciate that.

(Applause.)

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COUNCILMAN ORTIZ: Shahiid.

MR. ROBINSON: Good afternoon, Councilman Ortiz. As you know, we have met one another quite a few times at different meetings. What I'm here to speak to you today about is, I'm an ex-inmate that just came home from the State penitentiary. I suffer with HIV, hepatitis A, hepatitis B, and hepatitis C.

COUNCILMAN ORTIZ: Shahiid, identify yourself for the record.

MR. ROBINSON: Shahiid Robinson.

COUNCILMAN ORTIZ: Okay.

MR. ROBINSON: And I'm a member of ACT UP-Philadelphia and also a graduate of TEACH Outside, and I'm also going through TEACH, Project TEACH right now, at Philadelphia Fight.

What I would like to speak to you about is HIV and AIDS inside the prisons, people with lived who are incarcerated and the deadly lack of access to health care they face while they are doing time. AACO's shameful lack of funding for their own programs in the Philadelphia jails and their chronic unfunding of lifesaving programs that focus on inmates and ex-inmates living with

the virus, health care in the Philadelphia jails, exactly statistics are hard to get, but from the little we know, of the 7,000 prisoners doing time in Philadelphia, anywhere from 5 to 12 percent are living with HIV and AIDS, very high. The high quality of HIV and AIDS ratio in the Philadelphia jails are higher for the women, more so than it is for the men in any prison across the state, federal, or county system.

The present health care is run like a business up on State Road. Our tax dollars pay health services and HMO to run an aspect of health care. ACT UP has learned that Prison Health Services would rather increase their profits than provide the basic medical care that all Philadelphians with AIDS are entitled to.

There are common complaints. I want to share this one with you. A prisoner was diagnosed inside the Philadelphia jail that had -- he needed insulin to sustain his life. This man was denied the insulin that he needed. His name is Jose Ortiz. This man was placed inside of a cell. He went into a diabetic coma, he never came out of it.

We turned around -- we have letters coming in from the -- all the Philadelphia prison systems that we decided to send into the prisons and ask inmates about the standard of care that they receive. So far, myself, since I'm the contact person, I have about 30 letters that then came back to me from inmates inside the prisons that's telling us what's going on inside there. Now --

COUNCILMAN ORTIZ: I would appreciate it if you would give me copies of those letters.

MR. ROBINSON: You will copies of them as of tomorrow night.

COUNCILMAN ORTIZ: Okay, thank you.

MR. ROBINSON: Also, I don't have that much time Councilman Ortiz, 'cause I have teaching I must do. There's one other thing I would like to touch base on, and I will continue all of this at our town meeting tomorrow night at Temple University.

Something that Mr. Cronauer said earlier during his testimony that medication is given to inmates upon release. That's a lie. Medication is only given to State inmates upon

release. A State inmate receives 30 days' worth of medication and a State inmate receives a packet which he is given access to different protocols of services that's provided outside on these streets.

Inmates that are coming from the Philadelphia jails, these county prisons, are not getting any kind of packets like this. They're not getting any kind of medications. They're not even seeing HIV specialists; they are seeing just a primary care doctor, a doctor that handles just chronic illnesses, but not a specialist that specializes in HIV and other opportunistic infections, they do not see this.

You have inmates that come inside the Philadelphia prisons that, when they are arrested, they have medications on them. The medications is taken from them and thrown in the trash.

You have inmates inside there, upon coming into the prisons, once they get there, it takes them anywhere from two weeks to three weeks to see a doctor. When you put in sick-call slips, you don't see no physician; you see a physician's assistant.

Now, this city pays Prison Health Services $25 million a year to provide a standard of care, which the standard of care is not being provided.

COUNCILMAN ORTIZ: We're having hearings on those, and they're not finished yet, Shahiid, so we're going to be investigating the prison health system even further. We will have hearings on the prison health system and you can come back at that time and testify to it. But we will have the follow-up hearing on that very soon.

MR. ROBINSON: Okay. The only thing we would ask, that ACT UP would ask of City Council, is that as we know, the Prison Health Services contract runs out as of next month. We asking the City Council to take in -- not to allow their contract to be renewed.

COUNCILMAN ORTIZ: City Council doesn't renew the contract.

MR. ROBINSON: No, we are saying that you can take in -- we know you don't renew the contract, but you have a big say in their contract renewal.

COUNCILMAN ORTIZ: We will have a say

in it, that's right.

MR. ROBINSON: And we trust that it's up to you and the people of this city to stop them from going back there and causing catastrophe and death again.

COUNCILMAN ORTIZ: We'll have a say in it.

MR. ROBINSON: Thank you.

COUNCILMAN ORTIZ: Okay. Sir?

MR. BUSH: Okay, my name's Barry Bush and from ACT UP-Philadelphia. And I'm here because I'm actually our appointed overseer for the names-reporting, stopping names-reporting campaign, and find myself in really a unique position, so unique that my ending sentence to my speech was going to be "I urge Council to pass a resolution demanding the City Board of Health adopt a noncompliance stance." And I say thank you, 'cause I've already heard you say that you're already going to do that.

Regrettably, I don't think -- I'm disappointed in some of the response you've gotten from your questions from some of the people regarding this issue. They seemed not totally

well enough informed. You'll see in front of you, I've passed up a fax sheet.

COUNCILMAN ORTIZ: I think we know about that issue very well.

MR. BUSH: Okay.

COUNCILMAN ORTIZ: The fax sheet will be put into the record. We will put the resolution in. Like I said, if you can help us with the wording and the drafting --

MR. BUSH: Absolutely.

COUNCILMAN ORTIZ: -- it would be very nice. You know, just forward it to my office.

MR. BUSH: Sounds good.

Could I just finish by saying -- I was going to say anyway that I don't want to take up any more time just between me and you in reading this out loud.

COUNCILMAN ORTIZ: No, it's --

MR. BUSH: Okay, that's the reason I passed it to you.

COUNCILMAN ORTIZ: You know, you're preaching to the choir.

MR. BUSH: Okay, but if I could be of any help to your staff in writing the resolution,

I --

COUNCILMAN ORTIZ: Very good. Just talk to Mike.

MR. BUSH: Mike?

COUNCILMAN ORTIZ: Thank you.

MR. BUSH: I thank you very much.

COUNCILMAN ORTIZ: Well, that concludes the hearing of the Health and Human Services Committee hearing on Resolution 010116. And this committee stands in recess until the call of the Chair.

I want to thank the Health Department and the Commissioner and the staff for the work and all of the individuals that really helped make this hearing possible. This will not be the end of this because I think we need to continue the educational aspect of this on and on.

If you have some clarification, because I saw you shaking your head, just write it up so we could put it into the record, okay?

Thank you very much, all of you, for being patient and being here.

(Adjourned 2:17 p.m.)

C E R T I F I C A T E

I HEREBY CERTIFY that the foregoing proceedings of the Council of the City of Philadelphia of Tuesday, May 1, 2001, were reported fully and accurately by me, and that this is a correct transcript of same.

RE: COUNCIL COMMITTEE ON HEALTH & HUMAN SERVICES
RES. NO. 010116

_____,
JOSEPHINE CARDILLO,
Registered Professional Reporter