ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672
8492 SENATE STATE AFFAIRS

George Thrall NONE

HCR 64 BOX 440

Seward 99664

Affiliation

Subject

Response SU
Constituency N
Distribution 20
Date POM Sent 05/04/94
Bill Number HB 351

I WOULD LIKE HB 351 PASSED WITH NO WATERING DOWN AND JUST THE WAY IT IS.

Mr. Joe Bazan 262-5168

PO Box 312

Sterling 99672

Affiliation self

Subject

Response SU
Constituency N
Distribution 60
Date POM Sent 05/04/94
Bill Number HB 351

I SUPPORT THE PASSAGE OF HB 351 AS AMENDED BY THE SENATE.

Ms. Jolene Hall 581-4084

PO Box 180

Unalaska 99685

Affiliation

Subject

Response OP
Constituency N
Distribution 02
Date POM Sent 05/04/94
Bill Number HB 320

I WOULD LIKE YOU TO REALLY CONSIDER -NOT- TO HEAR THE 'HEALTHY STUDENTS ACT' THAT IS IN THE SENATE STATE AFFAIRS AS HOUSE BILL 320.

not to worry, it's in my "coffin"

Supplemental references to youth and related education need in *Healthy Alaskans 2000* in 8/31/93 draft:

Pg. 33: "In all studies, over 70% of Alaskan students in grades 10-12 reported having used alcohol at some time during their lives. This far exceeds the 46% reported nationally."

"Frequent use increases among Alaskan youth as they advance in grade peaking at about 25% in grade 11."

"However, the level of use (marijuana) among Alaskan youth remains far above the 10% level of lifetime use by the same age group nationwide. Frequent use of the drug also exceeds nationally reported levels.

"Alaskan youth are about one-third more likely than youth in the rest of the nation to try cigarettes (62% compared to 38% nationally."..."Importantly Alaskan youth are far more likely to use cigarettes and smokeless tobacco on a frequent basis than youth in the rest of the nation. .

"Experimentation with inhalants among Alaskan youth though at a lower level than use of alcohol and marijuana, is more than three times the level reported by youth nationally (26% compared to 7%)."

"Anecdotal evidence indicates inhalant use is becoming particularly prevalent in some small rural communities and has already had devastating effects."

Pg. 34: ""up to 25% of all deaths in Alaska are alcohol or drug related

Pg. 105: "More than 100 people die of AIDS every day in the U.S.-one every 15 minutes-and the pace is accelerating."

Pg. 106-7 "Alaska adolescents between the ages of 15 and 19 years comprised 22.6% of total 1991 cases (gonorrhea) but only 6.5% of the state population."

"Cocaine use has increased 500% in Alaska since 1984 (Division of Alcoholism and Drug Abuse). The exchange of sex for crack

cocaine has been linked in other areas of the country to outbreaks of syphilis and sexual transmission of HIV infection."

Pg. 37: "Alaska had the nation's second highest pregnancy rate for 15-19 females in 1985."

Pg. 38: "Alaska teens report sexual activity rates high above national norms. Among sexually active adolescents, the mean age of first intercourse for males is 13.2 and for females is 14.0."

Pg. 42: "15.1% of Alaska Native suicides were committed by those 18 and under: 10.5% of White Alaska suicides were committed by those 18 and under

Pg. 43: "Most projects (suicide prevention) emphasize primary prevention-activities which focus on children and youth in the pre-high suicide risk years."

Pg. 49: All victims of violent and abusive behavior are at increased risk for alcohol and drug abuse and suicide. Programs aimed at prevention, intervention, and counseling the victims of abuse are critical in breaking this pattern of violence.

Pg. 54: "Support activities aimed at increasing high level collaboration between Head Start and state administered programs that serve low income families with young children (Alaska Head Start Collaboration Project and the Alaska Interdepartmental Committee on Young Children)."

Pg. 88: "(Fetal Alcohol Syndrome) Now considered the leading preventable cause of mental retardation in the nation."

Pg. 89: "Alaska has an estimated rate of teen pregnancy higher than all but one state, and a teen birth rate higher than that of some developing countries....With no consistent reporting of abortions or fetal deaths in the state, an accurate pregnancy rate cannot be determined, but estimates placed the 1985 rate at 81 pregnancies per 1,000 Alaskan young women aged 15 through 17."

Pg. 90: Children whose families have abused, neglected, or abandoned them, or who have witnessed their mothers being beaten, are deprived of the most effective buffer against the stresses of adolescence and beyond: a healthy family system. Alcohol and drug abuse, teen pregnancy, school dropout, intentional and unintentional injuries due to high risk behaviors, suicide, eating disorders, other mental and emotional illness, and multi-

generational child abuse are among the long-term effects of abuse and neglect. These effects of the deterioration of family trust, communication, and pride may occur if a family is not assisted promptly in learning the skills to overcome abusive patterns.

"The health of children, the socio-economic welfare and self esteem of teens, and the economic cost to government (for AFDC and other public assistance programs) are all strong arguments in favor of a reduction in teen pregnancies. Births to school-age teens often result in lost education opportunities and lower income for future years as well as difficulties in parent/child bonding.

"Babies born to Alaska teens are more likely to die before their first birthday."

Sec. 14.08.115. Advisory school boards in regional educational attendance areas. (a) A regional school board shall establish advisory school boards in each community in the regional educational attendance area that has more than 50 permanent residents, and by regulation shall prescribe their manner of selection and organization, and, in a manner consistent with (b) of this section, their powers and duties.

(b) An advisory board shall advise the regional school board on all matters concerning school [illegible] the community in which the advisory board is established. (§ 2 ch 24 SLA 1979; am §§ 6, 7 ch 173 SLA 1990)

Sec. 14.30.360. Curriculum. (a) Each district in the state public school system shall be encouraged to initiate and conduct a program in health education for kindergarten through grade 12. The program should include instruction in physical health and personal safety including alcohol and drug abuse education, cardiopulmonary resuscitation (CPR), early cancer prevention and detection, dental health, family health, environmental health, the identification and prevention of child abuse, child abduction, neglect, sexual abuse and domestic violence, and appropriate use of health services.

(b) The state board shall establish guidelines for a health and personal safety education program. Personal safety guidelines shall be developed in consultation with the Council on Domestic Violence and Sexual Assault. Upon request, the Department of Education, the Department of Health and Social Services, and the Council on Domestic Violence and Sexual Assault shall provide technical assistance to school districts in the development of personal safety curricula. A school health education specialist position shall be established and funded in the department to coordinate the program statewide. Adequate funds to enable curriculum and resource development, adequate consultation to school districts, and a program of teacher training in health and personal safety education shall be provided. (§ 1 ch 188 SLA 1976; am § 1 ch 106 SLA 1978; am § 1 ch 37 SLA 1984; am § 1 ch 24 SLA 1986)

References to health education in *Healthy Alaskans 2000* in 8/31/93 draft:

Pg 16: "A **physical fitness curriculum should be mandatory** for all schools, and physical education mandatory in all elementary schools."

"The Department of Education should develop physical fitness testing standards for use in all schools, and **health/P.E. graduation requirements should be increased** and should not include waivers for athletics."

Pg. 20: "**Alaska does not have a standardized school health education curriculum.** Nutrition education is routinely taught in certain grade levels, but it is not a sequential, integrated component of health education in all Alaska schools."

Pg. 21: "**Nutrition education** and establishing good dietary habits in children is especially important. Eating habits established in children, good or bad, are likely to be maintained in adulthood."

Pg. 22: "**Provide** public information and **educational programs** that promote healthy eating behaviors through culturally sensitive literacy and **age-appropriate materials** in a manner that empower people to take charge and assume responsibility for their own health and that of their families.

"Ensure quality **school-based nutrition education** programs for children and adolescents."

Pg. 29: "Support statewide efforts to **develop a comprehensive school health education curriculum** and advisory services for high risk groups to combat use of tobacco products."

Pg. 35: "**Increase efforts to educate youth** about the harmful effects of drugs, with continued special emphasis on: drinking and driving; inhalants, especially targeted to rural youth; issues unique to Alaska Native youth."

"**Increase the availability of comprehensive prevention programs teaching personal and social skills** which will enable youth to resist social influences leading to substance abuse."

Pg. 37: "**Increase the proportion of teens who have discussed human sexuality, including values surrounding sexuality** with their parents and/or have received information through another parentally endorsed source, such as **school youth** or religious programs."

"During the 1989-1990 school year, **43% of 5th-12th graders in the Alaska Public School system received some form of family life education in which human sexuality is discussed."**

Pg. 39: "**Implement** culturally sensitive, developmentally appropriate **K-12 school health curriculum statewide."**

"The **Peer Helper Program** identifies, trains, and provides on-going support and supervision for high school students most often sought out by their peers as good listeners and helpers. The **program requires the cooperation of the high school(s) and the local community mental health center.** Thirteen CMHC-school district "pairs" participate in FY93.

"Head Start, a federally sponsored program to provide services for low-income children and their families, **has also recently developed a mental health component."**

Pg. 50: **Support mandatory school health education** that includes life skills and human relations curriculum with a focus on non-violent conflict resolution to problems.

Pg. 52-53: **"Increase proportion of Alaskan K-12 schools with planned and sequential quality health education."**

"**Health education in a school setting is especially important** for helping children and youth develop the increasingly complex knowledge and skills they will need to avoid health risks and maintain good health throughout life. **Quality school health education that is planned and sequential for students in kindergarten through 12th grade and taught by educators trained to teach the subject has been shown to be effective in preventing risk behaviors.** Quality school health education addresses and integrates education, skills development, and motivation on a range of health problems and issues (ie: nutrition, physical activity, injury control, use of alcohol, tobacco and other drugs, sexual behaviors that result in HIV

infection, other sexually transmitted diseases and unintended pregnancies) at developmentally appropriate ages.

"As part of the new vision for public education in Alaska, the Alaska Department of Education recommends the development of high performance standards for students and assessment methods in the subject area of "Skills for a Healthy Life" as part of the Alaska 2000 Education Initiative."

"Fifty-three of fifty-four school districts in Alaska have formally "adopted" a health curriculum for elementary and secondary schools. However, it is difficult to determine the degree to which these curricula are being implemented."

"Studies have shown that properly designed and implemented school health education programs can be effective in preventing risk behaviors. Children and adolescents are an especially important target group, not only because they are at risk for many preventable diseases, injuries and risky health behavior, but also because they carry many of the habits, including health habits, formed during these years into their adult lives. Attainment of the many objectives expressed in *Healthy Alaskans 2000* will depend substantially on educational and community-based programs to promote health and prevent disease and premature death."

"Support implementation of K-12 quality health education in the schools."

"Provide comprehensive early childhood programs, pre-school through third grade, that includes integrated health curriculum."

"Expand continuing education for school teachers in health education and promotion and continuing education for Certified Health Education Specialists in the state."

"Conduct Health Education School Surveys to monitor the extent to which schools provide and students receive school health education."

Pg. 77: "Provide comprehensive educational information through the schools and media regarding necessary precautions for food preparation storage and handling in the home."

Pg. 82: "Increase dental education efforts in the schools and incorporate it into all types of other client health education programs, especially in rural areas of the state where less dental professionals are available.

Pg. 83: "Incorporate education on prevention of baby bottle tooth decay as part of all pregnancy and parenting classes, especially in rural areas of the state where the problem is more evident."

Pg. 99: "Implement a statewide comprehensive school health education curriculum."

Pg. 104: ""Proportion of schools that have age-appropriate counseling on prevention of HIV & other sexually transmitted diseases: Statewide baseline: 28% secondary (1989-1990), 67% junior/high school and Alaska Objective Year 2000: 95%."

"Proportion of schools that have age-appropriate counseling on prevention of HIV and other sexually transmitted diseases: Statewide baseline: 28% secondary (1989-1990) and 67% junior/high school, National Baseline: 66% of districts (1989), Alaska Objective Year 2000: 90%."

"Providing specific information and opportunities for skill building, and supporting changes in peer norms among persons at risk, will encourage and help sustain positive behavior changes."

"Services targeted to include risk reduction education include those reaching HIV positive individuals, sexually active people (sexually transmitted disease, family planning, and prenatal clinics), substance abusers, especially injection drug users, crack users, and their sex and needle-sharing partners (treatment programs, correctional facilities, street outreach programs), youth at risk (schools, shelters, and youth corrections facilities), and those at increased risk due to social or economic disadvantage (the poor, racial/ethnic minorities, homeless, and mentally ill).

"The State Department of Education receives federal funds for AIDS prevention targeting youth in school. Both DOE and DHSS recommend incorporation of HIV prevention education into comprehensive health education for grades K through 12. DOE and DHSS staff collaborate closely to support this effort. A 1990 survey

found that 67% of junior and senior high schools were providing some HIV-related education (Department of Education). Surveys of the general public have consistently shown strong support for teaching AIDS education in schools within comprehensive health education (96.2% in 1992) as well as for including instruction on condoms (83.2% in 1992) (State Section of Epidemiology). DOE and DHSS offer a number of age-appropriate curricula, as well as teacher training to implement these curricula, to interested school districts at no cost. The Indian Health Service, DOE, and DHSS have also jointly supported several rural school districts to pilot the nationally recognized curriculum, "Growing Healthy."

Pg. 109: "Provide age-appropriate education on STD/HIV for all Alaska children in grades K through 12 and provide risk reduction education for students in all colleges, universities, vocational schools, and other post-high school training settings."

Pg. 111: "Proportion of middle and secondary schools that include instruction in STD transmission prevention in the curricula preferably as part of quality school health education: Statewide Baseline: 67% jr/sr high students (1989). National Baseline: 95% (1988). Alaska Objective Year 2000: 95%.

Pg. 113: "Implement a culturally sensitive, developmentally appropriate, sequential K-12 comprehensive school health curriculum in Alaska's 54 school districts that clearly addresses STD health issues."

Pg. 120: "Support activities that encourage curriculums in the state public elementary and secondary school systems that develop an interest in health careers and ensure appropriate pretraining for pursuing these careers."

State of Alaska Epidemiology Bulletin

Department of Health and Social Services
Margaret R. Lowe, MEd, EdS, Commissioner

Division of Public Health
Peter M. Nakamura, MD, MPH, Director

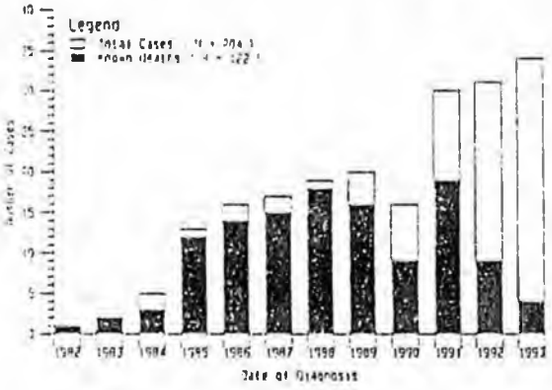
Section of Epidemiology
John Middaugh, MD, Editor

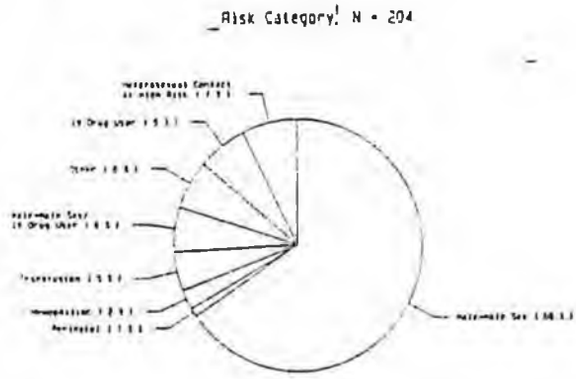
3601 C Street, Suite 576, P.O. Box 240249, Anchorage, Alaska 99524-0249 (907) 561-4406

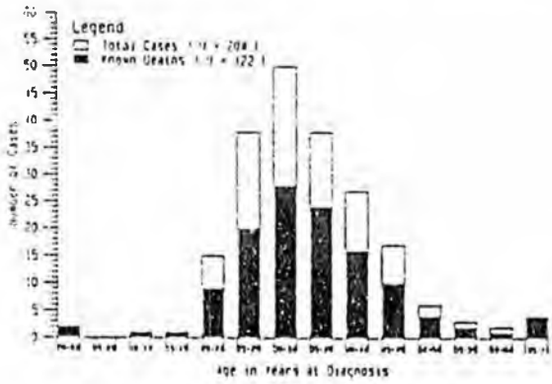
Bulletin No. 5 January 28, 1994

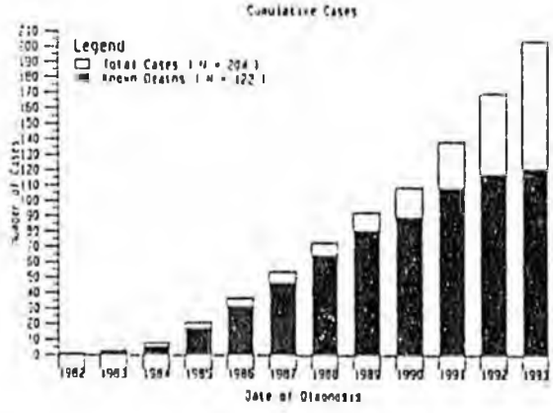
AIDS - ALASKA

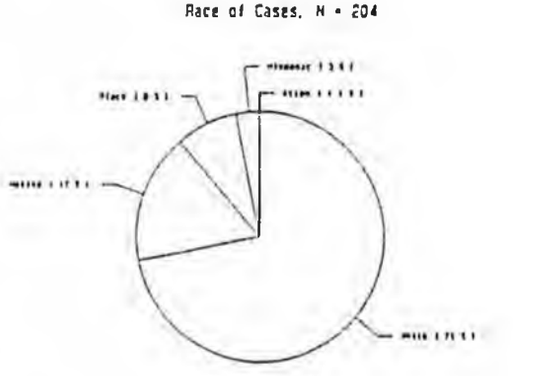
Through December 31, 1993, 204 Alaskans have been confirmed to have AIDS. Of these, 122 are known to have died. Of the 204 AIDS cases, 182 are in males and 22 in females. Data below employ the 1993 Expanded Case Definition for AIDS. All cases are shown as diagnosed in the year the person first met the revised case definition. Residence at time of diagnosis will now be shown by census area.



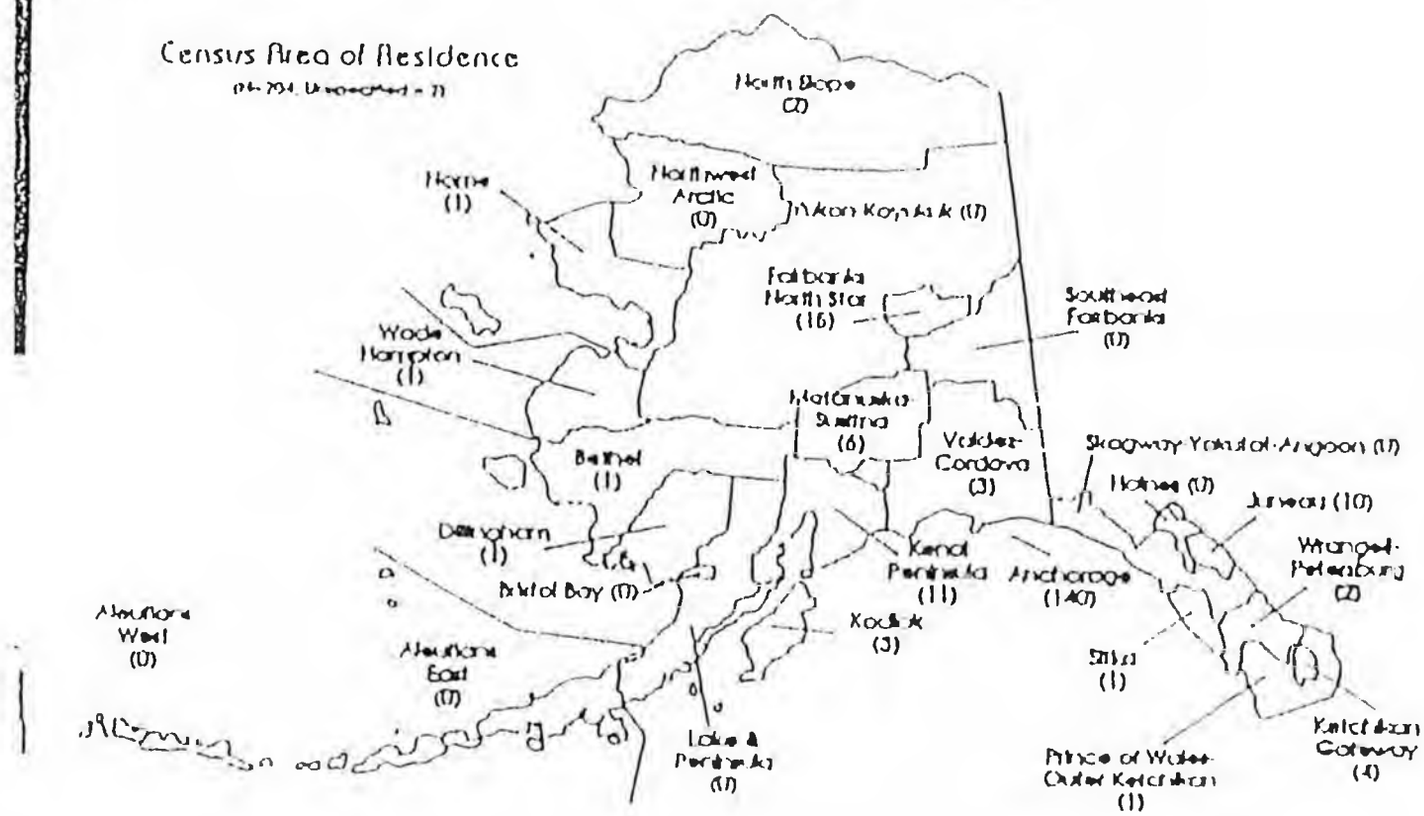








[1]The category "other" includes heterosexual contact with persons(s) of unknown risk, occupationally exposed health care workers, and persons for whom risk factor has not been determined.


Census Area of Residence
North Slope
(2)
Northwest
Arctic
(0)
Nome
(1)
Wade
Hampton
(1)
Fairbanks
North Star
(16)
Southwest
Fairbanks
(1)
Matanuska-
Susitna
(6)
Valdez-
Cordova
(3)
Bethel
(1)
Dillingham
(1)
Bristol Bay (1)
Kenai
Peninsula
(11)
Anchorage
(140)
Skagway-Yakutat-Angoon (1)
Haines (1)
Juneau (10)
Wrangell-
Petersburg
(2)
Aleutians
West
(0)
Aleutians
East
(1)
Kodiak
(3)
Sitka
(1)
Lake &
Peninsula
(1)
Ketchikan
Gateway
(4)
Prince of Wales-
Outer Ketchikan
(1)

Support HB 320

THE HIGH "COST" OF INADEQUATE HEALTH EDUCATION

FACT SHEET
1993

ADOLESCENT HEALTH

- 219 Alaskans, ages 10 -19 years old were infected with gonorrhea in 1991
- 1,133 teens gave birth in Alaska during 1990, including 426 in Anchorage
- In 1989, 6.3% of all births to teens in Alaska produced low-birthweight babies, 13.7% in Anchorage

COST TO ALASKA

- Teen mothers in Alaska cost the taxpayers $4 million in 1989
- Alaska families, begun when the mother was a teenager cost Alaska taxpayers $51.4 million in 1988 alone
- U.S. taxpayers paid $19.83 billion in 1988 to support families started by teen parents

---

TEENAGE SEXUAL BEHAVIOR: A CHALLENGE TO BREAK THE CYCLE

12 MILLION U.S. TEENAGERS ARE SEXUALLY ACTIVE

- In the United States, 53% of teen girls aged 15-17 have had intercourse at least once.
- 60% of sexually active teen women aged 15-19 in the U.S. have had two or more sexual partners.
- 1,281 teens requested birth control from the Municipality of Anchorage (MOA) Family Planning Clinic in 1991. This does not include those receiving birth control elsewhere or those not using any protection.
- Nationally, 44% of all adolescent girls will experience one pregnancy before the age of 20.
- 84% of teenage pregnancies in the U.S. are unintended.
- 430 teens had pregnancy tests in 1991 at the MOA Family Planning Clinic. This accounted for 35% of all pregnancy tests performed there that year. Home pregnancy tests or tests at other facilities are not included.
- An estimated 14% of all national teen pregnancies end in miscarriage and 40% end in abortion.

CHILDREN ARE HAVING CHILDREN: 3 A DAY IN ALASKA

- In 1990, 1,133 teenagers, or 3 a day, gave birth in Alaska. Of these, 17 were under 15 years old.
- Of those 1,133 teenagers who gave birth, 426 were from Anchorage. Six of these were under 15 years old.
- The birthrate for U.S. teens 15-17 was higher in 1989 than in any year since 1974; 19% higher than in 1986.
- Nationally, approximately 50% of teen births are out of wedlock. In Alaska, 65% of teen births are out of wedlock. In the U.S. only 4% of unmarried teenagers who give birth place their babies up for adoption.
- Seven in ten births to teens result from unplanned pregnancies.

HEALTH RISKS TO TEENS AND THEIR BABIES

- The number of babies who die during their first 12 months is much higher among babies born to teen mothers.
- Primary reasons for poor health among children of adolescents are inadequate prenatal care and nutrition.
- In 1989, only 59% of Alaska teens reported adequate prenatal care, 67% in Anchorage.

TEENAGERS AND RISKS OF DISEASE

- 2.5 million teenagers contract sexually transmitted diseases (STD's) annually in the United States.
- Sexual activity prior to age 20 increases the risk of cervical cancer.
- Teens are more susceptible to STD's due to increased probability of multiple partners and immaturity of cervical cells.
- Chlamydia represents the most prevalent STD in the U.S., infecting about 4 million people per year. Adolescents have the highest rate of chlamydial infection and associated complications such as pelvic inflammatory disease, ectopic pregnancy and infertility.
- In 1991, the MOA Family Planning Clinic screened 947 teens of which 203 had abnormal pap smears.
- Nearly one million cases of genital warts are believed to occur each year. One study found that 38% of sexually active teens examined were infected with genital warts.
- In 1991, 20 cases of gonorrhea occurred among 10 - 14 year olds in Alaska.
- Teens aged 15-19 accounted for 23% (or 199) of the total Alaska gonorrhea cases in 1991.
- 24% of Alaska's AIDS cases occur in 20 - 29 year olds. Given the average time of 10 years from HIV infection to AIDS, many of these people were probably infected as teens.

PREGNANT AND PARENTING TEENS SUFFER ACADEMIC FAILURE AND POVERTY

- Teen mothers frequently find it difficult to return to school due to unavailability of child care.
- Nationally, 60% of teen mothers drop out of school.
- Teens who drop out of school are more likely to have successive pregnancies.
- In 1987, 18% of births to teens in Alaska were second or subsequent births; 28.2% in Anchorage.
- Public funds pay for the delivery costs of at least 1/2 of births to teenagers.

HOW CAN WE DECREASE THE RISKS OF TEEN PREGNANCY?

1. Provide health education at home and through schools, religious groups, youth agencies and the media. Education should include:
   - Facts about the biology of fertility and reproduction
   - Information about the emotional and physical aspects of sexual activity including the increased risk of cervical cancer with early intercourse
   - Support for the decision not to have sexual intercourse
   - Discussion about responsible decision making
   - Support to foster the development of self-confidence and healthy self-esteem
   - Factual information about birth control and where it is available
   - Facts about the current epidemic of sexually transmitted diseases to include HIV infection (AIDS)
   - Parenting courses for parents of teenagers and teenage parents
2. Expand the availability of confidential birth control services for sexually active teenagers.
3. Provide quality medical care with emphasis on early prenatal care and proper nutrition for young mothers and their babies.
4. Offer unbiased information and appropriate referrals for those pregnant teens who choose not to become parents.
5. Assure continuing education, social services, and job training for teen parents.

DATA SOURCE:

Alaska vital statistics - (1988-91); Children's Defense Fund; National Center for Health Statistics; U.S. Facts in Brief- The Alan Guttmacher Institute - 1993; MOA, DHHS, Family Planning Program - Statistics 1990-91; State of AK - Epidemiology; MOA, DHHS, Adolescent Outreach Information Sheet,1987; Center for Population Options 1990

Prepared by: Family Planning Advisory Committee
Municipality of Anchorage, Department of Health and Human Service
Family Planning Program
825 "L" Street
Anchorage, Alaska 99501
Telephone: (907) 343-4623

AWARENESS, UNDERTANDING AND PREVENTION
NORTON SOUND REGIONAL HIV CONFERENCE

BERING STRAIT HIV/AIDS TASK FORCE
December 22, 1993

A resolution calling for all of the Bering Strait Region residents to be educated and made aware of HIV and AIDS.

Whereas; due to the high rates of Alaska's teen pregnancy, sexuality, alcohol and substance abuse - which leads to high risk and self destructive behavior, child molestation, sexual assault, and sexually transmitted diseases, and

Whereas; 489 Alaskans have been diagnosed as HIV positive and it is estimated that this number is only 10% of Alaskans who are HIV positive. This means that 90% of the people who are HIV positive in Alaska are not aware of their HIV status and

Whereas; 1,000,000 tourists and seasonal workers come to Alaska each year, many of them engaging in high risk behavior and certainly bringing the AIDS virus into our communities.

Therefore be it resolved; whereas the residents of our Bering Strait Region are severely vulnerable to the AIDS epidemic and that HIV/AIDS education, understanding and awareness concerning transmission and prevention is vital and critical to our communities and whereas there is presently nor in the forseeable future no cure, the spread of this virus can lead to death and the destruction of our communities.

Therefore be it further resolved; that we strongly urge all people of the region to take a stand, be responsible and suppport preventive activities and be equally supportive of persons living with HIV/AIDS and that the governing bodies of the Bering Straits region will explore and support strategies and interventions to meet the needs that are arising and that will have an impact on the people of the region by this epidemic.

Directed to:
NSHC Board of Directors
Kawerak Board of Directors
BSSD Board of Directors
Nome-Beltz School District Board of Directors
Bering Straits City Governments
Bering Straits IRA Governments
Bering Strait Corporation Governments
Alaska State Legislature
Governor Hickel

Get smart about AIDS education

'Healthy Students Act' must pass

It's a simple, four-page bill with a relatively tiny $39,400 price tag. Yet the "Healthy Students Act," which orders AIDS education in Alaska, is one of the most critical bills facing the Legislature this year.

Here's why: AIDS is a totally preventable disease that continues to spread and continues to kill.

Our state, our communities and our families are not immune. By the end of last year, 204 people in Alaska had been diagnosed with AIDS. Of those, 122 had died. At least 500 more have HIV, the human immunodeficiency virus that causes AIDS.

The key provision of the measure, House Bill 320, would order school districts throughout the state to set up health curriculums that include instruction on AIDS and HIV.

There's really nothing complicated about the bill. The more students learn about AIDS and HIV, the more they'll do to prevent infection.

Considering that the AIDS epidemic already has killed more Americans than the Korean, Vietnam and Gulf Wars combined – and considering that many people, especially young people, continue to have unprotected sex – trying to stop the spread of the virus is imperative.

Unfortunately, the politics surrounding the bill aren't as clear-cut. Because some people are uneasy about sexual issues, some lawmakers apparently are hesitant about ordering AIDS education.

But the bill, drafted by Rep. Cynthia Toohey, R-Anchorage, and co-sponsored by a mixture of Republicans and Democrats, has been written to ease those political fears. School districts, for example, would be required to seek permission from parents before beginning AIDS or other sex-education instruction. Parents who object could keep their kids out.

The measure also calls on individual school districts to determine what's appropriate for different age groups. In other words, each community can help decide the level of AIDS education most appropriate for its students.

In some districts, like Juneau, such decisions already have been made; AIDS education is part of the curriculum. But a state law would guarantee that *all* Alaska students, except those whose parents object, would learn about AIDS in school and, more important, its prevention.

The bill finally moved out of the House Health, Education and Social Services Committee this week, after much hesitation, and awaits a hearing in House Finance. From there, it must win approval on the House floor, then make it through the Senate and be signed into law by the governor. It's a long path, but only short-sightedness stands in the way.

Anyone who needs further convincing can simply look at some of the statistics:

- The state Department of Health and Social Services reported in 1990 that, of 5,458 Alaska students surveyed, 73 percent of females and 67 percent of males said they'd had sexual intercourse by the 12th grade.
- Of those Alaskans with full-blown AIDS, 25 percent likely contracted the disease as teen-agers.
- Of the 498 HIV cases reported in Alaska at the end of 1993, 44 percent were among people age 20-29. That means many contracted the virus in their teens.
- The World Health Organization, citing 19 separate studies in six countries, concludes that education about condom use does *not* lead to earlier or increased sexual activity. In many cases, there was a decrease of sexual activity.
- In surveys taken by the state in 1988, 1990 and 1992, 96 percent of respondents said AIDS education should be taught in schools as part of a comprehensive health program. Yet in 1992, only 78 percent of parents said they'd discussed AIDS with their school-age children. Just 52 percent reported that their kids had received AIDS education in school.
- The National Conference of State Legislatures reports that, in 1992, the percent of AIDS cases grew most rapidly among American Indians and Native Alaskans.
- So far, AIDS/HIV education is mandated in 33 other states.

Who, then, would vote against House Bill 320? Worse, which lawmakers would kill the measure through procedural delays, requests for more study or other political moves designed to prohibit an up-or-down vote on the issue?

Alaskans should watch closely.

TIPS AND INFORMATION FROM YOUR INTERNIST, A SPECIALIST IN ADULT MEDICAL CARE

SPRING 1994

Inside HEALTH

JOHN KREHLIK, M.D. JOHN ALLEN M.D. ANGELA HIND, M.D.

JUNEAU MEDICAL CLINIC 9309 Glacier Highway Juneau AK 99801 (907) 789-3700

difference between life and death.

AIDS Update

NEW PATTERNS EMERGING FOR FEMALES

As it has since the beginning of the epidemic, AIDS in the U.S. remains a scourge mainly associated with males who use intravenous drugs or have homosexual sex. Nevertheless, women represent a growing proportion of Americans with this incurable disease. Recently released figures show that in 1992, cases of AIDS in women jumped 9.8%, while cases in men rose just 2.5%. In addition, data indicate that today a woman is more likely to develop AIDS as a result of heterosexual intercourse than from intravenous drug use.

The growing numbers of women with AIDS should concern us all. Because women infected with HIV, the virus that causes AIDS, can pass the virus on to their unborn children, the health of two generations is under attack. And the fact that more women contract AIDS today from male-female sex than from intravenous drug use indicates the entire heterosexual community is at risk.

To protect their health and the health of their children, women should take serious precautionary steps. Women of all ages in our practice need to learn about the sex and drug histories of their sexual partners. Aside from abstinence, your best defense against sexually transmitted diseases such as AIDS is the regular use of condoms, either the tradidonal male type or the new female condom.

For confidential information on how to keep yourself safe from AIDS, feel free to make an appointment with our office.

AIDS cases shoot up

Heterosexuals in the lead

By A.J. HOSTETLER
The Associated Press

ATLANTA — The number of new AIDS cases unexpectedly more than doubled last year under a broader definition of the disease and boosted by a sharp increase in the number of infections among heterosexuals.

The federal Centers for Disease Control had projected 1993 AIDS cases would jump 75 percent in the first year of the new definition. It actually increased by 111 percent, from 49,016 in 1992 to 103,500 in 1993, the agency reported Thursday.

Last year, the CDC expanded its definition to include those infected with HIV who also have a severely suppressed immune system, tuberculosis, recurrent pneumonia or invasive cervical cancer.

Most of the AIDS cases under the new definition were reported in the first three months of the year. The surge had dropped off by the end of 1993, and the CDC expects the number in 1994 cases to drop below last year's figure.

The groups most affected by the expanded definition were women, blacks, heterosexual intravenous drug users and hemophiliacs.

The increase was greater among women (151 percent) than among men (105 percent), and greater among blacks and Hispanics than whites.

The largest increases reported were among teens and young adults, mostly from heterosexual transmission.

AIDS cases resulting from heterosexual contact jumped 130 percent last year over 1992, from 4,045 to 9,288.

Overall health of nation's youth gets low grades

By CASSANDRA BURRELL
The Associated Press

WASHINGTON — If children and adolescents were graded on their overall health they would get barely a passing grade from a nonprofit group that studies American health habits.

They would earn just a "C-," the American Health Foundation said in its second annual Youth Health Report Card.

Large numbers of minors continue to hurt themselves by using tobacco, alcohol and illegal drugs or eating too much dietary fat, the group said.

Too many don't exercise enough, the report said. Only 42 percent participate in daily school physical education programs.

And too many contract avoidable infections, have high cholesterol or find themselves with sexually transmitted diseases.

"Last year, the overall grade was a 'C-.'" the group said. "Not only did the overall grade fail to improve at all this year, but in some specific areas the grade dropped dramatically."

The 1993 assessment was released in advance of today's observance of Child Health Day, a yearly tradition started 65 years ago during Calvin Coolidge's administration.

The country "certainly cannot point to the accumulative below-average grade with any sense of pride or accomplishment," foundation President Ernst Wynder said. "I hope our report card is a wake-up call for parents, health educators and others who are responsible for helping to convey the message of preventive medicine to our children."

The foundation graded 65 categories after analyzing information primarily from government-sponsored studies on nutrition, immunization, teen pregnancy, infant mortality, communicable diseases, injuries and tobacco, alcohol and drug use.

About one-fourth of U.S. children are overweight, earning them a "C" in that area.

The nation's youth got a "D" in the AIDS category. There were 771 new AIDS cases among children age 13 and under in 1992, the foundation. In 1985, there were 128 new cases.

Overall health of nation's youth gets low grades

By CASSANDRA BURRELL
The Associated Press

WASHINGTON — If children and adolescents were graded on their overall health they would get barely a passing grade, from a nonprofit group that studies American health habits.

They would earn just a "C-," the American Health Foundation said in its second annual Youth Health Report Card.

Large numbers of minors continue to hurt themselves by using tobacco, alcohol and illegal drugs or eating too much dietary fat, the group said.

Too many don't exercise enough, the report said. Only 42 percent participate in daily school physical education programs.

And too many contract avoidable infections, have high cholesterol or find themselves with sexually transmitted diseases.

"Last year, the overall grade was a 'C-,'" the group said. "Not only did the overall grade fail to improve at all this year, but in some specific areas the grade dropped dramatically."

The 1993 assessment was released in advance of today's observance of Child Health Day, a yearly tradition started 65 years ago during Calvin Coolidge's administration.

The country "certainly cannot point to the accumulative below-average grade with any sense of pride or accomplishment," foundation President Ernst Wynder said. "I hope our report card is a wake-up call for parents, health educators and others who are responsible for helping to convey the message of preventive medicine to our children."

The foundation graded 65 categories after analyzing information primarily from government-sponsored studies on nutrition, immunization, teen pregnancy, infant mortality, communicable diseases, injuries and tobacco, alcohol and drug use.

About one-fourth of U.S. children are overweight, earning them a "C" in that area.

The nation's youth got a "D" in the AIDS category. There were 771 new AIDS cases among children age 13 and under in 1992, the foundation. In 1985, there were 128 new cases.

Sec. 14.08.115. Advisory school boards in regional educational attendance areas. (a) A regional school board shall establish advisory school boards in each community in the regional educational attendance area that has more than 50 permanent residents, and by regulation shall prescribe their manner of selection and organization, and, in a manner consistent with (b) of this section, their powers and duties.

(b) An advisory board shall advise the regional school board on all matters concerning schools in the community in which the advisory board is established. (§ 2 ch 24 SLA 1979; am §§ 6, 7 ch 173 SLA 1990)

Sec. 14.30.360. Curriculum. (a) Each district in the state public school system shall be encouraged to initiate and conduct a program in health education for kindergarten through grade 12. The program should include instruction in physical health and personal safety including alcohol and drug abuse education, cardiopulmonary resuscitation (CPR), early cancer prevention and detection, dental health, family health, environmental health, the identification and prevention of child abuse, child abduction, neglect, sexual abuse and domestic violence, and appropriate use of health services.

(b) The state board shall establish guidelines for a health and personal safety education program. Personal safety guidelines shall be developed in consultation with the Council on Domestic Violence and Sexual Assault. Upon request, the Department of Education, the Department of Health and Social Services, and the Council on Domestic Violence and Sexual Assault shall provide technical assistance to school districts in the development of personal safety curricula. A school health education specialist position shall be established and funded in the department to coordinate the program statewide. Adequate funds to enable curriculum and resource development, adequate consultation to school districts, and a program of teacher training in health and personal safety education shall be provided. (§ 1 ch 188 SLA 1976; am § 1 ch 106 SLA 1978; am § 1 ch 87 SLA 1984; am § 1 ch 24 SLA 1986)

Issue No.8 – April 1994

PTA BULLETIN

IN THIS ISSUE

Alaska PTA Convention April 28-30 Egan Convention Center Anchorage

National PTA Convention June 12-15 Las Vegas, Nevada

Keeping Teens Safe from HIV-Aids

By: Rockey Plotnik, Health Educator, Department of Education

"Schindler's List" is a powerful film about a man who risked his life to save 1,000 Jews from Nazi gas chambers. He was an unusual person because he broke through the denial about the death camps and he took action which resulted in the saving of human lives.

As a parent I am writing this article to create a sense of urgency among parents that HIV prevention is necessary in our homes and schools in order to save our children's lives. Like Oskar Schindler, we must be willing to break through our denial about HIV (the virus that causes AIDS) and take action which will result in our children leading long, healthy, productive lives. I cannot imagine anything worse than watching one of my children die a needless death and I believe that other parents, once they see the evidence, will agree we must act to prevent the nightmare from becoming a reality.

Our actions can be two fold. First, we can bring up the topic with our kids. It might be embarrassing, but no one has died of embarrassment. To prepare ourselves for the "discussion" we can learn the facts. The PTA will be sending materials to assist with this. Second, we can support age-appropriate HIV prevention in our schools. An abstinence-based program with an emphasis on posponement of sexual involvement is a sound approach, with condoms being mentioned as being safer than nothing, for those who have chosen to be sexually active.

Oskar Schindler was one person who was able to save 1,000 lives. Think of the lives we can save when we accept the challenge to take action by talking with our kids and supporting HIV prevention in the schools. The holocaust is considered to be one of history's darkest hours. Let's prevent the HIV epidemic from becoming another holocaust.

CHRISTIANITY TODAY

1994 Book Awards

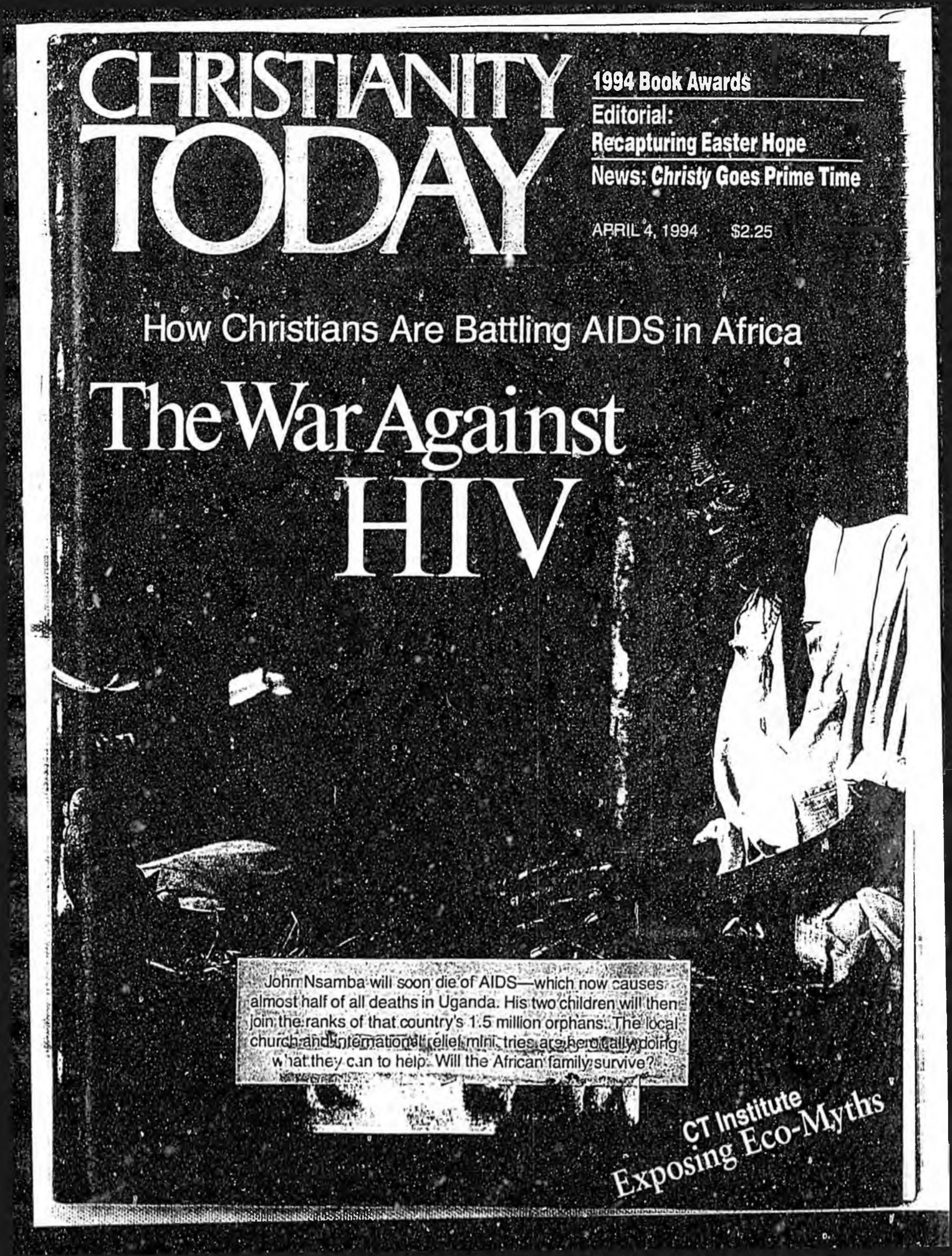
Editorial:
Recapturing Easter Hope

News: *Christy* Goes Prime Time

APRIL 4, 1994 $2.25

How Christians Are Battling AIDS in Africa

The War Against HIV

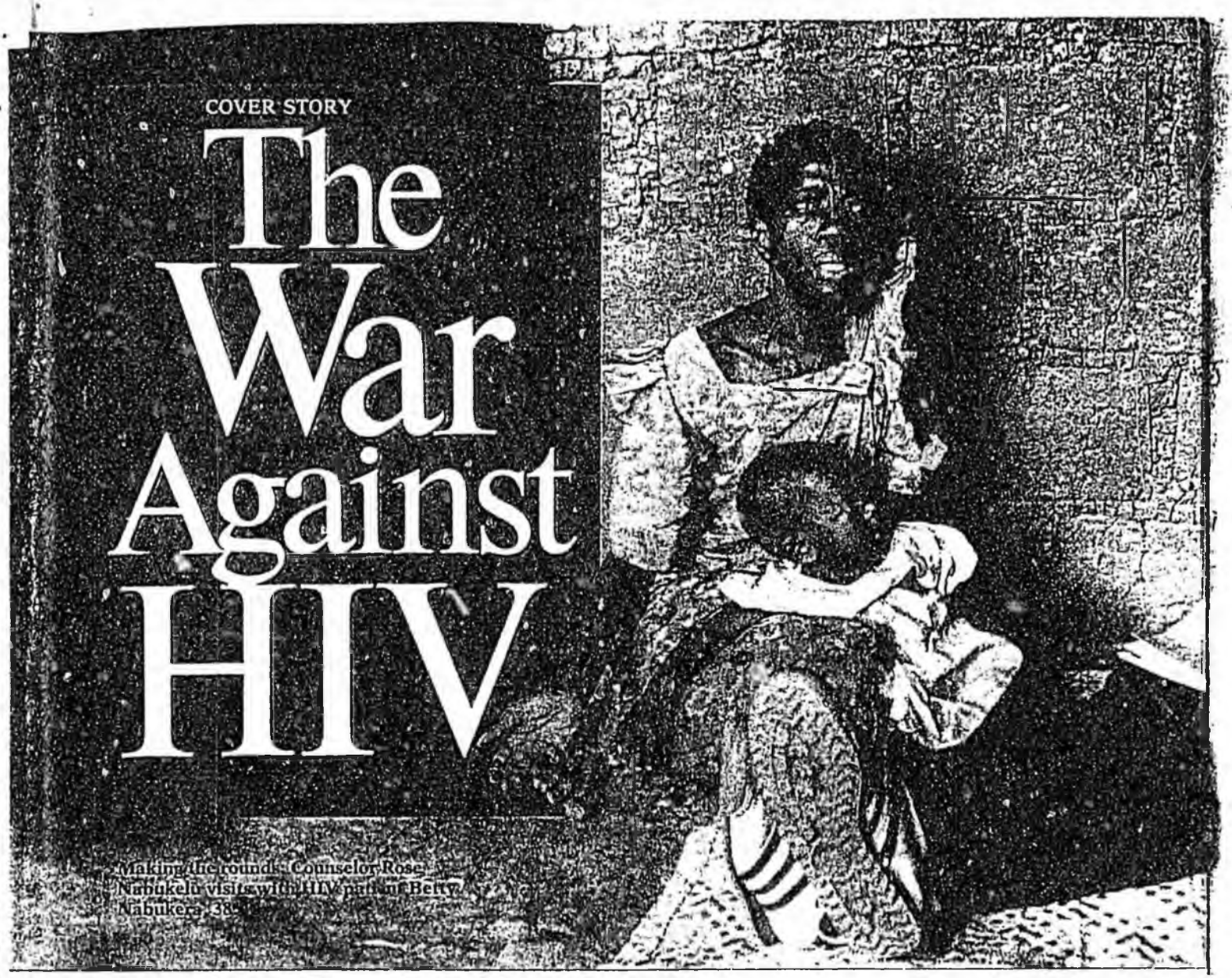


John Nsamba will soon die of AIDS—which now causes almost half of all deaths in Uganda. His two children will then join the ranks of that country's 1.5 million orphans. The local church and international relief ministries are frantically doing what they can to help. Will the African family survive?

CT Institute
Exposing Eco-Myths

COVER STORY

The War Against HIV



Making the rounds: Counselor Rose Nabukelu visits with HIV patient Betty Nabukera (38).

ALL PHOTOS: CHUCK BIGGER

Ugandans are learning a new way to fight AIDS. Christians are

John Nsamba waits outside his mud hut deep in the Ugandan hill country, knowing he soon will be among those buried in the banana groves that blanket the landscape with lush greenery.

"Slim," the euphemistic term that Ugandans have given to the disease of AIDS, has aged him so significantly that Nsamba easily looks 20 years older than his 42-year-old body.

With their mother and eldest brother already dead, the three remaining Nsamba children will be without immediate family, land, or household, because their father has been a tenant farmer. Vincent, who at 18 is the eldest child in the household, covers his face and sobs into his red T-shirt at the prospect of assuming the role of head of household when his father dies. His sister, meanwhile, cares for their younger sibling and attends a nearby primary school.

In this equatorial African country of 18 million, nearly every Ugandan family, whether rural or urban, rich or poor, Christian or Muslim, has been visited by the AIDS epidemic. AIDS has been no respecter of persons, infecting the dirt-poor families in rural villages as well as those residing in the plush compounds on Kololo, one of the seven hills within Kampala, the capital city of 800,000.

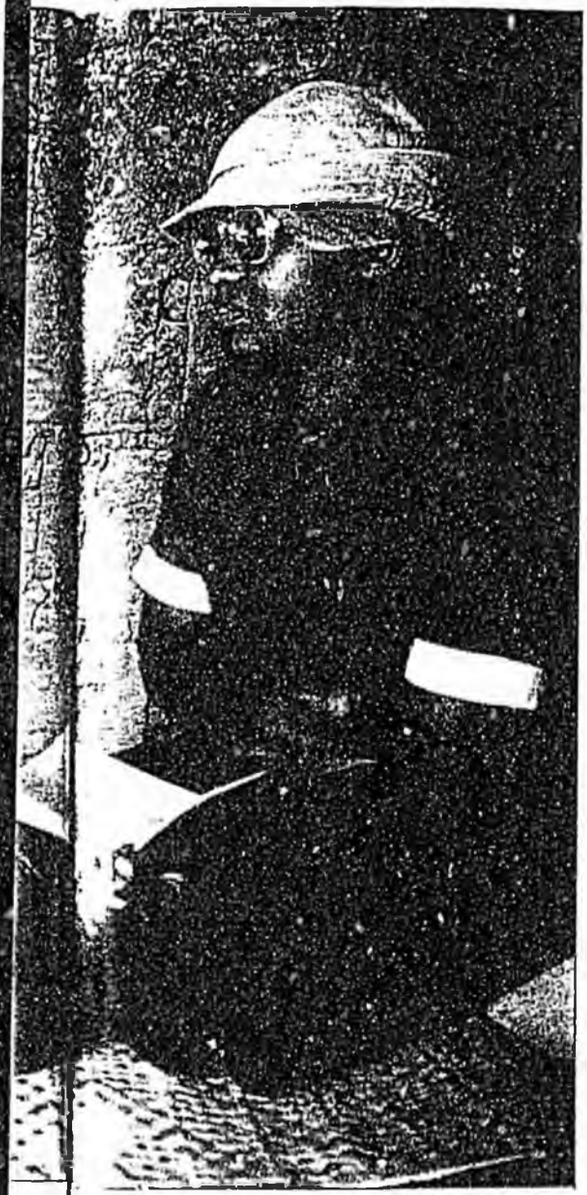
One in six

In 1988, five years after HIV was discovered in Uganda, scientists sampled the blood of 11,000 people and found that 1 in 16 was HIV positive. Today, it is estimated that 1 in 6 is HIV positive. The worldwide rate is 1 in 250, with 90 percent of new infections coming via heterosexual transmission. In Rakai, a southwestern district of 350,000, seropositive rates of 50 percent can be found in village and trading areas.

The AIDS Weekly, published by the Centers for Disease Control in Atlanta, reports that nearly 2 million Ugandans carry HIV, and there are an estimated 300,000 with AIDS symptoms.

Speaking on state-run Ugandan radio, Elizabeth Madra, a physician active in the AIDS Control Program, warned last year, "The nation is in danger of losing most of its people." Although Uganda has one of Africa's highest birth rates (3.4 percent annually), researchers project that the country's population-growth rate could reach zero by 2002 and decline thereafter, due primarily to AIDS. A 1993 study by the Uganda Virus Research Institute and the Medical Research Council found that half of all adult deaths in a region of 15 rural villages were in seropositive individuals.

Other studies show transmission is spreading widely among teenage girls. Of 2,000 Kampala teens hospitalized in



ıre showing them how.

DIANE FISHER

1992 for AIDS, 300 were male and 1,700 were female. Health officials are watching transmission rates in teens closely, because 57 percent of the population is under age 16. There are an estimated 1.5 million children who have lost at least one parent, putting extraordinary stress on the traditional extended family. The hardest-hit rural areas are populated mostly by the very young and very old. A generation of breadwinners has already succumbed to the epidemic.

Ugandans, unlike other African peoples, and in many ways like no other populace in the world, have engaged their common enemy and are responding to the HIV crisis with a warlike mobilization. The Uganda government, still laboring to overcome the 17 years of internal war that ended in 1986, has actively encouraged Christians and other religious leaders to be on the frontlines in the war against HIV.

The result has been an unprecedented level of cooperation among government bureaucrats, religious leaders, international relief agencies, and medical researchers. Although sharp, sometimes angry, debates occur with regularity over condom use, the role of traditional medicine, and other issues, many Ugandans realize they are waging a battle for their country's viability. Even the army is involved and has issued T-shirts that say, "National Resistance Army. AIDS kills. Avoid casual sex."

Duggan

Whether working in orphan care, medical research, public-health education, or hospital treatment, Ugandans are using what they call a "multisectoral" approach against the virus. The two-year-old national AIDS Commission, composed of government, community, religious, and medical leaders, is being replicated in 39 districts around the country so that leadership from each distinctive sector of society is actively engaged in combating the spread of HIV.

On the edge

As the country's survival instinct has kicked in, Uganda has unexpectedly found itself on the cutting edge in program development for changing the behavior of its people. HIV prevention is being incorporated into schools, churches and mosques, workplaces, and the news media as the number one policy objective. Because literacy levels are low in many areas, there has been a dramatic turn toward the arts—song, drama, poetry, storytelling, painting—as a means of coping with the emotional dynamic of death and dying, reinforcing behavior change, and in-patient care.

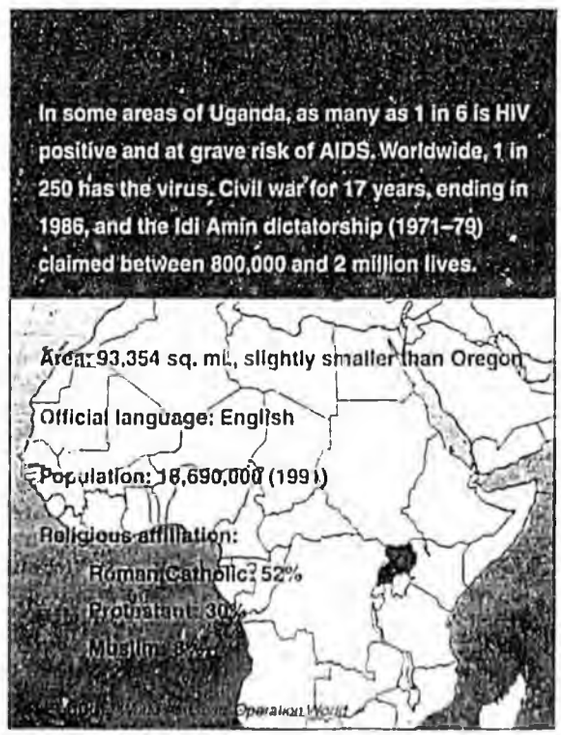
Recently Michael Cassidy, a leading evangelical from South Africa, noted why Africans are becoming more resourceful. "It is becoming evident that Africa is being marginalized in terms of aid and compassion priorities from the rest of the world," he said. "Africans are seeing that we are basically on our own. This means a new sense of responsibility for our own destiny."

At the surface level, Kampala appears to be a capital city quickly recovering from years of armed conflict that began in 1971 with Idi Amin's reign of terror. In 1990, a new Sheraton hotel opened and already is swollen with Western tourists. Retail stores are filled with eager consumers. Among other factors, one of the country's present economic worries is the falling value of the U.S. dollar, which has the unwelcome side effect of decreasing the value of foreign assistance.

Below the surface, however, Kampala's private pain can be seen. Not far from the city center, Hussein Seemuyamba, 22, and his crew of five workers, ages 9 to 18, make wooden coffins seven days a week. Seemuyamba has made coffins since 1988 and became shop manager when the owner died in 1992. At one time, they would make only coffins to order. Today, they work continuously, and every coffin sells, costing between $30 and $150.

As in most other parts of the world, condom use had engendered the sharpest debate in Uganda. Hardly a day passes when the leading, state-run newspaper, *New Vision*, does not publish an article pitting condom-use advocates against the "anti-condomites," as they are labeled here.

The debate over condom use and the place of sexual abstinence has created unexpected alliances within the Ugandan people. Born-again Christians find



Rural condom sales: With average incomes of $5 a month, most people go without.

themselves in harmony with African traditionalists and Roman Catholics. Some Anglicans, academics, and medical professionals end up allied with business and government leaders and the press, favoring "quiet promotion" of condom use in addition to stressing sexual abstinence. "Human beings are human beings," explains David Sentamu, Masaka district administrator, defending the government's policy.

Patient care

Ugandan studies have shown that the greatest risk factor in HIV transmission is location. And in the war against HIV, there is no battle line more evident than in the Masaka and Rakai regions.

Kay Lawlor, an American doctor working at Kitovu mission hospital in Masaka, a city of 100,000, changed her whole approach to dealing with the epidemic one day when a mother burst into tears on hearing that she did not have HIV. "She said, 'Now we will get no help,'" Lawlor recalls. "That went right through me. Help should not depend on the diagnosis. It should depend on the need of the person. It says something not so nice about society when it would be better to have AIDS so that you can get help."

Many relief workers, in their intense focus on those suffering with AIDS, have unwittingly put AIDS into an exclusive category. Meanwhile, other individuals are just as sick from malaria, tuberculosis, and a rogue's gallery of other communicable diseases.

To combat this, most hospitals do not segregate AIDS patients. They focus treatment on aggressively fighting the infections that come as HIV weakens a person's immune system.

In Kampala, Miriam Duggan, the outgoing medical director at Nsambya Hospital, which, with 360 beds is the second-largest in the country, has put together a well-trained force of counselors who visit AIDS patients in their homes. One counselor, Christine Namuteei, says, "When we go with food and drugs, there is a great sigh of relief." Most hospitals have taken the additional step of assisting AIDS patients in setting up "income-generating projects." After receiving a small amount of capital, patients will buy and sell charcoal, chickens, or mats.

At Mengo Hospital, run by the Anglican church and the oldest hospital in East Africa, HIV-positive women gather for a weekly support group on "living positively with HIV." Since the virus can remain dormant for many years, most people who are HIV positive do not realize it. When they eventually find they are, severe depression is common. Counselors are trained to help individuals cope emotionally and to teach them how HIV is transmitted.

In most cases, hospitals are not using AZT or other costly and experimental AIDS drugs. The money to pay for such drugs does not exist. Yet, Uganda is one of the few places in the world actively using traditional or herbal treatments against diseases brought on by the virus. Mengo Hospital, with government encouragement, recently opened a clinic for "traditional healers" to offer its services in a conventional setting.

"There are quacks among both traditional healers and medical doctors," says John Rwomushana, who is special assistant to the National AIDS Commission. "But there is no cure for AIDS today. The majority of Ugandans know that there is no cure."

In the upcountry of north Uganda, where rebels and refugees are still a major concern, Edith Wakumire and other Christian women formed Uganda Women Concerned Ministry, an interdenominational group, to educate people in rural villages and to care for orphans. A large grant from the AIDS Care Education and Training program, based in London, has helped set up the program. Wakumire says a family is thrown into turmoil when a husband dies of AIDS. In one case, she says, a man died leaving five wives, one of whom committed suicide. A total of 22 children had to be absorbed by the clan.

A generation of orphans

In unison, the cries of young black children fill the room: "Oh AIDS, why did you come? You destroyed the power of Africa. Where shall we go? You kill teachers. You kill doctors. You kill soldiers. You kill businessmen. Oh AIDS, where shall we go?"

So continues the litany that students, ages 7 to 16, at Masaka Baptist School have memorized. School officials keep a logbook showing that 50 percent of the 560 students have lost at least one parent, mostly due to the virus.

Masaka Baptist headmaster Vincent Lubega-Zaake says the rising number

Lawlor

Openu

of orphans has overtaxed families and clans. "When the number keeps growing, we wonder what are we going to do. Very few families are able to accept unrelated orphans into their homes."

With no free primary education in Uganda, education of orphans and other young children has proven to be a monumental task and been a major focus of international relief and child-development organizations.

In a region south of Masaka hit even harder by the AIDS epidemic, one school was closed because too many parents on committees had died. Jacques Masiko, Compassion International (CI) director for Uganda, says, "They were very desperate, and we had to help these people." Working with local leaders, CI and the African Rural Outreach and Development organization

helped to launch Mirembe Academy.

Living conditions for rural students can be very primitive. One household not far from Mirembe Academy is headed by Proscovia Naasiuun, her widowed aunt, and her widowed sister-in-law, whose husband is buried under banana trees next to their home. Proscovia has gained the admiration of Miremba headmaster Michael Katakbira. "I am very pleased that [she] encourages all orphans and widows who are in this clan to put some force behind going to school."

Uganda's cities are not friendly toward orphans and young children. At a church in the Nakulabye slum of Kampala, only four teachers in a child-development center care for 415 children. Administrator Carol Mastaba says 70 percent of the children live in one-room dwellings. She says the city hardens the personalities of orphans, causing them to have severe behavioral problems on top of frequent malnutrition and disease. The government has been overwhelmed by the magnitude of the problem and has yet to document the number and identity of orphans.

At the development center during a February Saturday morning, hundreds of young children were being prepared with Bic pens, notebook paper, and school uniforms for the next school term between sessions of singing American summer-camp songs: "Whose side are you dancing on? Dancing on the Lord's side!" accompanied by the boys' drum band.

Lessons for others?

Edward Delgado, CI's Africa director, says other countries, especially the United States, have a lot to learn from the Ugandan war against HIV.

"I feel extremely encouraged by what Uganda has done. They are taking ownership of the problem. They have identified the problem and are working at all levels," Delgado says. "Uganda, in fact, should be a model to the rest of the world. Even in surrounding countries, there is nothing that is as organized."

The methods that are successful include establishing parish-level health committees. Namirembe Anglican diocese in Kampala set up grassroots committees to engage an entire community in HIV education and prevention. Agatha Seuyimba, diocesan health officer, says, "We may not all be infected, but we are all affected. We say, take care of your neighbor."

John Ekudu, pastor of Kampala Baptist Church, says the church's youth group has formed the Cross and the Virus, an interchurch teens group. They send out drama teams to local secondary schools to show how lifestyle choices have long-term consequences.

Another group of youths organized an HIV program fundraising event. One day 200 teens from different areas of Kampala took hospital beds through the city streets, going from business to business asking for donations. Enough money was raised to donate funds to a dozen programs. "It's a case of trying to get them to do things and be creative as opposed to saying, 'You're bad. You can't change,' " says Nsambya Hospital's Duggan. "They have a national theme song of what they want to be. The words include the phrase, 'Arise, Arise. Live a healthy life. We build a new nation.' It's youth ministering to youth. Young people want to change, but they don't know how to start. We don't just look at sexual behavior—we look at honesty, truthfulness, integrity."

Richard Otto, a Conservative Baptist missionary for 14 years in Uganda, has watched the church grow dramatically in spite of HIV and the war years. "There is tremendous influx into the church. In 1983, we had 100 congregations. Now there are over 500 Baptist groups."

No family untouched: Pastor Asiali Mihanda has lost five daughters to AIDS.

He has been moved by the people's ability to care for one another. "If you are going to be sick, Uganda is the place to be," Otto says. "They know how to be with people. It's called 'the presence,' and it's very much a part of this culture. They know what to do."

Way of the Cross

The words have ancient roots, but the context is 1994 Africa: "We adore you, O Christ, as you carry your cross along the dusty roads of Masaka, Uganda. We make the way of the cross in the homes and at the bedside of those with AIDS. We bless you because through this suffering you have redeemed the world." Using a personalized wording of the Way of the Cross liturgy, each week AIDS counselors make their rounds in the villages of Masaka and Rakai.

A local batik artist has painted on large white cloth a person holding an AIDS patient dying in her lap, along with the words of the ancient Christian liturgy. Each station of the cross has a sufferer's name at a different stage of disease. Station ten: "Jesus is stripped of all his garments—They put her out of the house; kept her clothes, saying they wouldn't fit her wasted body. They told her to go to her grandmother's to die. Once there she was again rejected—stripped of all, even her right to belong. Juliet was returned to the hospital, like an unwanted commodity."

What the artist illustrated in rural Masaka is daily life in urban Kampala for Peruth Openu, who learned she had HIV after her husband "took another lady," as she delicately describes it.

Today "the home is in chaos," Openu says. Her teenage children, Andrew and Nathalie, face the prospect of losing both parents, and Peruth's sick husband, Nathan, requires constant care.

"When I think I am suffering and I don't deserve it, I think of the sufferings Jesus Christ underwent. He carried the cross. Each time I'm lifting my husband, it makes me love Jesus more than ever before," Openu says. "Andrew does look to God. Nathalie, she's angry. I tell her there is a greater Papa in heaven. The only hope I know is that God cares. He does when you cling to him. His promises are true."

By Timothy C. Morgan in Kampala.

HB320

LTNM 2-21-94

AZT slows transfer of HIV to newborns

The New York Times

WASHINGTON—A federally financed study has found that the drug AZT dramatically reduces transmission of HIV, the virus that causes AIDS, from infected mothers to their newborns, government health officials said Sunday.

The findings were considered so significant that the study, which began in April 1991, was ordered stopped on Friday, and officials are spending the holiday weekend notifying the 59 medical centers in the United States and France participating in the study to offer AZT to the pregnant women who had just been receiving a placebo.

In addition, said Dr. Anthony S. Fauci, the head of the National Institute of Allergy and Infectious Diseases, the data from the study were being distributed as a "clinic alert" through the National Library of Medicine, which has a computer network available to health care workers around the world.

Dr. Harold W. Jaffe, an epidemiologist and the top scientist on HIV at the Centers for Disease Control and Prevention in Atlanta, said in an interview Sunday that the finding was one "of major public health importance."

"It is the first indication that mother-to-child transmission of HIV can be at least decreased, if not prevented," he said, "and it will provide a real impetus for identifying more HIV-infected women during pregnancies so that they could consider the benefit of AZT treatment to themselves and their children," he said.

About 4 million women give birth in the United States each year, and the disease centers estimate that 6,000 to 7,000 of the women are HIV-infected. About 1,500 to 2,000 of their babies later become HIV-infected.

The transmission of the virus to newborns is a much bigger public health problem in developing countries in Africa, Asia and South America, where millions of people are infected and where infection rates among childbearing women can reach 10 to 30 percent in some areas, said Dr. James Curran, coordinator of all HIV activities at the disease centers. He added that in some areas of the United States, including some urban areas in the Northeast, the comparable figure is as high as 5 percent.

On average, about 25 percent of pregnant women who are HIV-infected pass along the virus to their babies. The researchers had confidence in the study because it found that 26 percent of newborns born to mothers who received a placebo bill during pregnancy were infected. But the infection rate was only 8 percent for those whose mothers received AZT, officials said.

The officials said that they could find no difference in the number and type of birth defects in babies whose mothers received AZT or the placebo. They added that there has been no significant health hazard among the children during the first 18-month follow-up period.

"This is a real breakthrough and it has worldwide implications," Curran said.

The development is another strange twist in the up-and-down reputation of AZT.

HB320

SAM BISHOP, Editorial Page Editor; 456-6661 (Ext. 274)

'Fairbanks Daily News-Miner'

Monday, March 28th, 1994

MAR 2 9 1994

from Rep Toohey

Please read ...

FAIRBANKS
Daily News - Miner
"Independent in All Things — Neutral in None"
Established in 1903
CHARLES L. GRAY, Publisher Emeritus — PAUL J. MASSEY, Publisher
SUE MATTSON, Managing Editor — JACK KREFLE, Asst. Managing Editor — SAM BISHOP, Editorial Page Editor

WHAT OTHERS SAY...

Mandatory AIDS education

It's a simple, four-page bill with a relatively tiny $39,400 price tag. Yet the "Healthy Students Act," which orders AIDS education in Alaska, is one of the most critical bills facing the Legislature this year.

Here's why: AIDS is a totally preventable disease that continues to spread and continues to kill.

Our state, our communities and our families are not immune. By the end of last year, 204 people in Alaska had been diagnosed with AIDS. Of those, 122 had died. At least 500 more have HIV, the human immunodeficiency virus that causes AIDS.

The key provision of the measure, House Bill 320, would order school districts throughout the state to set up health curriculums that include instruction on AIDS and HIV.

A state law would guarantee that all Alaska students, except those whose parents object, would learn about AIDS in school and, more important, its prevention.

The bill finally, after much hesitation, awaits a hearing in House Finance. From there, it must win approval on the House floor, then make it through the Senate and be signed into law by the governor. It's a long path, but only short-sightedness stands in the way.

Anyone who needs further convincing can simply look at some of the statistics:

The state Department of Health and Social Services reported in 1990 that, of 5,458 Alaska students surveyed, 73 percent of females and 67 percent of males said they'd had sexual intercourse by the 12th grade.

Of those Alaskans with full-blown AIDS, 25 percent likely contracted the disease as teen-agers.

Of the 498 HIV cases reported in Alaska at the end of 1993, 44 percent were among people age 20-29. That means many contracted the virus in their teens.

The World Health Organization, citing 19 separate studies in six countries, concludes that education about condom use does not lead to earlier or increased sexual activity. In many cases, there was a decrease of sexual activity.

In surveys taken by the state in 1988, 1990 and 1992, 96 percent of respondents said AIDS education should be taught in schools as part of a comprehensive health program. Yet in 1992, only 78 percent of parents said they'd discussed AIDS with their school-age children. Just 52 percent reported that their kids had received AIDS education in school.

The National Conference of State Legislatures reports that, in 1992, the percent of AIDS cases grew most rapidly among American Indians and Native Alaskans.

So far, AIDS/HIV education is mandated in 33 other states.

Who, then, would vote against House Bill 320? Worse, which lawmakers would kill the measure through procedural delays, requests for more study or other political moves designed to prohibit an up-or-down vote on the issue?

Alaskans should watch closely.

—Juneau Empire, March 6

State of Alaska Epidemiology

Bulletin

Department of Health and Social Services
Margaret R. Lowe, MEd, EdS, Commissioner

Division of Public Health
Peter M. Nakamura, MD, MPH, Director

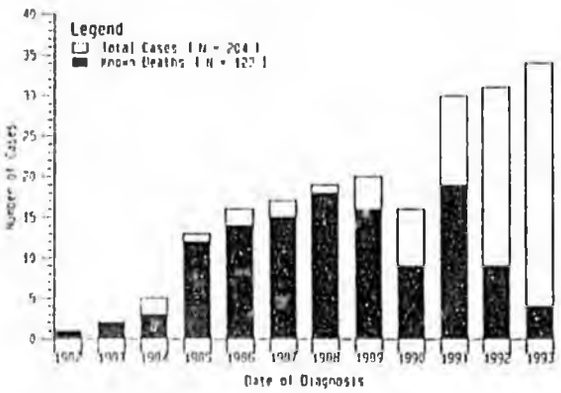
Section of Epidemiology
John Middaugh, MD, Editor

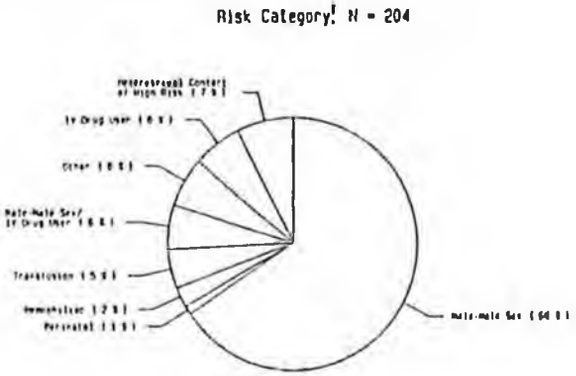
3601 C Street, Suite 576, P.O. Box 240249, Anchorage, Alaska 99524-0249 (907) 561-4408

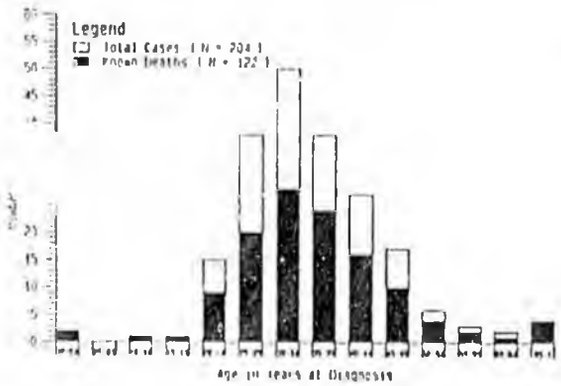
Bulletin No. 5 January 28, 1994

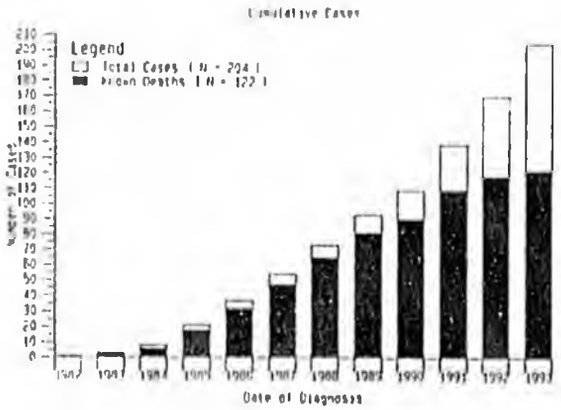
AIDS - ALASKA

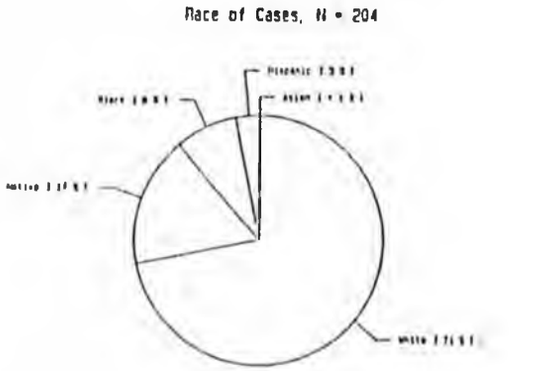
Through December 31, 1993, 204 Alaskans have been confirmed to have AIDS. Of these, 122 are known to have died. Of the 204 AIDS cases, 182 are in males and 22 in females. Data below employ the 1993 Expanded Case Definition for AIDS. All cases are shown as diagnosed in the year the person first met the revised case definition. Residence at time of diagnosis will now be shown by census area.



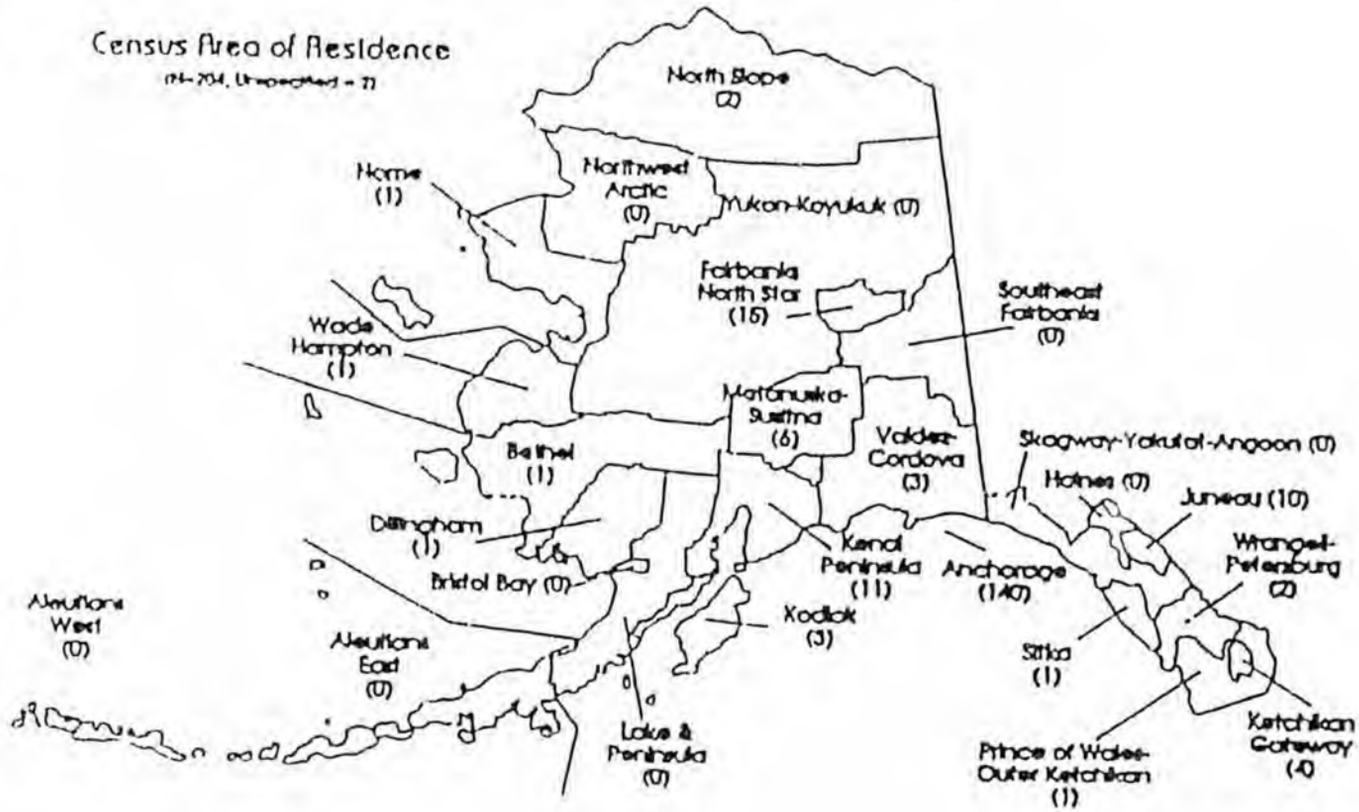








[1]The category "other" includes heterosexual contact with persons(s) of unknown risk, occupationelly exposed health care workers, and persons for whom risk factor has not been determined.


Census Area of Residence
North Slope (2)
Nome (1)
Northwest Arctic (0)
Yukon-Koyukuk (0)
Fairbanks North Star (15)
Southeast Fairbanks (0)
Wade Hampton (1)
Matanuska-Susitna (6)
Valdez-Cordova (3)
Skagway-Yakutat-Angoon (0)
Bethel (1)
Haines (0)
Juneau (10)
Dillingham (1)
Kenai Peninsula (11)
Anchorage (140)
Wrangell-Petersburg (2)
Bristol Bay (0)
Aleutians West (0)
Kodiak (3)
Sitka (1)
Aleutians East (0)
Lake & Peninsula (0)
Ketchikan Gateway (4)
Prince of Wales-Outer Ketchikan (1)

1/25/94 WESTLAW SEARCH - NEW YORK CASE--ALFONSO V. FERNANDEZ

Citation	Rank(R)	Page(P)	Database	Mode
---N.Y.S.2d----	R 1 OF 1	P 1 OF 43	NY-CS	TERM

1993 WL 540636 (N.Y.A.D. 2 Dept.)

(Publication page references are not available for this document.)

NOTICE: THIS OPINION HAS NOT BEEN RELEASED FOR PUBLICATION IN THE PERMANENT LAW REPORTS. UNTIL RELEASED, IT IS SUBJECT TO REVISION OR WITHDRAWAL.

> In the Matter of Ignacia ALFONSO, et al., appellants,
>
> v.
>
> Joseph A. FERNANDEZ, et al., Respondents.

No. 92-06950.

Supreme Court, Appellate Division,

Second Department.

Dec. 30, 1993.

Before BALLETTA, MILLER, EIBER, COPERTINO and PIZZUTO, JJ.

OPINION & ORDER

PIZZUTO.

Today, we hold that the respondents are prohibited from dispensing condoms to unemancipated minor students without the prior consent of their parents or guardians, or without an opt-out provision. Condom distribution in the public schools is a health service rather than health education and thus, in the absence of a provision requiring the prior consent of unemancipated minor students' parents or guardians, or in the absence of an opt-out provision, lacks common-law or statutory authority. In addition, the respondents' plan to dispense condoms to unemancipated minor children without the consent of their parents or guardians, or an opt-out provision, violates the civil rights of the parent petitioners and similarly-situated parents or guardians under the substantive due process clauses of the Fourteenth Amendment of the United States Constitution and New York Constitution, article I, s 6.

THE FACTS

In September 1987 the New York State Commissioner of Education directed all elementary and secondary schools to include, as part of health education programs, instruction concerning the Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS) (see, 8 NYCRR 135.3(b)(2); (c)(2)). In late 1990, Joseph Fernandez, then Chancellor of the New York City Board of Education, suggested enlarging the existing HIV/AIDS curriculum to impart additional education about the transmission and prevention

of HIV/AIDS. The former Chancellor also suggested that condoms be made available to high school students upon request. On February 27, 1991, the New York City Board of Education voted to establish an expanded HIV/AIDS Education Program in New York City's public high schools, consisting of two components.

The first component calls for classroom instructions on various aspects of HIV/AIDS. Each public high school is required to adopt a curriculum which incorporates lessons on the various means by which one could be infected with HIV, and the methods of prevention. Abstinence from sexual activity is to be stressed. This component of the program is mandatory, but includes a parental opt-out provision whereby a parent may opt his or her minor unemancipated child out of the classroom instruction upon the assurance that the child will receive such instruction at home.

The second component of the program calls for the high schools to make condoms available to students who request them. Public high schools are to establish health resource rooms where trained professionals are to dispense condoms to students who request them. A student to whom condoms are dispensed must be given personal health guidance counselling involving the proper use of condoms, and the consequences of their use or misuse. Students are not required to participate in this component of the program and no sanction is imposed on a student who does not do so. Most importantly, this component of the respondents' program does not include a provision for parental consent or opt-out.

The petitioners, who are parents of New York City public school students, then commenced this hybrid proceeding and action, inter alia, to prohibit the implementation of the condom availability component of the expanded HIV/AIDS education program in New York City's public high schools.

The petitioners contend that implementation of the condom availability component of the program: (a) violates Public Health Law s 2504, because it constitutes "health service" to unemancipated, minor children without the consent of their parents or guardians, and therefore is not authorized by law, (b) violates their due process rights to direct the upbringing of their children, and (c) violates their rights to the free exercise of their religion as guaranteed by the First Amendment of the U.S. Constitution and N.Y. Constitution, Article 1, s 3.

Intense controversy has surrounded the expanded HIV/AIDS education program. The impetus for the program is a deadly public health threat of epidemic proportions. New York City teenagers allegedly account for 20% of the reported cases of adolescent AIDS in the United States, although they make up only 3% of the nation's teenagers. The supporters of the condom availability component of the plan view it as a legitimate and necessary part of public school health education directed at control of a public health crisis. On the other hand, many persons are concerned that the condom availability component of the plan is tantamount to condoning promiscuity and sexual permisiveness, and that the exposure to condoms and their ready availability may encourage sexual relations

among adolescents at an earlier age and/or with more frequency, thereby weakening their moral and religious values. They doubt the wisdom or the desirability of a public school system engaging in what they view as a controversial social program peripheral to the immediate task of educating children.

In this controversy, the court's role is a limited one. Its function is to determine whether or not the condom availability component of the program impermissibly trespasses on any of the petitioners' constitutional, common-law, or statutory rights. That role begins with its review of the record and ends with its determination of the legal issues. It is without power to legislate.

THE RIGHT OF PARENTS TO CONSENT OR WITHHOLD CONSENT TO THE RENDITION OF HEALTH SERVICES TO THEIR CHILDREN

At common law it was for parents to consent or withhold their consent to the rendition of health services to their children. The general incapacity of minors to consent to health services derives from this common-law rule that treated a minor's "normal condition (as) that of incompetency" (66 N.Y. Jur 2d, Infants, s 3; see also, Bonner v. Moran, 126 F.2d 121 (applying common-law rule requiring consent of parent to surgery performed on minor and reviewing relevant State cases)). As legal incompetents, minors could no more consent to medical treatment than they could enter into binding contracts and they continued to be incompetent in many circumstances to give effective consent to health care. The courts identified exceptions to the common-law rule regarding the incapacity of minors. For example, children were regarded as emancipated and competent to consent when they were married (see, Cochran v. Cochran, 196 N.Y. 86); or supported themselves (see, Cohen v Delaware, Lackawanna & Western R.R. Co., 150 Misc. 450); or were inducted into military service (see, Matter of Fauser v. Fauser, 50 Misc.2d 601); or when their parents abandoned them or failed to support them (see, Murphy v. Murphy, 206 Misc. 228). In addition, a physician could render health services to a minor in an emergency without first consulting his or her parents.

Public Health Law s 2504, which was enacted in 1972, codified some but not all of the common-law exceptions to the general incapacity of minors. That section dispenses with a parental consent requirement for "medical, dental, health and hospital service " (emphasis supplied) in five enumerated instances, none of which are applicable here. It reads as follows:

"1. Any person who is eighteen years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services for himself or herself, and the consent of no other person shall be necessary.

"2. Any person who has been married or who has borne a child may give effective consent for medical, dental, health and hospital services for his or her child.

"3. Any person who is pregnant may give effective consent for medical,

dental, health and hospital services relating to prenatal care.

"4. Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health.

"5. Anyone who acts in good faith based on the representation by a person that he is eligible to consent pursuant to the terms of this section shall be deemed to have received effective consent" (emphasis supplied).

The petitioners argue that the distribution of condoms to high school students is a health service, that such distribution does not fall within any of the exemptions set forth in Public Health Law s 2504 to the common-law requirement of parental consent, and therefore, that parental consent is required. The respondents argue that the distribution program is not a "health service" but merely an "adjunct to an education program" or an "aspect of instruction in disease prevention". Thus, the first issue which we must decide is whether or not the condom availability component of the respondents' plan is a health service. We conclude that it is.

The condom availability component of the respondents' program is not merely education, but is a health service to prevent disease by protecting against HIV infection. In the words of Dr. Robert A. Meyers, a former president of New York State Medical Society: "The purpose of (condom distribution) could only be prophylaxis, and there is no way that it could be considered a form of education".

Education relating to the use of a condom encompasses instruction concerning the benefits and risks of condom use and the proper method of condom application. The distribution of condoms is not, as contended by the respondents, an aspect of education in disease prevention, but rather is a means of disease prevention. Supplying condoms to students upon request has absolutely nothing to do with education, but rather is a health service occurring after the educational phase has ceased. Although the program is not intended to promote promiscuity, it is intended to encourage and enable students to use condoms if and when they engage in sexual activity. This is clearly a health service for the prevention of disease which requires parental consent.

Our conclusion that condom distribution is a health service is supported by a regulation of the Commissioner of the New York State Department of Education which defines the term health service to include "the several procedures * * * designed to * * * guide parents, children and teachers in procedures for preventing and correcting defects and diseases" (8 NYCRR 136.1(d)). Similarly, the Acting Commissioner of the New York City Department of Health has said that the condom availability component of the respondents' plan "is a strong and medically sound program that is responsive to critical health needs", and the resolution presented by the Chancellor of the New York City

public schools with respect to the program includes the following clause: "condoms have been cited by the former Surgeon General of the United States to be the best protection against the sexual transmission of the HIV virus" (emphasis supplied).

The next question is whether other regulations of the Commissioner of the New York State Department of Education, which authorize school boards to distribute condoms in the public schools as part of an "AIDS instruction program" (8 NYCRR 135.3(2)(ii)), or as part of a "program of sch health service" (8 NYCRR 135.3(c)), are determinative of the issue of whether such distribution constitutes a health service. We conclude that whether the condoms are distributed as an adjunct of a plan of instruction on HIV/AIDS or through school health offices is of no import. The supplying of condoms is conduct which constitutes a service separate and apart from education. The Legislature has not acted to authorize the provision of such a service without parental consent. Thus, the cited regulations which authorize condom distribution without prior parental consent or opt-out are contrary to the common law and of no effect.

It cannot be disputed that "the State has a compelling interest in controlling AIDS, which presents a public health concern of the highest order. Nor can there be any doubt as to the blanket proposition that the State has a compelling interest in educating its youths about AIDS. Education regarding the means by which AIDS is communicated is a powerful weapon against the spread of the disease and clearly an essential component of our nationwide struggle to combat it" (Ware v Valley Stream High School Dist., 75 N.Y.2d 114, 128). However, while the purpose of the condom availability component of the program may be commendable, the Legislature has not acted to abrogate the common-law rule and to authorize the New York State Commissioner of Education or the respondents to direct or permit the delivery of such a health service to minor, unemancipated high school students in public school buildings without some parental role through opt-out or consent.

Requiring parental consent or opt-out for the condom availability component of the respondents' program would not violate State and Federal statutory and constitutional law as urged by the amici, nor would it stymie every health care provider, compelling parental consent whenever an unemancipated minor seeks contraceptive services.

Under the sections of the Social Security Act governing Aid to Families with Dependent Children and Medicaid, family planning services and supplies must be provided to all eligible recipients, including sexually active minors (see, 42 USC ss 602(a)(15); 1396d(a)(4)(C)). The State laws governing these programs also require that contraception be made available to "eligible persons of childbearing age, including children who can be considered sexually active" (Social Services Law s 350(1)(e); see, Social Services Law s 365-a(3)(c); see also, 18 NYCRR 431.7, 463.2(b)(1); (b)(2); 463.6 (requiring provision of family planning services to minors eligible for public assistance, Medicaid, or

supplemental security income, and to foster children)). These laws entitle eligible minors to confidential services from any provider who treats them under the auspices of one of the public assistance programs previously mentioned.

In addition, title X of the Public Health Service Act, the largest source of Federal funding for family planning programs throughout the nation, mandates that minors receive confidential services (see, 42 USC s 300(a); 42 CFR 59.5(a)(4), 59.15). Interpreting these statutes as requiring that adolescents be treated confidentially, on the basis of their own consent, the Federal courts have invalidated both state laws and Federal and state regulations that imposed parental consent or notification requirements on teenagers entitled to family planning services under these programs (see, Jones v. T.H., 425 U.S. 986 (invalidating state regulations that mandated parental consent for family planning services to otherwise eligible minors); see also, Planned Parenthood Assn. of Utah v Dandoy, 810 F.2d 984; Jane Does 1 through 4 v State of Utah Dept. of Health, 776 F.2d 253; State of New York v. Heckler, 719 F.2d 1191).

These statutes are merely legislatively-enacted exceptions to requirements of parental consent (see also, Public Health Law s 2781(1) (providing that HIV-related tests may be administered upon the written, informed consent of anyone, including a minor if the person has an ability to understand and the capacity to consent); Public Health Law s 2305(2) (which dispenses with consent or knowledge of a parent in the diagnosis or treatment of a sexually transmissible disease)). It is for the Congress or the Legislature, not the courts--and certainly not the State Commissioner of Education or a Board of Education--to provide the exceptions to parental consent requirements. Neither Congress nor the New York State Legislature has enacted an exception for the health service at issue here. The distribution of condoms in our public high schools, where attendance is compulsory, even though condoms are nonmedicinal and require no prescription, is quite different from making them available at clinics, where attendance is wholly voluntary, or as part of public assistance programs. There is no specific authority for the condom availability component of the respondents' program, no matter how commendable its purpose may be.

Nor does Carey v. Population Servs. Intl. (431 U.S. 678), require a different determination. In that case, the United States Supreme Court struck down New York Education Law s 6811(8) which made it a crime to sell or distribute any contraceptive to a minor under the age of 16 years or for anyone other than a licensed pharmacist to distribute contraceptives to persons 16 years of age or over. The court held that the constitutional right of privacy in connection with decisions affecting procreation extends to minors as well as to adults. In declaring the statute unconstitutional, the court reasoned that a prohibition against all sales would have a devastating effect upon the freedom to choose contraception and that limiting distribution to licensed pharmacists imposed a significant impermissible burden upon such freedom.

Holding that the condom availability component of the program is unauthorized in no way affects or restricts the access to condoms which existed prior to the adoption of the plan. In an advisory opinion to the respondents, New York City Corporation Counsel conceded after reviewing Carey and related cases: "(S)ince the Board has no obligation to make condoms available and minors still have the opportunity to obtain condoms (freely or at minimal cost) from other sources without parental consent, it would be permissible for the Board to make parental consent a prerequisite to condom availability or to give the parents the opportunity to exclude their children from the program". (FN*)

The amici argue that "the (condom availability component of the) Program is * * * consistent with the practice of health providers in this state, who routinely prescribe and distribute contraceptives and offer other HIV/AIDS and reproductive health services to minors on the basis of their own consent". The amici miss the point. The primary purpose of the Board of Education is not to serve as a health provider. Its reason for being is education. No judicial or legislative authority directs or permits teachers and other public school educators to dispense condoms to minor, unemancipated students without the knowledge or consent of their parents. Nor do we believe that they have any inherent authority to do so.

PARENTAL RIGHTS TO REAR THEIR CHILDREN AS THEY SEE FIT

The petitioner parents are being compelled by State authority to send their children into an environment where they will be permitted, even encouraged, to obtain a contraceptive device, which the parents disfavor as a matter of private belief. Because the Constitution gives parents the right to regulate their children's sexual behavior as best they can, not only must a compelling State interest be found supporting the need for the policy at issue, but that policy must be essential to serving that interest as well. We do not find that the policy is essential. No matter how laudable its purpose, by excluding parental involvement, the condom availability component of the program impermissibly trespasses on the petitioners' parental rights by substituting the respondents in loco parentis, without a compelling necessity therefore.

The petitioners enjoy a well-recognized liberty interest in rearing and educating their children in accord with their own views (U.S. Const, 14th Amend; NY Const, art I, s 6; see also, Roe v. Wade, 410 U.S. 113, 153; Pierce v. Society of Sisters, 268 U.S. 510, 535; Meyer v. State of Nebraska, 262 U.S. 390, 399). Intrusion into the relationship between parent and child requires a showing of an overriding necessity (see, Wisconsin v. Yoder, 406 U.S. 205, 214; Matter of Marie B., 62 N.Y.2d 352, 358). The minority points to the fact that student participation in the condom availability component of the expanded HIV/AIDS program is wholly voluntary, devoid of any penalty for nonparticipation, and that parents are still free to provide guidance on this and related (or unrelated) issues. However, these factors do not constitute proof that the petitioners are not being forced to surrender a parenting right--specifically, to influence and guide the sexual

activity of their children without State interference.

Parents must send their children to school (see, Education Law s 3205, s 3212, s 3233), and unless they pay for private education (something the petitioners assert they are financially unable to do) that school must be one controlled by the respondents. This is the key distinction between the situation these petitioners face and that faced by the parents who sued in Doe v. Irwin (615 F.2d 1162). In Doe the plaintiffs were attempting to enjoin the distribution of contraceptive devices to their children at a public clinic. The clinic, however, was not inside a school or other building where the parents were obliged by law to send their children. Consequently, in Doe there was no State compulsion on parents to send their children into an environment where they had unrestricted access to free contraceptives, which is precisely what the petitioners in the instant matter must do.

This is not a case in which parents are complaining solely about having their children exposed to ideas or a point of view with which they disagree or find offensive. We would agree that, standing alone, such opposition would falter in the face of the public school's role in preparing students for participation in a world replete with complex and controversial issues (see, Mozert v Hawkins County Board of Educ., 827 F.2d 1058, cert denied 484 U.S. 1066). However, the condom availability component of the respondents' distribution program creates an entirely different situation. Students are not just exposed to talk or literature on the subject of sexual behavior; the school offers the means for students to engage in sexual activity at a lower risk of pregnancy and contracting sexually transmitted diseases. The extent to which individual minors would be affected by the availability of contraceptives in the public school system if the distribution of condoms on the scale envisioned by the respondents were to become commonplace, cannot presently be ascertained.

Undoubtedly, the respondents, too, do not wish to encourage sexual activity among minors but only to slow the spread of AIDS. Nevertheless, in determining whether this program intrudes on parental rights in the first instance the issue is not one of purpose but one of effect. We must take great care not to be blinded by the concept that the end justifies the means. In accord with the foregoing, we conclude that the policy intrudes on the petitioners' rights by interfering with parental decision making in a particularly sensitive area. Through its public schools the City of New York has made a judgment that minors should have unrestricted access to contraceptives, a decision which is clearly within the purview of the petitioners' constitutionally protected right to rear their children, and then has forced that judgment on them.

Because we believe that the petitioner parents have demonstrated an intrusion on their constitutionally-protected right to rear their children as they see fit, we turn next to the issue: whether a compelling State interest is involved and whether this program is necessary to meet it. There is no question, as the Court of Appeals has stated, that "the State has a compelling interest in controlling AIDS, which presents a public health concern of the

highest order" (Ware v Valley Stream High School Dist., 75 N.Y.2d 114, 128, supra). However, the court also noted that "(a)s with other grave risks we have faced during the past two centuries, the threat of AIDS cannot summarily obliterate this Nation's fundamental values" (Ware v Valley Stream High School Dist., supra, at 129). Accordingly, we must ask whether an interference in the petitioners' rights is necessary to meet this public health threat. Specifically, can it be said that absent the program challenged by the petitioners, sexually active students, educated by the schools to the danger of sexually transmitted diseases, will be unable to acquire condoms without difficulty? The answer must clearly be no. We no longer live in an age where minors find it difficult or socially unacceptable to obtain contraceptives at a local drug or convenience store. It is hardly a secret that condoms are now displayed next to vitamins and cold remedies. Moreover, minors may purchase condoms legally (see, Carey v. Population Services Intl., 431 U.S. 678), and the cost is hardly exorbitant (as the petitioners note, a condom may be purchased for about the same price as a slice of pizza). Further, in their brief in support of the respondents, the amici point out that there are publically funded nonschool programs where condoms are available to minors as part of confidential family planning, as provided under the Social Security Act and Public Health Service Act.

Finally, the distribution can go forward without interfering with the petitioners' rights simply by allowing parents who are interested in providing appropriate guidance and discipline to their children to "opt out" by instructing the school not to distribute to their children without their consent. We are not blind to the possibility that children of parents who elect to "opt out" will become or remain sexually active, but in view of the access to condoms discussed previously this possibility cannot serve as a reason to interfere with the parents' right to discourage that behavior.

We conclude that the condom availability component of the respondents' program violates the petitioners' constitutional due process rights to direct the upbringing of their children.

FREE EXERCISE OF RELIGION

The condom availability program does not violate the petitioning parents' rights to the free exercise of their religion.

As stated in Mozert v Hawkins County Board of Educ. (827 F.2d 1058, 1063, supra), the "question to be decided is whether a governmental requirement that a person be exposed to ideas he or she finds objectionable on religious grounds constitutes a burden on the free exercise of that person's religion as forbidden by the First Amendment" of the United States Constitution or New York Constitution, article 1, s 3. The answer is that it does not.

The gist of the petitioners' claim is that they find the condom availability component of the program to be objectionable on religious grounds because it may tempt their children to stray from their religious beliefs. Such a contention does not state a viable claim based on the Free Exercise clause.

"The central question in identifying an unconstitutional burden is whether the claimant has been denied the ability to practice his religion or coerced in the nature of those practices" (St. Bartholomew's Church v. City of New York, 914 F.2d 348, 355). At bar, any student who fails or refuses to participate is not visited with a sanction. Nor is this a case in which anyone who refuses to participate is held criminally liable (see, Wisconsin v. Yoder, 406 U.S. 205, supra) or denied a benefit (see, Thomas v Review Bd of Indiana Employment Sec. Div., 450 U.S. 707; Shebert v. Verner, 374 U.S. 398).

The petitioners' contentions that the students are "bombarded" with information respecting the program, and that they may be tempted to succumb to peer pressure, do not rise to the level of a constitutional violation. "It is true that * * * indirect coercion or penalties on the free exercise of religion, not just outright prohibitions, are subject to scrutiny under the First Amendment * * * This does not and cannot imply that incidental effects of government programs, which may make it more difficult to practice certain religions but which have no tendency to coerce individuals into acting contrary to their religious beliefs, require government to bring forward a compelling justification for its otherwise lawful actions. The crucial word in the constitutional test is 'prohibit' " (St. Bartholomew's Church v. City of New York, supra, at 355, quoting Lyng v Northwest Indian Cemetery Protective Assn., 485 U.S. 439, 450-451).

The condom availability component of the respondents' program does not prohibit the petitioning parents and/or their children from practicing their religion. Nor does it directly or indirectly coerce them to engage in conduct or practices which are contrary to their religious beliefs. "Moreover, parents have no constitutional right to tailor public school programs to individual preferences, including religious preferences" (Ware v Valley Stream High School Dist., 75 N.Y.2d 114, 125, supra; see, Epperson v. Arkansas, 393 U.S. 97, 106). Merely because the petitioners find the program objectionable does not render it violative of their right to the free exercise of their religion (see, Mozert v. Hawkins County Bd of Educ., 827 F.2d 1058, supra; Smith v Board of Education, North Babylon Union Free School Dist., 844 F.2d 90).

CONCLUSION

In light of our determination that the condom availability component lacks common-law or statutory authority, and violates the petitioners' civil rights to rear their children as they see fit, the order and judgment must be reversed insofar as appealed from. Accordingly, the respondents are prohibited from dispensing condoms to unemancipated, minor students without the prior consent of their parents or guardians, or without an opt-out provision, and the petition is granted to the extent that (1) it is declared that the condom availability component of the respondents' plan constitutes a health service rather than health education and thus, in the absence of a provision requiring the prior consent of unemancipated, minor students' parents or guardians, or in

the absence of an opt-out provision, lacks common-law or statutory authority, and (2) it is declared that the respondents' plan to dispense condoms to unemancipated, minor children without the consent of their parents or guardians, or an opt-out provision, violates the civil rights of the parent petitioners and similarly-situated parents or guardians under the substantive due process clauses of the Fourteenth Amendment of the United States Constitution and New York Constitution article I, s 6. In all other respects, the petition is denied.

BALLETTA, J.P., and COPERTINO, J., concur.

EIBER, Judge (dissenting).

As is by now well known, Acquired Immune Deficiency Syndrome (AIDS) results from infection with the Human Immunodeficiency Virus (HIV). The virus, which damages an infected person's immune system by destroying white blood cells, is transmitted chiefly through the exchange of blood and blood products, and through sexual relations. Although sexual abstinence and refraining from certain high risk behavior will prevent the transmission of the AIDS virus, Dr. Margaret Hamburg, the Acting Commissioner of the New York City Department of Health, has noted that "the reality is that adolescents are engaging in sexual intercourse in large numbers". Dr. Hamburg has further noted that while New York City adolescents comprise only 3% of the nation's teenagers, they account for 20% of all reported cases of adolescent AIDS in the United States. Moreover, 29% of all AIDS cases in the United States are diagnosed in young adults between the ages of 20 to 29. Since the disease has an 8 to 10-year latency period, according to Dr. Hamburg, "this statistic suggests that the majority of those persons must have been infected as adolescents".

In an effort to prevent the spread of the HIV virus and to protect this city's youngsters, in September 1987, the Regulations of the New York State Commissioner of Education were amended to direct all elementary and secondary schools to provide appropriate AIDS instruction as part of the health education curriculum (see, 8 NYCRR 135.3(b)(2), (c)(2)). Following his appointment in late 1990, former Board of Education Chancellor Joseph Fernandez proposed expanding the existing HIV/AIDS curriculum to provide comprehensive education in the transmission and prevention of the disease. In addition, former Chancellor Fernandez proposed supplementing classroom instruction by making condoms available, on a voluntary basis, to high school students who requested them. Thereafter, on February 27, 1991, the New York City Board of Education voted to adopt a resolution authorizing the former Chancellor to make condoms available to those students who request them in New York City High Schools as part of an overall HIV/AIDS education program. Although the Board considered the possibility of allowing parents who disapprove of the distribution of condoms to opt out of the voluntary program, the Board concluded that an opt-out provision would be unwise because students whose parents disapprove of

premarital sexual relations may especially "be in need of a place where they can obtain condoms without having to account for any expenditures of funds or having to identify themselves in order to get the condoms". Moreover, the respondents were concerned that a parental opt-out provision, which would require students to identify themselves before they could be given a condom, "would so seriously limit participation in the program as to make it ineffective in reaching many of those students who most need it".

By verified petition dated November 25, 1991, the petitioner parents commenced this proceeding seeking, inter alia, a declaration that the condom distribution program implemented by the former Chancellor violated their civil rights under the substantive due process clause of the Fourteenth Amendment of the United States Constitution, and a declaration that Public Health Law s 2504 required the respondents to obtain the prior consent of the parents or guardians of unemancipated minor students before the respondents may dispense condoms and provide personal health guidance to and counseling regarding condoms to such students. Although the Supreme Court dismissed the petition, concluding that the condom distribution program did not violate the parents' constitutional rights or the New York State Public Health law, the majority would reverse and grant the petition. For the reasons which follow, I respectfully dissent.

The majority concludes, in essence, that the condom distribution component of the expanded HIV/AIDS curriculum is a "health service" within the meaning of Public Health Law s 2504, and that since the statute does not expressly dispense with the need for parental consent to distribute condoms to students under the age of 18, the program violates the common-law prohibition against providing health care to minors absent such consent. (FN*) However, I cannot agree with the majority's conclusion that the condom distribution program constitutes a "health service" of the same nature as the invasive medical, dental, health and hospital treatment contemplated by the statute or the common law.

Public Health Law s 2504 authorizes individuals over the age of 18 to consent to medical, dental, health, and hospital services. The statute, which was enacted in 1972, when the age of majority in this State was 21, represents a modification of the common-law rule that a minor is not legally competent to give binding consent to any medical services rendered to him or herself (see, Hughson v St. Francis Hosp. of Port Jervis, 92 A.D.2d 131, 135; see also, Skeels, In Re E. G.: The Right of Mature Minors in Illinois to Refuse Lifesaving Medical Treatment, 21 Loy U Chi LJ, 1199-1200, 1209).

Prior to the enactment of Public Health Law s 2504, there were no statutory guidelines for physicians to follow in treating persons under 21 years of age, and legislative history indicates that this provision was enacted in order to "expedite the delivery of health care to those under 21" (see, Letter of Tarky Lomardi, Jr., Chairman of Senate Comm. on Health, May 8, 1972, Bill Jacket, L 1972, ch 769). The creation of a statutory right enabling a minor over the age of 18 to consent to medical treatment was further noted to be consistent with

"the recent movement towards enlargement of the political and legal responsibilities of persons in the 18 to 21 year bracket" (Mem of New York State Dept. of Social Servs., May 26, 1972, Bill Jacket, L 1972, ch 769). In keeping with the goal of expediting the provision of health care to minors, the statute additionally permits emergency medical treatment to be rendered to children under the age of 18 without parental consent where an attempt to secure such consent would delay treatment and thus increase the risk to the child's life or health. Although the statute does not expressly codify the common-law rule that an infant is unable to consent to medical, dental, health or hospital services, "an implicit corollary" of the provision is that a person under 18 years of age may not give effective consent for such services (see, Matter of Thomas B., 152 Misc.2d 96).

Despite the fact that neither the statute nor the common law defines the phrase "health services", the majority would construe the phrase so broadly that it encompasses the distribution of condoms, which are noninvasive devices which protect the body without affecting it. The majority cites no authority of any kind for its sweeping construction of the term "health service", and instead points to various portions of the record in which the respondents acknowledge that the condom distribution program is intended to prevent the spread of HIV. However, the fact that the program may have the salutary effect of reducing a sexually active adolescent's risk of being infected with HIV and AIDS does not render the condom distribution program a health service which can be provided to a child under the age of 18 only with parental consent.

While the condom distribution program is, as the Supreme Court recognized, clearly "health related", neither Public Health Law s 2504, which was enacted to expand the ability of certain minors to consent to medical treatment, nor the common-law rule, contemplated preventing high school students from participating in such a program. AIDS is a new threat which the common-law rule was not designed to meet, and nothing in the common law or legislative history of the statute suggests that it was intended to restrict an unemancipated minor's access to nonprescriptive devices to prevent the spread of disease. Thus, it is anomalous to construe the phrase "health services" as a means of restricting the rights of minors of high school age to voluntarily request condoms, which minors in this State are permitted to purchase or obtain from a variety of other sources.

Moreover, contrary to the majority's contention, to engraft a parental consent requirement onto the condom distribution program would run counter to the United States Supreme Court's holding in Carey v. Population Services Intl., (431 U.S. 678). At issue in Carey was the constitutionality of a New York statute which made it a crime for any person to sell or distribute a contraceptive device to a minor under the age of 16. In concluding that the statute was invalid, the plurality opinion noted that minors, as well as adults, are protected by the Constitution and possess constitutional rights, including the right to privacy in connection with decisions affecting

procreation (Carey v. Population Services Intl., at 692-693). The plurality opinion further reasoned that:

"Since the State may not impose a blanket prohibition, or even a blanket requirement of parental consent, on the choice of a minor to terminate her pregnancy, the constitutionality of a blanket prohibition of the distribution of contraceptives is a fortiori foreclosed. The State's interests in protection of the mental and physical health of the pregnant minor, and in protection of potential life are clearly more implicated by the abortion decision than by the decision to use a nonhazardous contraceptive" (Carey v Population Services Intl., supra, at 694).

Furthermore, the majority's conclusion that the distribution of condoms is encompassed by the common-law prohibition against providing medical treatment without consent, is at odds with the fact that minors in this State are permitted to obtain abortions and treatment for sexually transmitted diseases without parental consent or notification (see, Public Health Law s 2305). Surely, if minors are permitted to obtain treatment for the consequences of unprotected sexual intercourse without parental consent or notification, it is inconsistent to restrict their access to the means by which they can prevent an unwanted pregnancy or protect themselves from sexually transmitted diseases, including the deadly HIV virus.

In addition, while the majority turns a blind eye to the potential ramifications of its interpretation of the common-law rule, the fact remains that if the distribution of condoms is a "health service" which cannot be undertaken without parental consent, then the many family planning clinics throughout this State which distribute condoms and other contraceptive devices to minors must also be deemed in violation of the common law and statute. Similarly, if condoms cannot be provided to minors in the absence of parental consent, then it logically follows that the commercial sale of condoms to minors violates the Public Health Law and is illegal. Thus, a broad interpretation of the the term "health services" to preclude distribution of condoms to minors without parental consent would have a significant impact upon the ability of minors to obtain condoms, and thus violate their constitutionally-recognized right to make such decisions privately.

I further disagree with the majority's conclusion that the condom distribution program unreasonably interferes with the petitioner parents' liberty interest in directing the upbringing and education of their children. This right was first recognized by the United States Supreme Court in Meyer v. State of Nebraska (262 U.S. 390), where the court considered the validity of a statute which prohibited the teaching of foreign languages to children who had not yet completed the eighth grade. The avowed purpose of the statute was that "the English language should be and become the mother tongue of all children reared in this state" (Meyer v. State of Nebraska, supra, at 398). The Supreme Court concluded that the Nebraska statute unreasonably infringed upon the liberty guaranteed to the plaintiff under the Fourteenth Amendment, which

provides that "(n)o state shall * * * deprive any person of life, liberty, or property, without due process of law". In reaching this conclusion, the court observed that while it had not "attempted to define with exactness the liberty" guaranteed by the Fourteenth Amendment, "without doubt, it denotes not merely freedom from bodily restraint but also the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men" (Meyer v. State of Nebraska, supra, at 399). The court further noted that this liberty interest "may not be interfered with, under the guise of protecting the public interest, by legislative action which is arbitrary or without reasonable relation to some purpose within the competency of the State to effect" (Meyer v. State of Nebraska, supra, at 399-400). The court then found that although the Nebraska Legislature's desire "to foster a homogeneous people with American ideals" was easy to appreciate, "the means adopted * * * exceed the limitations upon the power of the State and conflict with the rights assured to plaintiff * * * the interference is plain enough and no adequate reason therefor in time of peace and domestic tranquility has been shown" (Meye. v. State of Nebraska, supra, at 402).

Following Meyer v. Nebraska (262 U.S. 390, supra), the Supreme Court again concluded, in Pierce v. Society of Sisters (268 U.S. 510), that an Oregon statute which required all children between the ages of 8 and 16 to attend public school unreasonably interfered with the liberty of parents and guardians to direct the upbringing and education of children under their control. In sustaining a parent's authority to provide religious schooling to his or her children, the court declared that "the fundamental theory of liberty upon which all governments in this Union repose excludes any general power of the State to standardize its children by forcing them to accept instruction from public teachers only. The child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations" (Pierce v. Society of Sisters, supra, at 535).

In contrast, in Prince v. Massachusetts (321 U.S. 158), the Supreme Court upheld the conviction of a Jehovah's Witness who permitted her niece to sell copies of the Watchtower in violation of Massachusetts' child labor laws. In reaching its conclusion that the Massachusetts statute which banned children from selling newspapers and magazines was not unconstitutional, the court reasoned that although "it is cardinal with us that the custody, care, and nurture of the child reside first in the parents", the "family itself is not beyond regulation in the public interest, as against a claim of religious liberty * * * And neither rights of religion nor rights of parenthood are beyond limitation" (see, Prince v. Massachusetts, supra, at 166). In this

regard, the court added that:

"Acting to guard the general interest in youth's well being, the state as parens patriae may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor and in many other ways. Its authority is not nullified merely because the parent grounds his claim to control the child's course of conduct on religion or conscience. Thus, he cannot claim freedom from compulsory vaccination for the child more than for himself on religious grounds. The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death" (Prince v. Massachusetts, supra, at 166-167).

Here, the majority attempts to bring this case within the ambit of Meyer v. Nebraska (262 U.S. 390, supra) and its progeny by reasoning that, despite the voluntary nature of the program, the petitioner parents are being forced to surrender their right to influence and guide the sexual activity of their children without state interference. However, the mere fact that parents are required to send their children to school does not vest the condom distribution program with the aura of "compulsion" necessary to make out a viable claim of deprivation of a fundamental constitutional right. Unlike Meyer v. Nebraska (262 U.S. 390, supra) where a state attempted to totally prohibit parents from permitting their children to study a foreign language until after completion of the eighth grade, or Pierce v. Society of Sisters (268 U.S. 510, supra) where a state attempted to prohibit parents from sending their children to private parochial schools, the element of compulsion is totally absent here. The petitioners are free to impart their religious and moral values to their children in the privacy of their own homes, and to instruct their children not to participate in the condom distribution program.

Similarly, in Doe v. Irwin (615 F.2d 1162), the Sixth Circuit Court of Appeals rejected a claim that parental rights were violated by a publicly-operated family planning clinic which provided teenagers with contraceptives without notice to their parents. Although the plaintiff parents in Doe v. Irwin (supra), as in the case at bar, argued that the clinic's practices violated their liberty interest in raising their children, the Sixth Circuit rejected this argument, noting that there was a fundamental difference between a birth control clinic which dispensed contraceptive devices and family planning information only at the request of an interested individual, and the fact patterns of cases such as Meyer v. Nebraska (262 U.S. 390, supra) and Pierce v. Society of Sisters (268 U.S. 510, supra), where a state was either requiring or prohibiting some activity. In support of its holding, the court reasoned:

"The State of Michigan, acting through the Center and defendants, has imposed no compulsory requirements or prohibitions which affect the rights of the plaintiffs. It has merely established a voluntary birth control clinic. There is no requirement that the children of the plaintiff avail themselves of the

services offered by the Center and no prohibition against the plaintiffs' participating in decisions of their minor children on issues of sexual activity and birth control. The plaintiffs remain free to exercise their traditional care, custody and control over their unemancipated children * * * Since we find no unconstitutional interference with the plaintiffs' rights as parents, there is no need to consider whether a 'compelling' state interest was involved. For the same reason, it is not necessary to determine whether parental rights 'outweigh' those of minor children" (Doe v. Irwin, supra, 615 F2d, at 1168-1169).

The majority's assertion that Doe v. Irwin (supra) is distinguishable because the petitioners at bar are compelled to send their children into an environment (i.e., the public high schools) where condoms are available is without legal merit. Although placing a health resource room in each high school where condoms and educational information about their use may make condoms more readily available to teenagers, the fact that students are in closer proximity to a potential source of contraceptive devices does not change the fundamentally voluntary nature of the program. While condom distribution programs are in place in the high schools that the petitioner's children attend, nothing compels the petitioners' children to participate in the program. Moreover, while the petitioners argue that to expose their children to an environment where condoms are available undermines their efforts to impart their religious and moral values to their children, it should be noted that the instructional component of the HIV/AIDS curriculum takes pains to stress, in accordance with State regulations, that abstinence is the most appropriate and effective premarital protection against AIDS (see, 8 NYCRR 135.3(b)(2); 135.3(c)(2)(i)), and that among the reasons for abstinence is adherence to the values of one's parents and one's religion.

The constitutionality of condom distribution to minors without parental consent has clearly been established by our highest courts (see, Carey v. Population Services Intl., 431 U.S. 678, supra; Doe v. Irwin, 615 F.2d 1162, supra). State and Federally funded programs providing for condom distribution to minors without parental consent have been in effect for years. The significant issue in this case is whether voluntary condom distribution to minors in public schools so differs from accepted similar Federal and State-funded programs as to be violative of constitutionally protected parental rights. Stated differently, do parents have constitutionally protected rights in regard to school condom programs which do not exist in regard to State and Federally funded clinics and in spite of a minor's ability to purchase such devices readily at public vending machines? Since I do not view the distribution of condoms as a health service, but rather as a practical accessory to effectuate a health education program, I find no rational basis for discerning either statutory violations or a violation of constitutionally-protected parental rights resulting from the distribution of these non-intrusive devices, merely because preventive health concerns affecting children

are being addressed in public schools.

Although the majority correctly points out that children are compelled to attend school (as contrasted to health clinics), it fails to consider that they are not compelled either to seek or accept the distribution of condoms, as it remains a purely voluntary program. Moreover, the distribution of condoms in the public schools is entirely consistent with the accepted role schools have traditionally assumed in regard to health education, i.e., preventive health care. Clearly, it is not the proper role of the educational system to ignore reality. Despite the fact that teenagers are instructed that abstinence is the most effective method of preventing the transmission of the HIV virus, many teenagers are nevertheless sexually active, and must be advised that condom use is imperative. Public schools, with their unique ability to reach large numbers of teenagers, can play a significant role in urging the benefit of abstinence, in increasing AIDS awareness, and in alerting those students who are sexually active of the importance of using condoms in order to reduce the risk of disease. Moreover, the condom distribution component of the educational program makes condoms more readily accessible to those students who are already sexually active and might otherwise engage in unprotected intercourse. In view of the public policy interest in slowing the spread of the HIV virus, the condom distribution program is not inconsistent with the educational mission of the public schools.

It must also be recognized that at the heart of the petitioners' argument that the condom distribution program violates their right to raise their children as they see fit is their belief that the program constitutes an endorsement of teenage sexual activity because it tells their children, "in actions far louder than words that they are free to disobey their parents' express instructions". However, this is but a variation upon an argument which was rejected by the Supreme Court in Carey v. Population Services Intl. (431 U.S. 678, supra). As previously noted, Carey involved the constitutionality of a New York statute which prohibited the sale or distribution of contraceptives to minors under the age of 16. The State of New York argued that significant State interests were served by restricting minors' access to contraceptives because free availability to minors of contraceptives would lead to increased sexual activity among the young, in violation of the policy of New York to discourage such behavior. In rejecting this argument, the plurality opinion noted that the State's argument was in essence that "minors' sexual activity may be deterred by increasing the hazards attendant on it", but that such an argument could not be taken seriously because "it would be plainly unreasonable to assume that (the State) has prescribed pregnancy and the birth of an unwanted child (or the physical and psychological dangers of an abortion) as punishment for fornication" (see, Carey v. Population Services Intl., 431 U.S. 678, supra, at 694-695, relying upon Eisenstadt v. Baird, 405 U.S. 438).

Moreover, Justice Stevens, separately concurring, in part, in the plurality opinion in Carey, aptly observed:

"Common sense indicates that many young people will engage in sexual activity regardless of what the New York Legislature does; and further, that the incidence of venereal disease and premarital pregnancy is affected by the availability or unavailability of contraceptives. Although young persons theoretically may avoid those harms by practicing total abstention, inevitably many will not. The statutory prohibition denies them and their parents a choice which, if available, would reduce their exposure to disease or unwanted pregnancy.

"The State's asserted justification is a desire to inhibit sexual conduct by minors under 16. Appellants do not seriously contend that if contraceptives are available, significant numbers of minors who now abstain from sex will cease abstaining because they will no longer fear pregnancy or disease. Rather appellants' central argument is that the statute has the important symbolic effect of communicating disapproval of sexual activity by minors. In essence, therefore, the statute is defended as a form of propaganda, rather than the regulation of behavior.

"Although the State may properly perform a teaching function, it seems to me that an attempt to persuade by inflicting harm on the listener is an unacceptable means of conveying a message that is otherwise legitimate. The propaganda technique used in this case significantly increases the risk of unwanted pregnancy and venereal disease" (Carey v Population Services Intl., supra, 431 US, at 714-715).

Similarly, at bar the petitioners seek to force the Board of Education to, at minimum, allow parents to "opt-out" their children from participation in the program. If an opt-out feature is adopted, however, students will no longer be able to request condoms anonymously. The respondents have reasonably concluded that this loss of confidentiality would deter student participation in the condom distribution program, thus reducing its effectiveness. In the years following the Supreme Court's decision in Carey v. Population Services Intl. (431 U.S. 678, supra), the spread of AIDS has reached alarming proportions giving rise to a compelling state interest to halt the growth of the epidemic. Clearly, many parents, such as the petitioners, are seeking to provide guidance to their children and to protect their health and morality. The majority overlooks the unfortunate reality that many children lack such interested parents. Many children have no parents to provide guidance and discipline or who are even available to consent to the child's participation in the program should an "opt-out" be mandated. Since the consequence of contracting AIDS is death, providing practical protection against the spread of the virus which causes it, to a high risk population, in my view, outweighs the minimal intrusion into the parent/child relationship of the more protected, more fortunate portion of the adolescent population of New York City.

Consequently, I would affirm the order and judgment appealed from.

MILLER, Judge (dissenting).

I wholeheartedly concur with Justice Eiber's dissent but do so separately merely to emphasize one additional point. The intrusion into the relationship between parent and child represented by the fact that the respondents' condom distribution plan contains no parental consent or opt-out provision is indeed supported by overriding necessity. That the New York City adolescent population is significantly over-represented in reported HIV cases nationwide is persuasive evidence of an unusually high-risk population and therefore of a particularly strong and compelling state interest, justifying this program. Justice Eiber has noted the unfortunate reality that a significant number of New York City high school students do not have parents interested in providing them with appropriate guidance and discipline, or who are available to consent to their child's participation in the program. Moreover, some students who have interested parents are beyond their practical control in matters of sexuality. The undeniable fact is that many children are at risk. Because AIDS is deadly, minimal intrusion into the parent/child relationship is justified in this case by an overriding necessity to protect all adolescents from infection with HIV by the most effective means possible.

Consequently, I too, vote to affirm the order and judgment appealed from.

ORDERED that the order and judgment (one paper) is reversed insofar as appealed from, without costs or disbursements, and the respondents are prohibited from dispensing condoms to unemancipated minor students without the prior consent of their parents or guardians, or without an opt-out provision, and it is further,

ORDERED that the petition is granted to the extent that (1) it is declared that the condom availability component of the respondents' plan is a health service rather than health education and thus, in the absence of a provision requiring the prior consent of unemancipated minor students' parents or guardians, or in the absence of an opt-out provision, lacks common-law or statutory authority; and (2) it is declared that the respondents' plan to dispense condoms to unemancipated minor children without the consent of their parents or guardians, or an opt-out provision, violates the civil rights of the parent petitioners and similarly-situated parents or guardians under the substantive due process clauses of the Fourteenth Amendment of the United States Constitution and New York Constitution, article I, s 6; and it is further,

ORDERED that the petition is denied in all other respects; and it is further,

ORDERED that the matter is remitted to the Supreme Court, Richmond County, for the entry of an amended order and judgment accordingly.

FN* Parents United for Better Schools v School Dist. of Philadelphia Board of Educ. (25 Phila. 27) is the only reported case in the United States (that we have found) which deals with the availability of condoms in public high schools. In that case, the Philadelphia School Board authorized "teachers and the like" to give condoms to public high school students on a

request and pilot basis, but provided for a parental opt-out. The court held that because of the opt-out provision, the plaintiffs did not have standing under Pennsylvania law to bring the proceeding and therefore dismissed the complaint.

FN* While the majority seems to suggest that the dictates of the common-law rule could be satisfied by allowing parents to opt their children out of the voluntary program, this position is inconsistent. If the condom distribution program is indeed a health service as contemplated by Public Health Law s 2504 and the common law, students under the age of 18 may participate in the program only with parental consent. A parent or guardian's failure to "opt-out" is not the equivalent of consent.

N.Y.A.D. 2 Dept.,1993.

>In the Matter of Ignacia ALFONSO, et al., appellants, v. Joseph A. FERNANDEZ, et al., Respondents.
END OF DOCUMENT

You can let the children impacted by this devastating epidemic know that they are important, that someone understands the difficulties they face every day. Here are just a few ways you can be involved:

- Make a cash donation that will be spent on gifts for children. ASAP spends $25-$30 on each child enrolled. We try to purchase one item of clothing and one educational toy.

- Purchase a gift yourself for a child enrolled. The day we receive your call, fax, or reply form we will send you the information requested about a child you can purchase a gift for. (Gifts need to be shipped back to the ASAP office to arrive not later than December 10.)

- Talk to others in your community about participating in the ASAP Holiday Gift Program. Civic, religious, youth, professional or educational organizations might be interested in donating or becoming involved.

- Ask your employer about making a corporate donation to the 1993 Holiday Gift Program.

- Suggest that a school class "adopt" a family or child to provide gifts for this holiday season.

Take time now to complete the reply form and let us know what you plan to do to help the many children impacted by AIDS/HIV.

On behalf of the thousands of children across the nation served through this program, Thank you!

ASAP
1993 Holiday Gift Program
P.O. Box 17433
Washington, D.C. 20041

Tel: 703/471-7350
FAX: 703/471-8409

You Can Help Children Impacted by AIDS/HIV Through ASAP's

Holiday Gift Program

Earlier this year experts released an estimate that 2 million children worldwide are now orphaned because of AIDS. They expect that number to rise to 10 million by the end of this decade. They place the number of children to be orphaned in the United States because of HIV disease at 80,000 by the year 2000. Although these are estimates, all experts agree that unless the epidemic's pace is slowed the number of children impacted will steadily increase over time.

Since 1988, ASAP's Children's Assistance Fund has provided direct service to families in which one or both parents have suffered from AIDS/HIV. The fund's programs cover three areas: emergency financial assistance for necessities such as rent, utilities, medical or funeral expenses, etc.; resource materials, counseling and referrals to service providers; and the Holiday Gift Program.

The Holiday Gift Program is a vital help to families dealing with the daily financial, physical and emotional stress of HIV disease.

In four years, ASAP's Holiday Gift Program has grown from serving 2 children in 2 states to more than 2,500 in 38 states. This year we expect to serve approximately 4,000 children in 40 states. All these children have parents diagnosed with AIDS/HIV. Many of them are infected themselves, and even more of them are uninfected but will lose brothers and sisters to the disease as well.

The Holiday Gift Program works through hospitals, clinics, local organizations, and also serves families directly. Here are a few comments from the 1992 Holiday Gift Program:

"Many images last in our minds: little children clutching packages almost as big as they are, older children who are too 'cool' to get excited grinning nonstop despite their best efforts, and parents enjoying their children's delight. Thank you!"

Albert Einstein College of Medicine
of Yeshiva University
Children's Evaluation &
Rehabilitation Clinic

"Our sincere thanks and gratitude for your gifts and expressions of love and concern to our HIV-infected children and their families. Treasures, no matter how big or small, bring pleasure and relief to our families as seen by smiles, laughter, and gorgeous glowing faces of those affected by this dreadful disease. May God continue to bless your endeavors."

Harlem Hospital Center
Department of Pediatrics

"I want to send my most gracious blessing to you for the Christmas you made for my children. Before Santa came to the door we only had a few presents under the tree for the kids. As I write this to you I have tears in my eyes. I thank God for people like you who have hearts to help people like us. We have been through a lot and yet have a lot to go through, but through it all God shows us the way. Thank you for the presents you sent and the smiles that they have brought."

M.C.
Colorado

"Thank you for the Christmas gifts you sent to my daughter. They provided a welcome bright spot for a little girl who has been through more than any child should ever have to suffer. Thank you for your kindness and generosity."

C.P.
Maryland

R E P L Y F O R M

1993 ASAP Holiday Gift Program

☐ Enclosed is my donation of $_____ to help purchase gifts for children enrolled in ASAP's 1993 Holiday Gift Program.
(Please make checks payable to ASAP Children's Fund. All gifts are tax deductible.)

☐ I would like to purchase gifts myself. Please send me information on a child I can help.

☐ I would like to help a child of either sex or any age. ☐ I would like information on _____ child(ren).

☐ Please send information on *(check all that apply)*: ☐ 0-4 years ☐ 5-7 years ☐ 8-13 years ☐ 13-17 years ☐ Female ☐ Male

☐ I plan to talk with others in my community about participating in ASAP's 1993 Holiday Gift Program. Please send me:

_____

_____

Name _____

Address _____

City/State/Zip _____

Telephone (day) _____ (evening) _____

Please return the completed form to:
ASAP 1993 Holiday Gift Program
P.O. Box 17433, Washington, DC 20041
Tel: 703/471-7350; FAX 703/471-8409

ASAP
CHILDREN'S
ASSISTANCE
FUND

Since AIDS was first diagnosed in 1981, clinicians and researchers have learned that the Human Immunodeficiency Virus causes AIDS, and have developed accurate tests to diagnose the virus. They also have discovered treatments for diseases that prey upon those with depleted immune systems.

Education and prevention programs are underway nationwide; community-based organizations have mounted a massive effort to serve, counsel and assist all those infected with HIV. Although much more needs to be done, progress in the last few years has been enormous.

But today Americans must face yet another facet of HIV infection and AIDS: the indirect results of the disease . . . the legacy of AIDS.

The Magnitude of the Problem

AIDS and HIV infection will impact our nation's economy, social structure, and cultural institutions. But the children living with the legacy of AIDS don't have to wait to understand this. They face all these issues now. They not only lose their families, they most often lose any economic stability they have, and in many cases they must relocate, consequently losing their friends and support structures.

Chris Norwood of the National Women's Health Network AIDS Committee, released a report that found, based on average numbers of births and reported infection rates, if just 80 percent of the women already infected in New York City die of AIDS-related diseases, they will leave behind between 52,000 and 72,000 living, orphaned children.

And that is if no new infections occur. "The family and social disintegration is almost unimaginable," she said. These children do not have the virus because they were either born before their parents were infected or did not contract the virus from their infected mothers.

Most Americans equate HIV infection and AIDS to gay men, IV-drug users, and those who received infected blood transfusions before 1985. In truth, AIDS and HIV infection is increasingly being seen in men and women equally in their teens and early 20s. And these are the peak childbearing, parenting years.

ASAP Children's Assistance Fund

In response to this critical need, Americans for a Sound AIDS/HIV Policy (ASAP) established the ASAP Children's Assistance Fund in early 1988.

The Fund's purpose is to be a support and resource to families afflicted with AIDS and HIV infection by providing direct funding for specific needs; networking between social service organizations, the medical community, and infected parents; and producing basic materials for families and service organizations.

Researchers are actively working on pediatric AIDS issues, and organizations exist to assist children with AIDS and HIV infection. The ASAP Children's Assistance fund supports and complements these essential efforts.

Some specific ways the ASAP Children's Assistance Fund offers support include:

- Providing practical information to HIV-infected parents for planning the family's future, including legal, financial, and therapeutic support opportunities.
- Providing housing opportunities for families undergoing treatment at medical facilities.
- Identifying and developing a national directory of all service organizations that could provide support to families with HIV infection.
- Identifying families interested in providing foster care or adopting children orphaned because of AIDS and HIV infection.
- Impacting public policy related to foster care and adoption, to facilitate placement of children orphaned because of AIDS and HIV infection.
- Assisting community organizations and institutions, including the religious community, in developing support systems and enrichment programs for children orphaned by this disease.

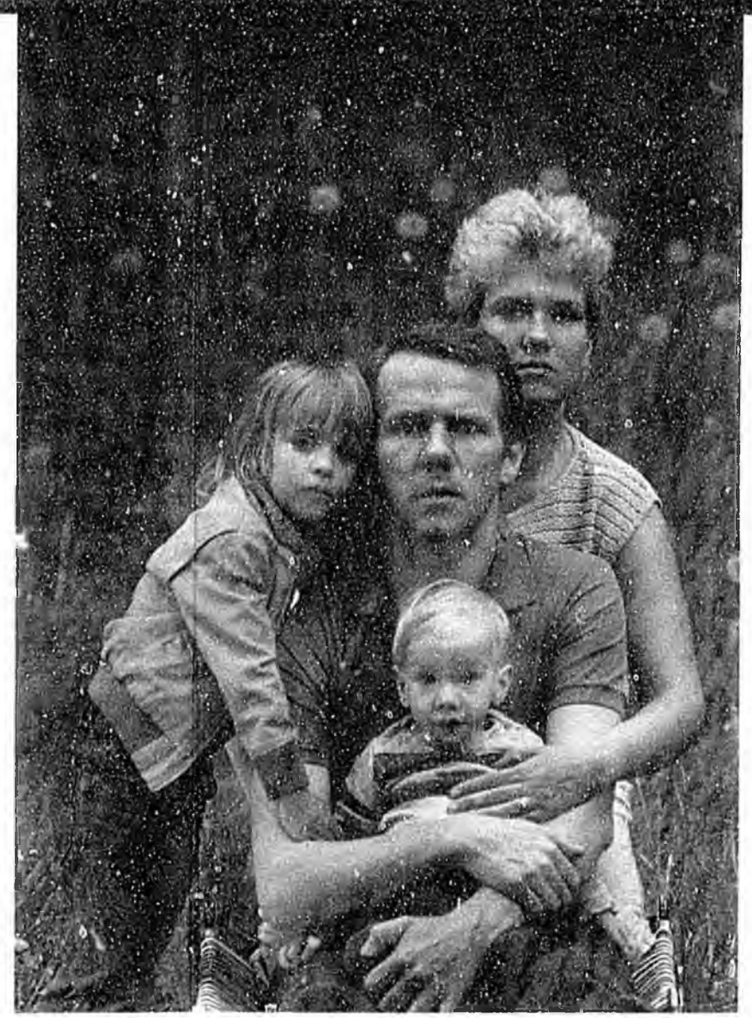
How You Can Help

By pulling together resources and expertise in the public and private sectors, involving concerned individuals, corporations, medical experts, social service agencies, and policymakers, the ASAP Children's Assistance Fund provides support for families who face these devastating issues today.

The fund has already begun identifying medical and social services for families, networks of organizations that can offer assistance, and individuals interested in providing foster or adoptive care. As the fund grows, more families and children will begin to receive greater practical assistance.

Today you can be part of the solution to the devastation that AIDS and HIV infection will have on our nation. You can help children like Nicole look forward to more than the legacy of AIDS. You can help give them hope, encouragement, and love. You can do this by giving to the ASAP Children's Assistance Fund.

ASAP
CHILDREN'S
ASSISTANCE
FUND



The Burk family in 1985. Since then both father and son have been lost to AIDS. Nicole (left) remains the only family member not infected.
Photo: Lynn Johnson

In Pennsylvania, 8-year-old Nicole lives with her mother who is HIV positive. Nicole's father and baby brother have already died of AIDS.

In Manhattan, a 10-year-old boy is watching his world fall apart. His mother and father are both infected with HIV. The baby is sick. His family will all die, leaving him alone.

In Queens, five children orphaned when both their mother and father died of AIDS, were sent to different locations, wherever social services could place them.

In Boston, a former Marine officer struggles with his illness. His wife and infant son have died. Six-year-old Maureene is the only family member who is uninfected. The father's primary concern is to provide for her future.

These children are only a few of literally thousands today who are living with the legacy of AIDS and HIV infection.

Americans for a Sound AIDS/HIV Policy • W. Shepherd Smith, Jr., President • P.O. Box 17435 • Washington, D.C. 20041 • 703/471-7581

I want to help children like Nicole through the ASAP Children's Assistance Fund.

- ☐ Enclosed is my gift of $ _____
- ☐ Please send me _____ ASAP Children's Assistance Fund brochures to give to my friends and colleagues.
- ☐ Please add me to the ASAP mailing list to receive regular updates on the Children's Fund and other ASAP programs.
- ☐ Please contact me. I am interested in providing foster or adoptive care for a child orphaned by AIDS and HIV infection.

Name _____

Address _____

City/State/ZIP _____

Telephone _____

Mail your completed form to:
Americans for a Sound AIDS/HIV Policy
Children's Assistance Fund
P.O. Box 17435
Washington, D.C. 20041

ASAP is a broad-based, non-profit citizens organization founded in 1985 to address AIDS and HIV from a medical/public health perspective. All gifts to ASAP are tax deductible.

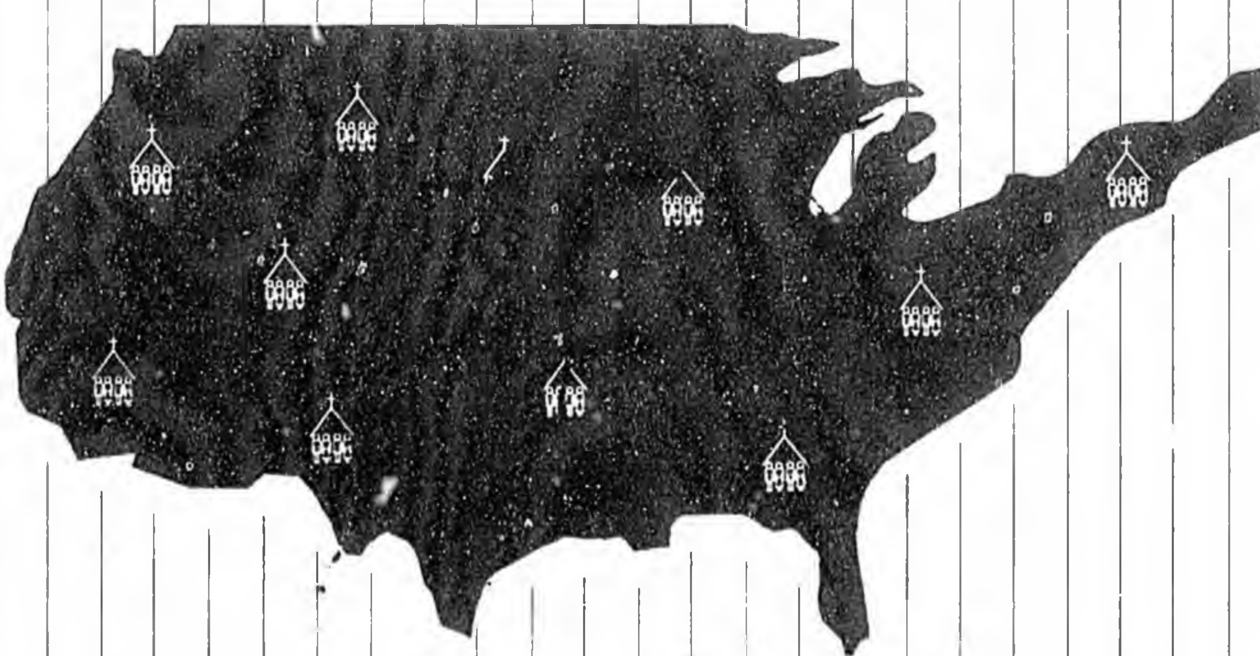
ASAP
CHILDREN'S
ASSISTANCE
FUND

Impacting the Legacy of AIDS

THE CHURCH'S RESPONSE TO THE CHALLENGE OF AIDS/HIV

A Guideline for Education and Policy Development

DL – info for
when/if we have
to deal w/ Toohey's
sex ed. bill.
Drew
3/31



To order additional copies call or write:

Americans for a Sound AIDS/HIV Policy
P. O. Box 17433
Washington, D.C. 20041
703/471-7350

or:
MAP International
P.O. Box 50
Brunswick, GA 31521-0050
912/265-6010

1-9 copies $4.95
10+ copies $3.95

Prices include domestic postage and handling only. Please include payment with every order; no purchase orders accepted. Visa and Mastercard orders accepted by MAP International. For overseas orders, please add 25%. Cost and availability of these materials are subject to change without notice. Please allow 4 to 6 weeks for delivery.

THE CHURCH'S RESPONSE TO THE CHALLENGE OF AIDS/HIV

A Guideline for Education and Policy Development

PREFACE

Jonathan is eight. He has bright, dark eyes and a brilliant smile. Jonathan also has AIDS.

Infected when 18 hours old through a blood transfusion, Jonathan has learned to live with his mortality and is looking forward to "seeing Jesus and being made all better."

Jonathan's mother, Sheila, sought support and acceptance from the churches in their Rocky Mountain community, knowing she couldn't continue to handle the stress alone. Three churches responded in the same way, "You may come to church, if you leave your son at home."

Hurt by rejection and unable to deal with the daily demands of AIDS, Sheila and Jonathan found compassion and mercy from others - outside the church. As the epidemic expands, ministries to families dealing with AIDS are being formed so these critical needs can be met.

AIDS is a challenge unlike most others the 20th century American church has faced. Although the problem is enormous and multifaceted, it grieves us to think that even one brave boy who loves Jesus has been turned away by the church. The tragedy is that there are thousands of Jonathans across the nation whom the church has feared and rejected.

Understanding that AIDS is overwhelming, we held a consultation on Church AIDS/HIV Policy in April 1989 to examine all aspects of the issue and ways the church can approach it. The group represented more than 12 denominations and a variety of professions, including local pastors, physicians, health care workers, ministry representatives, counselors, and educators. Participants reflected many levels of involvement with AIDS.

We know that in contemporary society the demands on the local church are great and that AIDS is often seen as just one more demand. But experts tell us by 1993 every person will know at least one individual infected by HIV. That means every church in the United States will ultimately have to address the issue.

This document, compiled from discussions at the consultation, is not designed to be an exhaustive discussion of the issue, but rather a framework for the local church's approach to AIDS/HIV. It touches on the fears and the facts related to AIDS and HIV infection, as well as ways to educate and involve a local congregation. Each local church will need to address AIDS/HIV in its own specific community.

We pray that this guideline will assist local church staff and lay leaders in the attempt to walk and act as Christ would in our nation today, offering compassion and redemption to all.

MAP International
Americans for a Sound AIDS/HIV Policy

AIDS presents a unique challenge to the church. It provokes the church to examine the effectiveness of the way it teaches values about sexuality to its congregations. It tests the church to see whether it will respond in compassion to those affected by AIDS and HIV infection. It forces the church to reach beyond its constituency to those in need who have never come through its doors.

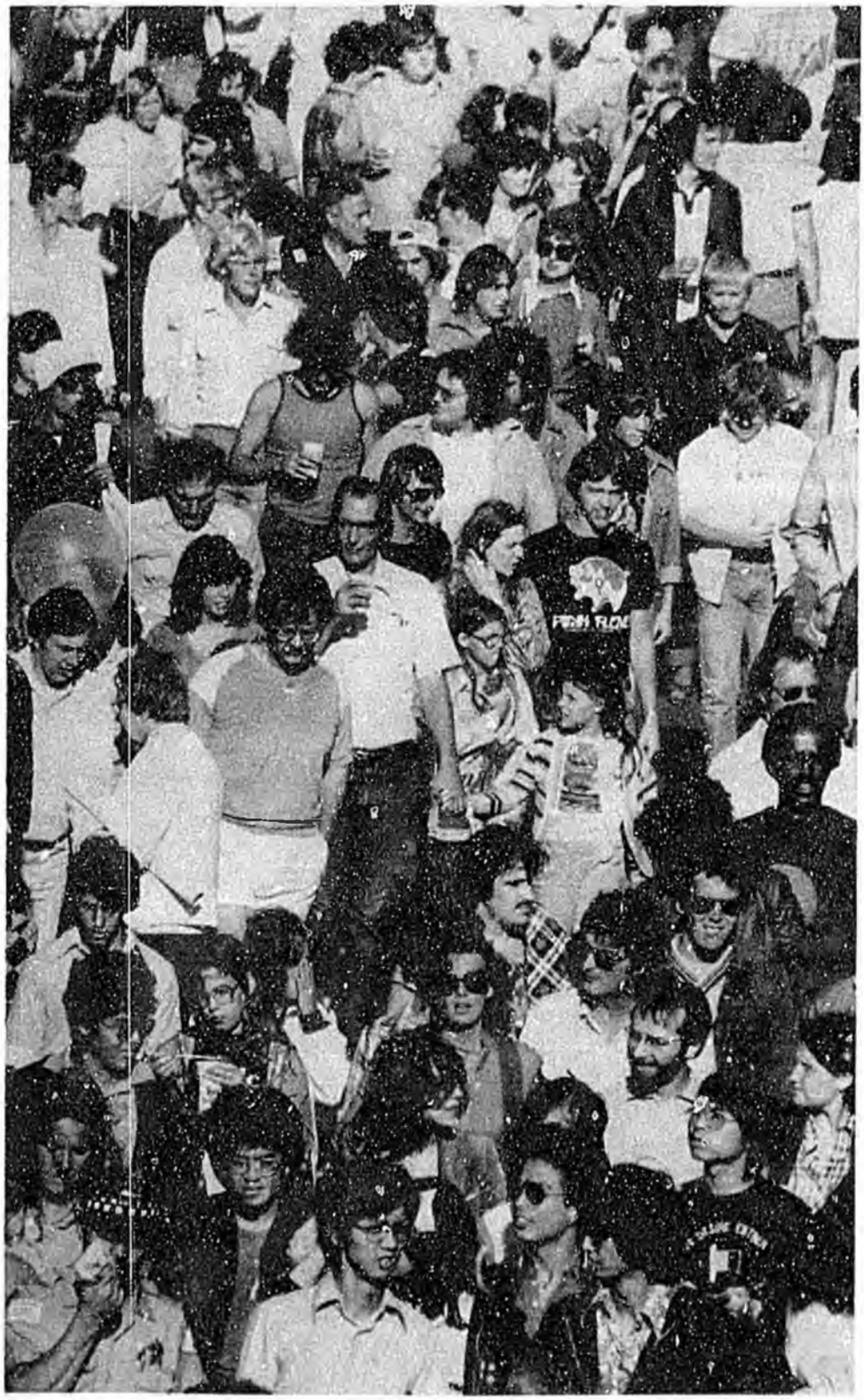


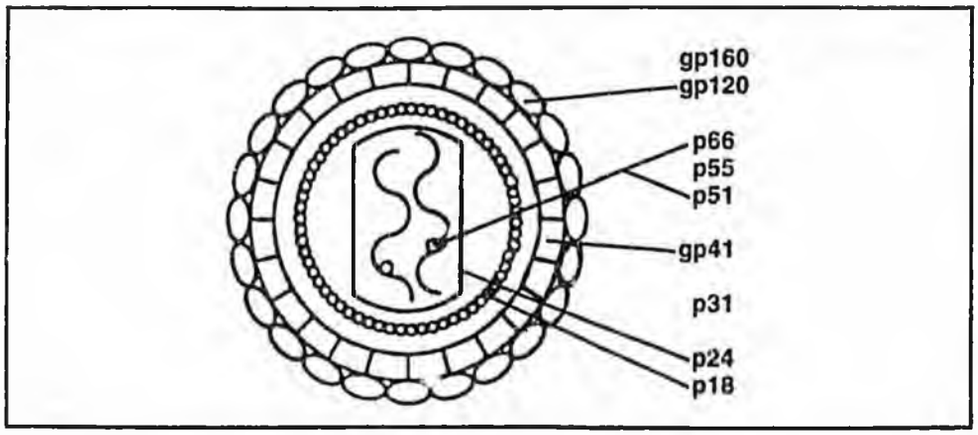
TABLE OF CONTENTS

THE CHALLENGE OF HIV

AIDS was first described in June of 1981 as an unusual disease that was causing primarily young homosexual men to lose their ability to fight off otherwise common and non-harmful diseases. GRID (Gay Related Immune Deficiency), as it was first called, soon took on the name of Acquired Immune Deficiency Syndrome, or AIDS, as it was shown to affect anyone who either sexually or through intravenous means became infected by some agent which caused the immune system to be destroyed over time.

The causative agent was a virus first discovered by Dr. Robert Gallo and Dr. Luc Montagnier, an American and a Frenchman, who called their discoveries HTLV I and LAV, respectively. Ultimately, the virus became known and is recognized today as the Human Immunodeficiency Virus, or HIV.

Illustrated are the various proteins and the reverse transcriptase which constitute the bulk of the HIV virus structure.



After the discovery of the virus, a test for detecting its presence was soon developed. By understanding the properties of the antibodies the body produces to defend itself against HIV, scientists were able to establish its presence by detecting these specific antibodies.

The discoveries of the virus and the tests for its antibodies have allowed us to understand a great deal about the modes of transmission, the progressive nature of infection, and the devastating effects it has on the body over time.

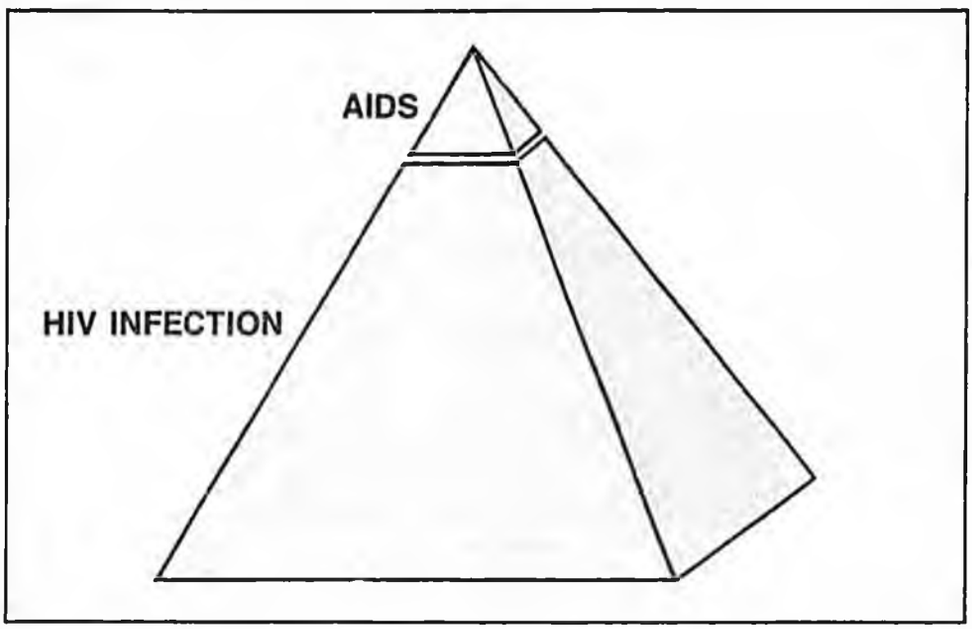
AIDS/HIV: A WORLDWIDE EPIDEMIC

Once the discovery of this disease was made in the early 1980s, scientists soon sought evidence to find out where it had originated so we might better understand its transmission characteristics, as well as gain insight into how to treat it and end its spread. As information came in increasing amounts to the Centers for Disease Control in Atlanta, Georgia, it became apparent that the United States was not the only country struggling with this newly discovered disease. Cases in Europe were soon identified and traced mostly to Central Africa. It is now believed that in all likelihood the HIV virus originated in Africa and has existed there for at least a number of decades.

Because of urbanization and international travel, as well as expanded land and air communication links within developing countries, people infected with the virus had great mobility and were able to spread it not only within their own borders, but from nation to nation, and from continent to continent. The actual location of the virus origin may never be known, and it is an issue that does not deserve a great deal of speculation. At this point, energies must be expended in dealing with what is an ever-increasing epidemic of dramatic proportions and not on speculation of its exact origin.

Countries of the world soon began reporting the number of cases they had, with developed countries being able to more accurately diagnose and report cases to a central health center, the World Health Organization (WHO). While it is believed many developing countries in Africa have higher incidences of HIV infection and AIDS, the United States leads all nations in both the total number of cases reported as well as the highest percentage of cases per unit of population.

Since the first cases of AIDS were recorded in mid-1981, the numbers have continually increased. In the United States alone, the cumulative figure of people symptomatic or who have died from this disease surpassed 150,000 in September of 1990 (1), and it is estimated that the doubling time will occur approximately every 30 months. The number of deaths compared to the cumulative number of reported cases is approximately 60 percent (2). The focus on AIDS is misleading, however, since it really represents only the tip of the iceberg, or the very top of the pyramid in relationship to the extent of the total problem created by HIV infection.

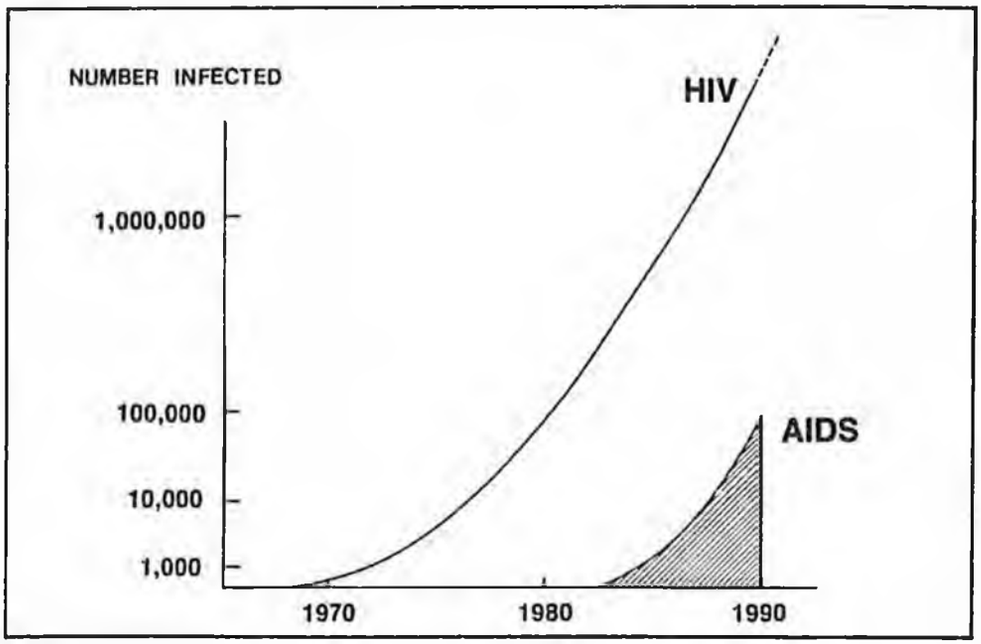


Symptomatic AIDS is only the tip of the iceberg or top of the pyramid of the total spectrum of HIV disease. Most infected individuals show no signs of illness, but will ultimately progress to the top of the pyramid with many more taking their place in the pool of infected individuals, represented here by the pyramid base.

The final report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic (often referred to as the President's AIDS Commission) states in the first point of its Executive Summary that "the term 'AIDS' is obsolete. HIV infection more correctly defines the problem. The medical, public health, political and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease. Continual focus on AIDS rather than the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic" (3).

The reason this point is made so dramatically is that once infection occurs when an individual first contracts the HIV virus, he or she remains infected for life. Anyone thus infected will eventually develop symptomatic HIV disease (AIDS) and die. HIV is a slow-acting virus. Those infected may not show symptoms for up to 10 years from the time of infection. Consequently, the HIV epidemic today is mostly unseen because individuals who are infected with the virus do not yet have symptoms. Today's HIV infections will ultimately become the AIDS epidemic of the future.

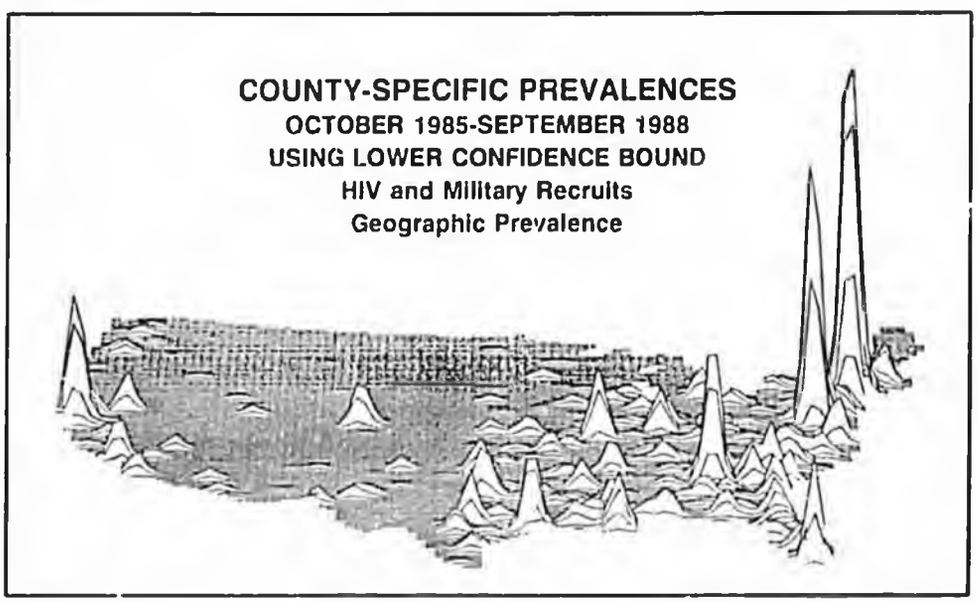
This graph illustrates the need to focus our attention on HIV rather than AIDS. The unseen HIV epidemic of the 1970s dictated the shape of the AIDS epidemic of the 1980s (lower right). Likewise, the AIDS epidemic of the 1990s has already been determined by the HIV infections of the 1980s (upper solid line).



Symptomatic AIDS is really the end-stage of a disease process which begins long before we see people who are physically ill. We now have glimpses of what the HIV epidemic looked like prior to our first recognizing symptomatic carriers in 1981 because of blood samples saved for other reasons. The most noteworthy study is what is known as the Hepatitis B Cohort of San Francisco.

In 1978, the public health community enrolled 6,800 homosexual men in San Francisco in a study of the spread of hepatitis B. They saved the blood serum samples and were later able to go back and examine each of them after an antibody test for the AIDS virus (HIV) had been developed. What they found was quite remarkable. In 1978, 3 percent of that cohort was already infected with HIV. It grew to 12 percent in 1979, and by 1981 when the first AIDS cases had been discovered, 36 percent of that group were already infected. Today, nearly 80 percent of the men in that study are HIV positive. While most still show no symptoms, the numbers of people developing AIDS continues to increase (4).

The Armed Forces tests all civilian military applicants for HIV. The map shows where they have found HIV infection through 1988. When looked at over time, plains become hills, hills grow into mountains, and mountains grow even higher, indicating an expanding epidemic.



Estimates of HIV infection in the general population vary widely. The Centers for Disease Control in Atlanta has maintained an estimate of one to one and one-half million Americans since mid-1986. The military routinely screens civilians applying for the Armed Services for HIV and continues to find a consistent level of people who are HIV positive. While the numbers they find underestimate the general population's infection because they largely exclude people who do not have high school degrees or are IV drug users or homosexuals, they have been able to show that this epidemic is spreading geographically as well as socio-economically, and increasingly into the young people of America, both male and female, of all races.

MODES OF TRANSMISSION

A great deal of study has been done on how the virus is transmitted. There are now three primary defined modes of transmission:

- Intimate sexual contact where body fluids are exchanged;
- Parenterally, through IV drug abuse, blood transfusions, or rarely by needlesticks (5); and,
- Perinatally, from an infected mother to her infant.

Scientists have done extensive studies to determine whether the virus can be transmitted in normal social settings. Definitive information shows that this cannot readily occur. Handshakes, toilet seats, doorknobs, etc. will not transmit HIV or AIDS. The only documented cases of transmission outside of the three primary modes have been of health care workers exposed to infected blood or body fluids. In these health care workers, HIV-positive body fluids were either ingested or spilled on skin with cuts or abrasions. Although this risk is very low, it should alert health care workers to the dangers of transmission in the work place, either in the hospital or other health care settings. It should also inform others, who do not have similar exposure, that the risk of exposure to this virus is minimal outside the three major modes of transmission described.

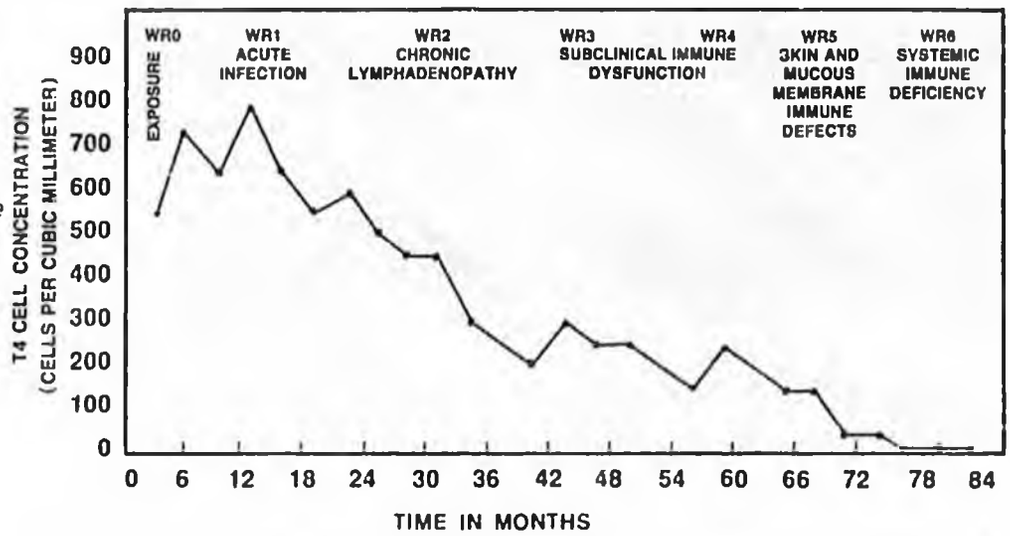
Intimate sexual contact is an efficient mode of virus transmission and will become the dominant route of epidemic spread in the future, particularly among heterosexuals. The virus only need come in contact with the white blood cells which act as both target cells and subsequently host cells of the virus. These are primarily T4 lymphocytes, monocytes, or macrophages. The theory that cuts or abrasions *inside* body openings are required for transmission to occur is obsolete. We now understand the role white blood cells in mucous membrane linings play in transmission. These cells absorb the HIV when present in fluid, and become the primary host (and target) cells for the virus.

The concept of risk groups is also obsolete, since anyone who is uninfected and comes into intimate sexual contact or shares IV drug paraphernalia with an individual who is infected is subject to acquiring the virus. It is incorrect to believe that the virus can differentiate between sex, race, age, economic status or even between specific sexual acts. The virus only needs to be absorbed by a white blood cell for infection to occur.

CLINICAL COURSE OF HIV INFECTION

Once an individual is infected, a slow process begins in the body which allows the virus to destroy an individual's immune system over time. This progression of events is now well-defined; the most significant co-factor to it occurring is simply time. Given time, the virus will eventually prevent an infected person from mounting an immune response to a number of different diseases, which will eventually result in death.

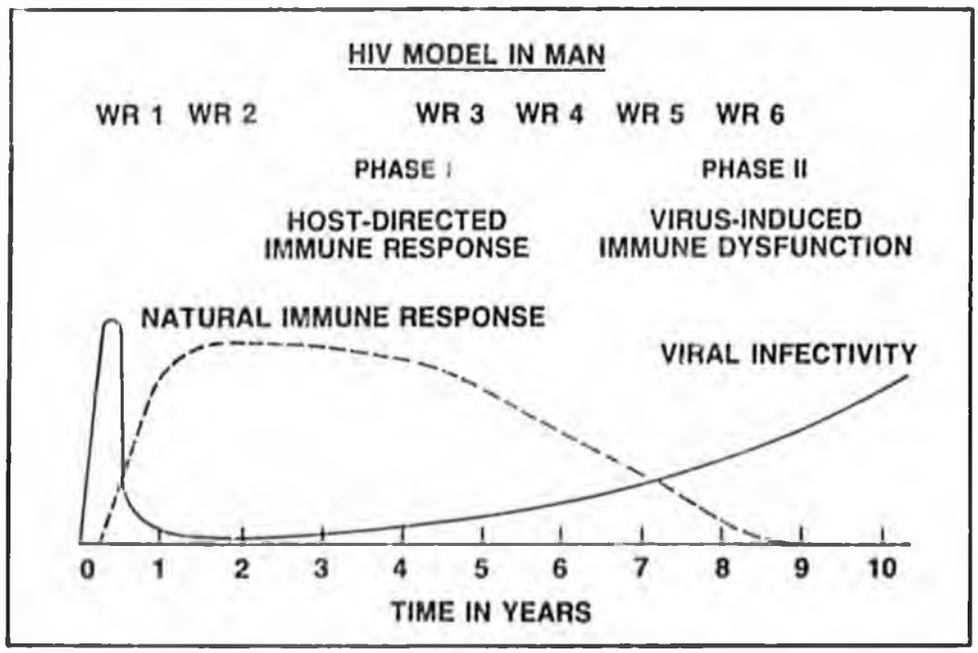
This graph is critical to understanding the effect of HIV on the immune system from point of infection onward as shown in an individual monitored over an 83-month period. The virus slowly destroys T4 lymphocytes until virtually none remain, eventually making it impossible for the body to defend itself against even the most common diseases.



Once the virus infects a white blood cell, it literally turns the cell into a virus-producing factory. The virus becomes a part of the cell's genetic composition, ensuring it literally will remain part of the infected person for life. The virus affects various white blood cells differently. It destroys T4 cells over time, while macrophages and monocytes are used as virus-producing factories without being directly destroyed themselves. The destruction of the T4 lymphocytes, the first line of the body's immune defense system, ultimately renders the individual susceptible to otherwise non-life-threatening diseases such as pneumocystis carinii pneumonia, Kaposi's sarcoma, or even herpes.

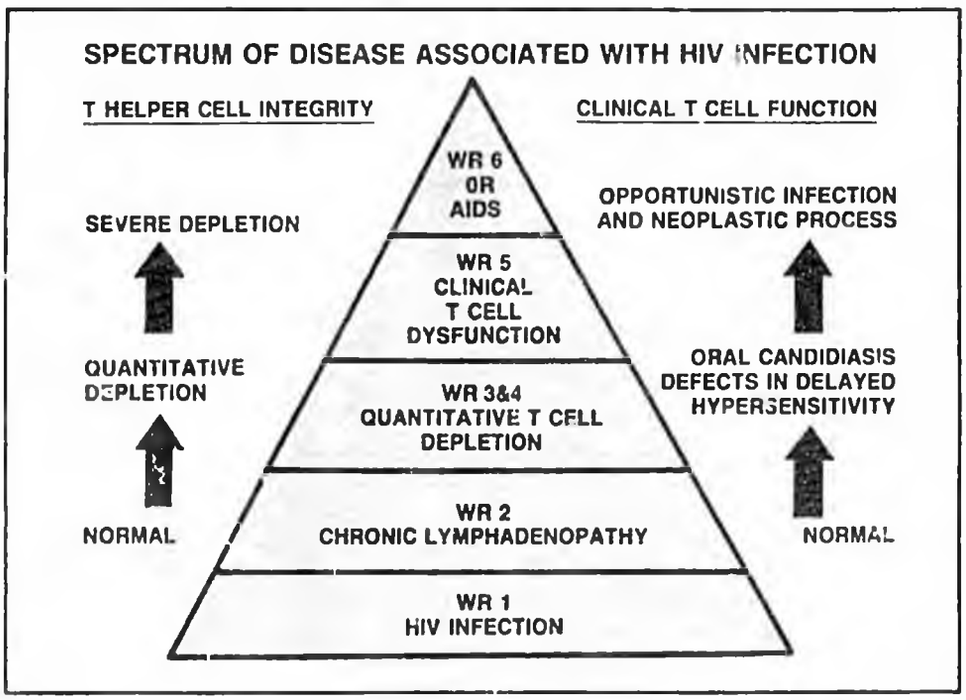
Clinicians have also speculated that the longer an individual is infected, the more infectious they become. This theory of "dynamic infectivity" arises because increasing quantities of virus are present as decreasing numbers of T4 lymphocytes are found in the blood. Consequently, learning not only one's HIV status, but also one's particular stage of infection can be helpful to both offering effective treatments and controlling the epidemic.

This illustrates the course of virus infection (solid line) and the body's immune response (dotted line). Shortly after infection the body mounts a strong response to the virus, but over time the virus is able to eventually destroy an individual's ability to produce antibodies. This argues for the concept of dynamic infectivity, wherein an individual becomes more infectious the longer he or she is infected, with increasing amounts of virus found in body fluids.



STAGING THE PROGRESSIVE CLINICAL COURSE OF HIV INFECTION

Because this is a progressive disease, it is important to be able to intervene clinically, offering treatments to individuals who are infected. A system to measure the progressive nature of the virus has been developed by the clinicians at Walter Reed Army Institute of Research. This is now widely accepted as the primary staging system of the virus. The stages of this classification run from 0, or exposure, to 6, or what would be known as symptomatic AIDS. The intervening stages are marked primarily by some clinical manifestations combined with the progressive destruction and declining numbers of T4 cells. Other markers which indicate disease progress by stages include: acute infection, chronic lymphadenopathy, subclinical immune defects, mucocutaneous immune deficiency, and systemic immune deficiency, often resulting in various opportunistic infections. An understanding of these progressive stages is important to physicians and clinicians who treat infected individuals.



In order to monitor the course of infection over time, various staging systems have been developed. This illustration was devised by the Walter Reed Army Institute of Research, and shows newly infected individuals (Walter Reed Stage 1s) progressing upward to symptomatic AIDS (Walter Reed Stage 6s).

THE ROLE OF TESTING

A great deal of controversy has existed about the role of testing in relationship to HIV. Most questions regarding testing and its value have centered on civil rights concerns rather than medical issues. The right to privacy and concerns about confidentiality of results, as well as discrimination fears of people found to be infected, have to date limited the amount of testing that has occurred in the HIV epidemic.

However, the medical value of an early diagnosis of all diseases has gained greater prominence in relationship to HIV infection. While the disease is still not curable, it is treatable through medical interventions. In addition to delaying disease progression and anticipating opportunistic infections, a positive serological diagnosis also allows an individual to plan priorities (as is true with any terminal illness) and - very importantly - it allows that person not to infect the partner they love.

BARRIER PROTECTION IN SEXUAL ACTIVITY

When the modes of transmission were first understood to be largely sexual in nature, many felt the promotion of condoms would eliminate virus transmission from one individual to another. Various studies indicate, however, that condoms offer a similar level of protection for HIV disease as they do in preventing pregnancy. In other words, while they reduce risk, they do not eliminate it. A prominent study done by Dr. Margaret Fischl showed that over a 12- to 18-month period, couples that were discordant (one HIV-positive and one HIV-negative) who exclusively used condoms seroconverted (infected) their partners 17 percent of the time. Similar couples that abstained from intimate sexual contact had zero seroconversions, and those that used no protection had 81 percent seroconversions (6).

This study occurred in individuals who knew their HIV status. Fully 80 percent of people today who are infected do not know they are infected and subsequently are unknowingly and unintentionally infecting others. Ultimately, the most effective way of breaking the chain of transmission of this virus will not be condoms but a modification of sexual behavior in which having more than one sexual partner is strongly discouraged. Only direct knowledge of infection status allows uninfected partners to consider a sexual relationship, and then only in marriage.

THE FUTURE OF THE HIV EPIDEMIC

Dramatic increases in rates of HIV infection are occurring in many cities throughout America, particularly inner cities on the East Coast. Once the virus becomes established within a community where multiple sexual or IV drug contacts occur, it is only a matter of time before it spreads progressively. Its rate of spread is partially dependent on the number of sexual or IV drug partners an individual has.

Because fidelity in marriage is often broken, and many single adults continue to have more than one sexual partner, this epidemic will be very difficult to stop and will exact a significant price on the United States. Church leaders can help limit the spread of the virus by the advice they give people in their congregations as well as through the way they conduct their own lives. By being an example to others, and by basing decisions on knowledge, everyone can play a significant role in their church and community in helping reduce the suffering and sorrow that are before us.

Medical science may ultimately develop a cure or vaccine for HIV infection. That in itself does not end the epidemic. We have had a cure for syphilis since 1945, yet syphilis increased in the United States 32 percent in 1987. Behavior will affect the course of this epidemic. The sexual revolution of the '60s and '70s has yielded an unfavorable result which we may some day view as even more threatening than nearly any other enemy we have ever faced. The solution lies in the way God has shown us how we should conduct our lives, individually, in marriage, and in relationship to those who suffer.

This epidemic is treatable, preventable, and predictable. It will cause considerable crises in many churches, but more important, it is an opportunity to show Christ's love.

II

THE CHURCH'S ROLE IN SOCIETY AND THE HIV EPIDEMIC

Jesus Christ challenges His followers to stand out in bold relief against the world around them. He calls the church to be a beacon of His truth, to season society with His grace, to permeate the world with His love and redemption. Therefore, the church has no choice but to interact with the surrounding culture by addressing physical, emotional, and spiritual needs, always pointing to Christ as the One who, through His church, provides hope and help for all of society.

The challenges of a new decade - the homeless, teen suicide, abortion, the elderly, drug abuse, HIV infection - require Christians to evaluate the church's role in relationship to people in need in new and daring ways, and to recognize the significant opportunities for evangelism.

In the face of a changing political and socio-economic scene worldwide, the church can step back, re-evaluate and set an agenda for the '90s which will reflect Christ's mandate of love in specific terms, and develop strategies that will balance the call to show Christ through both word and deed, never losing sight of the foundation: redemption through Jesus Christ.

A church building is a symbol in the community. But it is the people of the church who make the church in reality a place where truth is taught; a fellowship where people are cared for; a body of believers that reaches out to those in need.

PROBLEMS AND CONCERNS

Given Scripture's mandates, the church has the enormous and seemingly impossible task of proclaiming the Gospel through teaching and preaching, as well as through direct assistance to all in society who are hurting and needy. Certainly, without Christ the task would be impossible.

The threshold of a new decade offers the local church an excellent opportunity to: critique attitudes and past performance in light of Scripture; evaluate personal and corporate priorities; and discover creative ways to meet the ministry needs and challenges with limited financial and human resources.

POLICY GUIDELINES

The following decisions and guidelines provide a suggested structure for an evaluation of ministry needs and priorities; the moral and spiritual leadership needed to perform ministry; and ways the church can consolidate resources for more effective ministry.

DECISION #1

Determine the role that the local church and its leaders are scripturally mandated to play in society and the community.

Guidelines

As part of a regular evaluation process, church leaders can incorporate some of the following ideas designed to foster self-examination of church programs and leaders in an effort to remain true to biblical standards and local church goals.

1. Involve church staff and lay leaders in a Bible study related to the role of the church in society that can serve as a basis for evaluating church programs. This could be done in a series of special sessions, a retreat setting, or individually with study guides provided. Such a study could include examination of:
   a) The role of the church in society (Matt. 5:13-16; Matt. 22:34-40; Matt. 24:44-51; Matt. 28:16-20; Luke 13:6-9,18,19; John 8:1-11; Rev. 2,3).
   b) The call to ministry (Matt. 25:31-46; Luke 10:25-37; I John 3:16-20).
   c) The role of church leaders (Jer. 23:1-4; Ezek. 33:6; Ezek. 34:1-10; Matt. 19:16-Matt. 20:25-26; I Cor. 5; Eph. 5:1-21; Titus 1:5-9; I Tim. 3; James [illegible] John 1:6-7; I John 2:4-6).
   d) Characteristics of Christlike leadership:
      1) Servanthood (Isa. 43:8-10; 44:1-2, 21-26; 45:4; 48:20; 49:1-6; 50:4-19; Matt. 7:7-12; 20:25-28; 24:45-51; Mark 9:33-37; Luke 17:7-10; 19:11-28; I Pet. 2:18-25).
      2) Forgiveness (I Kings 11; Matt. 18:10-14; Luke 5:12-32; 6:37-38; 7:35-50; I John 1:9).
      3) Suffering (the Book of Job; John 9:1-3; Rom. 5:3-5; Phil. 1:20-29; I Pet. 1:3-9; 2:15; 2:18-25; 3:10-18; 4:1-2; 4:12-19; 5:6,7; 5:10-11).
      4) Judging others (Matt. 7:1-5; John 8; Rom. 2:1-16; James 4:11-12).
2. Gather church staff and lay leaders at a session or series of sessions to discuss highlights of the study suggested in #1 or to issue a challenge to leaders related to the role of the church and its leadership in the 1990s.
3. Ask congregational leaders to read the church constitution and any other denominational or congregational documents which outline the church's purpose and goals, particularly related to its role in society.

4. Examine the local congregation's participation with the national denomination or cooperative body; regional or state denominational or church association; local community activities and religious groups. Are the roles that the local church and its leaders take in each of these settings in keeping with biblical guidelines?
5. Request that leaders active in various church programs prepare reports outlining how existing ministries (including any materials used or produced for the program) fit into the overall local church program and how, in turn, they fit into the role of the church in society. (Use reports as input for some of the following suggestions.)

Evaluate existing church programs in light of the biblical example of the church's role in society.

DECISION #2

Guidelines

1. Review the local church budget to determine if money spent reflects stated priorities for ministry and outreach.
2. Review church programs for content focus, i.e., evangelism, discipleship, service, fellowship. Evaluate whether existing programs are balanced and consistent with the role of the church in society.
3. Evaluate existing programs in terms of intended audience, i.e., college students, teenagers, junior high students, shut-ins, babies, hearing impaired, families on welfare, engaged couples, etc. Determine whether existing ministries reflect church goals and scriptural mandates.
4. Examine curricula used in Sunday school, youth programs and other teaching and outreach ministries as a reflection of priorities and scriptural goals.

Evaluating church programs to see whether they meet the needs of various groups, such as teens, while reflecting church goals and existing mandates, is an important function for church leaders.

Determine needs of the congregation and community and design a church-wide program using existing resources that will meet those needs. It is sometimes difficult for church leaders to respond to ever increasing demands on the local congregation. The following points offer ideas for ensuring that existing ministries are meeting needs and using available resources in the most effective ways.

DECISION #3

Guidelines

1. Survey the congregation and community to discover ministry needs. Poll church lay leaders to ascertain needs they anticipate in the congregation and community in the coming year, in five years, in the decade.
2. Use data collected on existing church programs to determine whether projected and current needs are being met.
3. Determine areas of unnecessary overlap and how to use existing financial resources and manpower more effectively. For example, rather than starting a new program solely to minister to persons with AIDS, some aspects of this ministry might fit into existing programs, such as: prayer chain, shut-in visitation, or providing meals for those in need.
4. Research national, regional or local ministries active in your area to understand how they might augment and complement existing local church resources. For example, given the community and church needs and resources, a church might decide to actively support a national ministry to drug abusers rather than attempting to begin a similar local ministry.
5. Find creative ways to present church ministries to the congregation so members understand the scope of programs, how they interrelate, and the assistance needed to make them effective. These might include:
   a) A series of Sunday evening services featuring church ministry programs and their resource needs.
   b) A program in which lay leaders participate in church ministries on a rotating basis to help them fully understand the challenges and needs involved.
   c) Regular sharing of ministry experiences from a variety of programs with the congregation.
   d) A study of spiritual gifts, including an active attempt to match members with church ministries.

DECISION #4

Decide where HIV infection and AIDS fit into your church's ministry priorities, and determine how to address epidemic-related needs through programs.

Guidelines

1. Consult literature and experts to ascertain the future picture of HIV infection and AIDS in the nation and in your geographic area.
2. Evaluate existing programs to determine where HIV-related activities and ministries would best fit.
3. Use this document to structure a program for the local church which will:
   a) Educate the local church to facts about the epidemic.
   b) Lay groundwork for epidemic-related ministry.
   c) Help the congregation formulate appropriate prevention messages.
   d) Channel discussion preceding drafting of an HIV-related policy document, should the congregation decide to adopt a formal policy statement.

Golden Gate Church of the Nazarene, a small congregation of about forty members, felt a tug on our hearts to start a prayer group to pray specifically for the AIDS epidemic in San Francisco. Each Saturday morning for a year, ten to twelve people met together to discuss needs and pray for people with AIDS.

We prayed that the Lord would send us someone to minister to. After a year, a new family in the church discovered that their 6-year-old son had been infected by a blood transfusion at birth. We met at the hospital to pray for Joey and his family and began to recognize the Lord's hand guiding us into a ministry to families with AIDS.

As we learned more about the vast needs of families living with AIDS, we decided a fact-finding committee was needed. The committee composed a survey they felt would ask the questions needed to prioritize needs of those we wished to serve. Through the survey we: 1) identified a focus, 2) assessed the need, and 3) were led to respond with a heart of compassion as well as training efforts.

Child care was one of the top three needs listed by 62 percent of the agencies dealing with families that had HIV infection. We then established ourselves as an agency and hired a program coordinator to initiate a volunteer system which would provide child care for these families.

We organized this effort as a small, growing congregation. Many other churches have become involved. This cooperation means that none of the volunteers or congregations are taxed too heavily by the responsibility of the ministry. Today, nearly three years later, the prayer group still meets each Saturday morning. The ministry works and meets great needs, but the base is prayer and compassion. We couldn't continue without it.

Tere Brown

The Bridge

III

EDUCATING THE CONGREGATION

Many people still feel distant from the HIV epidemic. They believe the virus is something that only affects people who live in the inner cities. It is difficult to educate a congregation when people feel distant from the problem. The church, however, is the one institution that can offer hope for the spiritual battles that people face in dealing with the virus. The church also offers a message of morality and self-worth in educating people regarding the prevention of HIV. Thus, as congregations learn about HIV, they can be instruments of God in ministering to people in need.

The purpose of educating a congregation is so members will show compassion for persons with HIV, know how to protect themselves and their loved ones, and be challenged to minister to persons in need. The church represents a trusted, proven source of information, leadership, and opinion. It also can offer a forum for discussion in which members may feel comfortable, accepted, and able to share their questions and fears.

PROBLEMS AND CONCERNS

People give many reasons for not being concerned about individuals with HIV and AIDS, thereby missing a true opportunity for ministry, such as:

1. "AIDS is not really a big problem. It only affects homosexuals and drug addicts. We do not have the problem where we live."
2. "The AIDS problem is blown out of proportion in the news media and by the government. The reason why it grabs so much attention is that it makes a sensational news story."
3. "It will create a wrong image of our church if we become involved with a disease that affects homosexuals and drug addicts. There are other worthwhile things that our church can do more in keeping with the type of people in our congregation."
4. "It is their fault. God is punishing people for their lifestyles."

These attitudes are not in keeping with Christ's teaching or example, and effectively limit the church's ability to respond to the issue.

POLICY GUIDELINES

Following are some of the key decisions that church leaders will have to make when developing policies and plans for educating a congregation. Along with the list of decisions are some guidelines that can help everyone think through the issues.

DECISION #1

Begin by assessing the beliefs and attitudes of congregation members about HIV and AIDS.

Guidelines

1. Find out what people in the congregation believe and feel about HIV and AIDS. The best way to do this is through small group discussions in Sunday school or midweek services.
2. Identify people's fears and misconceptions regarding HIV and AIDS. Having this understanding can help church leaders anticipate problems and concerns that can affect the church. Sometimes correcting misinformation can reduce people's fears. Good sources of information are local health educators and public health nurses.

Through dialogue and careful consideration of the principles in God's word, church leaders can make sound decisons about developing policies and educational plans for their congregations with regard to AIDS/HIV.

Decide how to orient the congregation to the facts and to the needs.

DECISION #2

Guidelines

1. Define what people need to know about HIV and AIDS based on the assessment of beliefs and feelings. Address fears and misunderstandings and present biblically based information about how Christians should respond.

   List messages that should be communicated. The exercise of simply listing the key "messages" will help refine what needs to be said. Following are some examples of messages that one might want to communicate.

   a) Jesus' attitude toward the physically, spiritually and emotionally needy was one of charity. We should all have the same attitude.

   b) Jesus' actions toward the needy were those of servanthood. He was willing to reach out and heal the lepers when society had rejected and isolated them. He calls us to be servants just as He was.

   c) Jesus' command was to love our neighbor as ourself. His example of a neighbor was someone who was socially ostracized. He also demonstrated love to those who had disobeyed God's moral instruction.

2. Define the most important facts regarding AIDS/HIV. Include this information with the messages developed in Guideline #1 above. American Red Cross literature has concise information about the facts. Examples of key facts are:

   a) Early diagnosis is important for treating and preventing the spread of the disease.

   b) HIV is transmitted predominantly through sexual contact, IV drug use, and from mother to child. It is not transmitted through casual contact.

3. Anticipate congregational members' reactions based on what you have learned about their attitudes and beliefs. Recognize that people will go through predictable stages in their reactions to something that is threatening. These normal stages include:

   a) Denial, in which people refuse to acknowledge the reality of the problem.

   b) Anger, in which people realize what has happened and then strike out at others, often with irrational ideas and illogical actions.

   c) Panic, in which people are suddenly afraid regardless of the true risk.

   d) Acceptance, in which people admit to the problem and make rational commitments.

4. Train youth and adults in life skills which enable healthy behaviors and healthy relationships.

5. Think through the educational setting needed for effectively educating the congregation. Decide what is best communicated from the pulpit and what is best communicated through church committees, Sunday school, youth groups, church bulletins, etc.

6. Select educational materials and settings appropriate to the message that church leadership wants to communicate. See the resources listed in Appendix B.

AIDS was foreign to my understanding until Bill arrived at our church. The idea was not new, but its relevance to my church and ministry had never entered my mind. Like most pastors, I thought of it as a problem for "those" people.

Bill became involved in our church and we invested our lives in him. In that process, we learned of his addiction to heroin, his broken marriages, and the erratic condition of most areas of his life. During a period of absence, Bill married and then returned with his wife, Jane, and her child, Tammy. With the help of many in our congregation, this young family grew in their relationship with each other and with God. We were progressing.

But the virus brought our progress to a forceful halt. Upon learning of his former wife's infection, Bill and Jane were tested. The results were positive for HIV. And so was the test of their son, Michael, upon his birth several months later. This family's tragedy led our church into one of its most trying hours. Our burden to serve was attacked by fear; our desire to protect the uninfected was contested by the demand to guard the infected; and our call to compassion was forced to compete with our over-commitment to calendars. We struggled to do our best.

Bill is gone now, and the rest of his family has moved to another city. We know that we'll be called upon to serve others with this illness, and we pray to serve with wisdom.

Peter Pendell

Millington Baptist Church

IV

MINISTRY FOUNDATIONS

Persons infected and those close to them suffer many crises. They face the prospect of a painful, premature death and loss of loved ones. They may lose support of people close to them. They may experience economic hardship.

Because of the spectrum of needs caused by HIV infection, the church's ministry entails responding to the spiritual, material, emotional, and social dimensions of the infected, their families and care-givers.

Working as a team, the congregation can meet the ongoing, evolving crises of HIV infection. Above all, it can offer understanding and support so individuals already in the church will remain, and so those not in the church will come for help and hope.

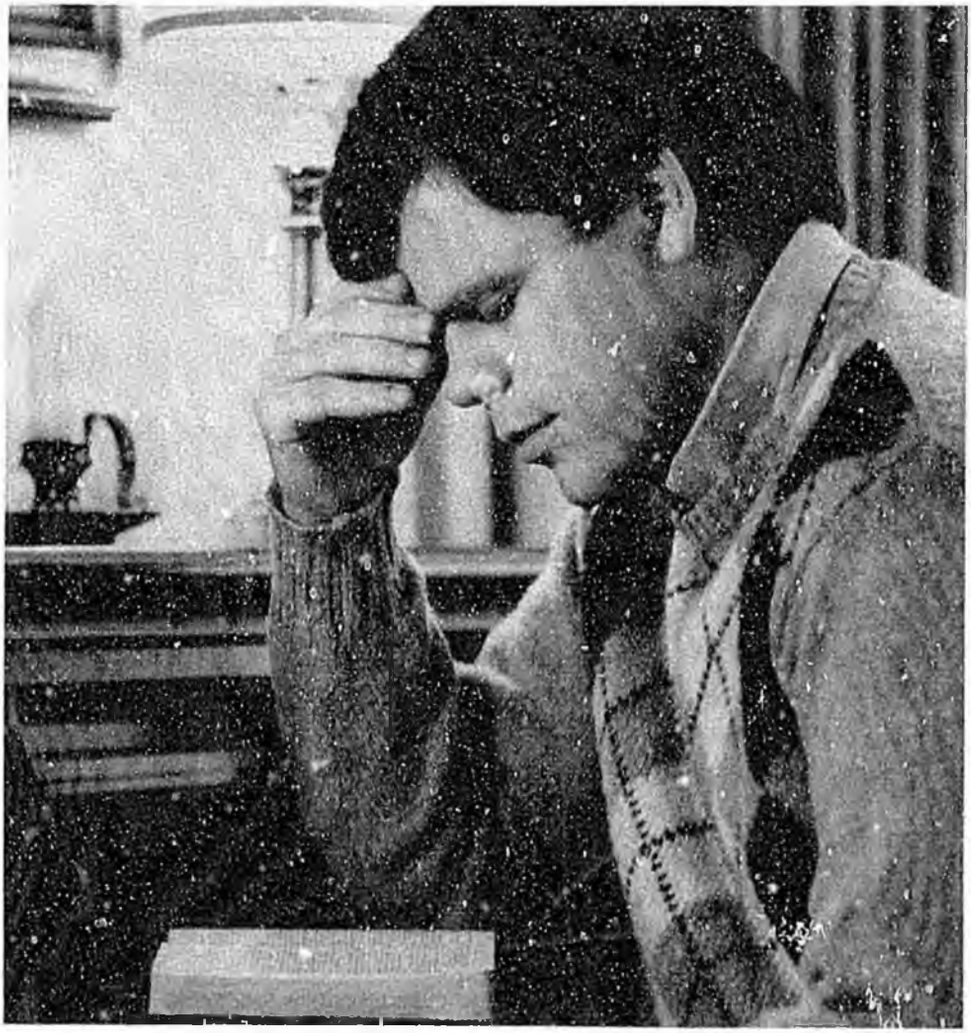
As ministry focuses on the needs of infected people, it dare not neglect strong prevention messages to avoid further infection. The educated and sensitized congregation will offer a balanced perspective and compassionate understanding of the concerns of the uninfected as well as the infected.

PROBLEMS AND CONCERNS

Traditionally, ministry both within the congregation and the community has been the role of pastors, church counselors, and laity. As the number of cases of HIV infection and AIDS rises, churches will experience new challenges because of the social complexities and impact of this fatal infection.

It is likely that congregations in virtually every community will be confronted with the pastoral needs of family units directly affected by an HIV-positive individual. Additionally, churches should address the needs of the HIV-positive individuals within the community. Church leaders need to raise the consciousness of members to provide services and emotional and spiritual support in a context of confidentiality and trust.

Churches can choose a variety of ministries to persons with HIV. Some will focus on needs of individuals and families within their own congregations. Others will extend their services outside the church: to those in prison, to foster care for children with AIDS, or to IV-drug users infected with HIV.



Church leaders should prayerfully consider how to guide their congregations in responding to the needs for HIV-related ministry.

POLICY GUIDELINES

Decisions which need to be made related to ministry concerns follow, along with guidelines to suggest important issues for consideration.

DECISION # 1

Consider what steps a congregation needs to take as it prepares to become involved in HIV ministry.

Guidelines

Church leaders play a key role in guiding the congregation in its ministry to those infected with HIV. The size of a church's membership and available funds often dictate the extent of the program that can be launched, but the following points will serve as guidelines regardless of congregation size. Church leaders can:

1. Become conversant with the many facets of the HIV epidemic and the needs of adults and children who test HIV positive. They vary quite broadly. For example, two thirds of infants who carry HIV virus antibodies at birth will not develop AIDS, but rather will become free of all traces of HIV infection, most often within 18 months.
2. Raise the congregation's consciousness on the scope of the crisis through regular presentations of information.

3. Form a fact-finding committee to assess the needs in the local community.
4. Establish an HIV advocacy group within the congregation that is made up of members with a broad base of community contacts and resources as well as those capable of guiding direct services.
5. Match the needs in the local congregation and community with the assets of the congregation.
6. Generate a list of possible services a congregation might provide.
7. Equip congregation members to serve by:
   a) Providing educational resources on HIV ministry.
   b) Conducting discussion groups to help potential volunteers work through their fears and feelings about HIV, sexuality, addiction, suffering, death, and other relevant issues.

DECISION # 2

Consider how to network with other groups involved in HIV ministry.

Guidelines

Other HIV programs and experiences provide a foundation for local church programs, as well as opportunities for involvement. Church elders might consider participation and cooperation with different local or regional groups. While some may have differing theological viewpoints, the church will have the opportunity to share its own perspective and values as it is involved. Church leaders can begin networking by taking steps to:

1. Identify the approaches of other religious, social and governmental agencies involved in HIV programs.
2. Evaluate the needs met through local community programs.
3. Identify ways that the congregation can supplement or support other HIV programs.
4. Contact congressional representatives and media to express convictions on allocation of government funding for HIV programs.
5. Develop services that can be carried out without government funding, which is limited.
6. Support larger HIV ministries with funding and/or manpower in addition to, or in place of, local church programs.

DECISION # 3

Consider which specific services your congregation should become involved in.

Guidelines

1. Demonstrate personal commitment by becoming involved with people infected with HIV. Include church members on home or hospital visits to those ill with HIV infection.
2. Motivate, enlist, and train volunteers for AIDS/HIV ministry. Important characteristics of volunteers vital and suited for this ministry are:
   a) Being sympathetic and loving.
   b) Having stability, humility, and a genuine concern.
   c) Willingness to learn and take risks in relationships.
   d) Having an understanding of the stages of HIV and the accompanying needs.
   e) Willingness to make a commitment to help throughout a person's illness.

3. Consider providing emotional support through a visitation or "buddy" program.
4. Establish a lay counseling service for HIV-positive individuals and their families.
5. Develop a group of trained volunteers who can support families and the ill with contributions of babysitting, day care, hot meals, assistance with transportation to medical appointments, and other activities of daily life.
6. Encourage members to provide foster care for HIV-positive infants or for children orphaned because their parents have died of AIDS-related diseases.
7. Provide financial assistance for such needs as health care costs, funeral costs, and expenses of daily living.
8. Have qualified church members assist with financial matters such as insurance forms, medical expenses, and the planning of a will.

V

COUNSELING

HIV develops into a devastating disease. Everyone it affects needs support and assistance in dealing with the emotional, physical, and spiritual ramifications of chronic disease and terminal illness. Just as those personally suffering from HIV need tangible assistance, so do those giving continual emotional and physical support: care-givers, families, and friends.

One challenge to the local church is to find ways of offering counseling support to all involved with HIV. Some might be done through existing programs, while other aspects related to HIV might dictate new training and approaches.

Whatever the approach, churches can provide biblically sound counseling for HIV-positive individuals, and symptomatic AIDS patients and their families in a supportive, caring environment focusing on: biblical principles; encouragement and prayer; sensitivity; and skillful listening and perception. The counseling can take place both one-on-one and in support groups, and needs to be available through all stages of HIV infection, from diagnosis to death.

The purpose of counseling HIV-infected individuals is twofold: first, to help those affected by HIV cope with the disease and its probable outcome; second, counseling needs to help individuals understand their responsibility to act in such a way as to not expose others to HIV infection, especially the person's spouse.

PROBLEMS AND CONCERNS

Churches seeking to help through a counseling ministry must grapple with several basic concerns. The church needs to decide what type of counseling ministry is appropriate, seeking out professional services in the community and tying in with those or developing a lay/volunteer ministry.

Support of those involved in HIV ministry needs to be considered. The content of counseling sessions needs to be considered, both for HIV-positive individuals and for the family and friends supporting them. A variety of obstacles that arise in counseling ministries must be addressed.

POLICY GUIDELINES

Following are some of the key decisions to be made regarding the counseling ministry of your church along with guidelines to help in consideration of the issues.

DECISION # 1

Decide whether the resources of the church can best be directed to a professional or a lay counseling ministry, or whether to cooperate with other churches or counseling ministries that already exist.

Guidelines

1. A professional counseling ministry is dependent on staff with appropriate credentials in counseling, but other issues need to be discussed as well. These include budgeting, allocating sufficient time for new clients, and serving referrals as well as church members who need counseling.
2. If the church embarks on a lay counseling ministry, the key issues to consider are:
   a) Who will provide the necessary training for volunteers?
   b) How will volunteers be recruited, trained, and supported?
   c) Who will the counseling ministry focus on? Potential individuals include congregation members as well as HIV-positive persons and those at risk in the community, such as sexually active youth, homosexual and bisexual men, intravenous drug users, hemophiliacs, sexual partners of HIV-positive individuals, and children of HIV-positive mothers.

DECISION # 2

Consider what content needs to be included in counseling.

Guidelines

1. All AIDS/HIV counseling needs to include at least the following elements:
   a) The facts about HIV infection and AIDS - what it is, how it is transmitted, how it is not transmitted, the signs and symptoms of AIDS, risk behaviors that expose an individual to HIV, and current treatments available.
   b) The resources available - centers for testing, health care providers, AIDS hotlines, support groups, educational materials, and supportive services for persons with HIV and AIDS.
   c) Material appropriate for the various stages of counseling. These stages include at least:
      1) People who are worried that they may be HIV positive or are at risk of contracting AIDS. These individuals need to be referred for testing and pre-test counseling.
      2) Those who have been tested and are negative need counseling to adopt behaviors which will not put them at risk for contracting HIV.
      3) Those who have been tested and are seropositive but not yet symptomatic. They need counseling as they progress through the normal grief stages of denial, anger, bargaining, depression and acceptance.
      4) Those with HIV and their families and loved ones need a counselor who is non-judgmental, who respects their confidentiality, and who encourages them in their right to make responsible decisions regarding their future.
2. Counseling for HIV-positive persons will cover a range of issues which will evolve as the disease runs its course.
   a) A crisis of faith. Where is God in this? Why did this happen to me?
   b) Fear of physical pain and suffering. Those with HIV often know of others who have died painful deaths and fear enduring the same.
   c) Fear of rejection. This may come from family, co-workers, acquaintances, and fellow believers.

d) Setting personal priorities for life with HIV illness. What relationships need mending? What financial and personal affairs must be set in order? How does a person's lifestyle need to be modified to live life as fully as possible with HIV illness?

e) Guilt over behavior which may have resulted in HIV infection. All individuals through repentance and faith in Christ can be free of the burden of guilt for actions committed and can experience peace and God's love in their lives.

f) Fear of death. People need the opportunity to share their fears in an understanding atmosphere. Christian counselors can share God's gift of eternal life through faith in Christ.

Counseling for family and friends of those infected with HIV can be a vital part of a church's ministry.

Consider what support is needed for individuals engaged in helping those with HIV infection.

DECISION # 3

Guidelines

The HIV-infected person has family and friends that need emotional support to cope with the illness of their loved one. Counseling geared to them may offer assistance in:

1. Coping with and supporting a terminally ill loved one. Not only will the HIV-positive individual go through the stages of grief, but those giving care will experience the same stages as well.
2. Coping and problem-solving skills for the evolving crises of HIV. A variety of problems that emerge with the stages of illness will affect those caring for the person with HIV.
3. Coping with society's response to HIV infection. Care-givers will find themselves frequently needing to be advocates in the community on behalf of the person with HIV.

4. Supporting married couples who are discordant, where one partner is infected and the other is not infected.
5. Dealing with the behavior that exposed the loved one to HIV. Often in cases where HIV has been contracted through promiscuous sexual behavior or intravenous drug use, there are resulting interpersonal tensions that need to be brought into the open and resolved in a loving atmosphere.

> I think the reason some people draw back from getting involved with people with HIV infection or AIDS is their concern over how emotionally draining it may be. Their fears of infection and dealing with death do have an influence - particularly at first. But as those fears are faced and you get to know the person with AIDS as a friend there is much to be gained from the experience. Brad, one man that I worked with, told me, "The sky is more blue . . . grass is greener, when you realize that you have limited time." I find that attitude contagious.
>
> I am more conscious of things around me . . . the seasons, beautiful music, a good laugh, lunch with a friend or the grandeur of the mountains . . . because I too have a limited time. Therefore, I am more aware of the many blessings God has given me that in my busyness are easily bypassed.
>
> My life is richer and more meaningful as a result of these relationships with my friends who have AIDS.
>
> Mike Malloy
>
> Christian Counseling Services

DECISION # 4

Generate ideas on ways the church can provide support for volunteers involved in a counseling ministry.

Guidelines

1. Devise a strategy to provide one-on-one or support-group counseling for care-givers.
2. Consider training lay counselors to augment professional ones in working with HIV-positive persons and their families.
3. Locate educational resources to equip professional and lay counselors for ministering spiritually and physically to HIV-positive persons and their families.

DECISION # 5

Develop strategies to overcome obstacles to an HIV-counseling ministry in a church.

Guidelines

Obstacles may arise that affect counseling HIV-infected persons. By anticipating what the obstacles might be, church leaders can be better prepared to deal with them.

1. Recognize the element of hopelessness related to HIV as a terminal illness and offer consistent but not unrealistic encouragement to those who are ill and their families.
2. Be aware of the possibility of burn-out, often related to grief or physical fatigue, experienced by care-givers. This can be reduced by making the meeting of needs more manageable through team ministry.
3. Be sensitive to the HIV-infected person's perception of rejection and lack of understanding within the church, which may lead him or her to go elsewhere for help.