Given the new leadership's proposals for welfare reform under the "Contract with America", it is possible that mandatory HIV testing of women of childbearing age may be introduced as a condition for receipt of public assistance or that other related amendments may be offered on mandatory newborn HIV screening. During the recent House hearings on Ryan White CARE act reauthorization, Republican representatives expressed great interest in HIV testing of pregnant and post-partum women. Speculation was also raised that an amendment may be offered on this issue in the Senate during action on CARE Act Reauthorization or in the House version of the bill.

CDC Suspends HIV Survey in Childbearing Women

On May 11, 1995 the Subcommittee on Health and Environment of the House Commerce Committee held hearings on HIV testing of women and infants. During the course of her testimony on behalf of the Administration, Dr. Helene Gayle stated opposition to any form of mandatory HIV testing of women and infants, and announced that CDC suspended the HIV survey in childbearing women. "All states [will be asked] to immediately suspend the current survey. A panel of outside experts will be convened to examine strategies to promote, implement and evaluate in all states the CDC guidelines for counseling and voluntary testing of pregnant women and their infants, and encourage the use of zidovudine (AZT) to reduce the risk of perinatal transmission of HIV."

Ackerman to Amend H.R. 1289, Calls for Mandatory HIV Testing

In response to this unexpected action which would serve to undermine his proposed Newborn Infant HIV Notification Act (H.R. 1289), Rep. Ackerman announced that very evening that he would amend his bill to call for mandatory testing.

What You Can Do

Communities of color must make their voices heard in opposition to mandatory testing of women and infants in any form. Our communities must let Congress know that any attempts to require mandatory testing as a provision of the Ryan White CARE Act or any other legislation will be vehemently opposed. Rep. Ackerman has garnered much support and already has 221 Congressional co-sponsors, including many members of color and liberal Democrats. He now wants to amend his bill to call for mandatory testing.

Call your Representative, (Capitol Switchboard, 202-224-3121) and ask her/him to oppose H.R. 1289; if already signed on as a co-sponsor, remove his/her name from the co-sponsor list; oppose any amended form of H.R. 1289 that calls for mandatory testing; and oppose any effort to attach H.R. 1289 or any HIV testing proposal as an amendment to any legislation including the Ryan White CARE Act Reauthorization. ■

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Update

NATIONAL MINORITY AIDS COUNCIL

Republicans Take Control of 104th Congress

Conservative Reforms Target the Most Vulnerable

By Miguelina Maldonado
NMAC's Director of Government Relations & Policy

The Republican victories in the 1994 midterm elections served to usurp over four decades of Democratic control of Congress and marked the beginning of a dramatic shift in ideology that minimizes the role of government in addressing major health and social problems. The Republicans succeeded in taking control of both houses of Congress, as well as a majority of the governorships and state legislatures throughout the country. This historic shift in power and ideology portends the adoption of more conservative HIV/AIDS and social welfare policy, on both the national and local levels.

On September 27, 1994, the House Republican leadership released a "Contract with America" and pledged to implement this road map for legislative change within the first 100 days of 1995. The Republican agenda as spelled out in the "Contract with America" includes proposals to reduce federal spending by $190 billion within the next five years. The proposed reductions in spending coupled with a tax cut will result in major cuts in health and social welfare programs and will ultimately have a negative impact on poor people — particularly communities of color.

Human Services Targeted

The change in the political environment and its likely adverse impact on communities of color is of major concern to the National Minority AIDS Council. While AIDS programs are not specifically mentioned in the "Contract with America", the sweeping reforms underway in Congress are aimed at people of color, the poor and the most vulnerable in America. The proposals target human services programs which have served to provide a safety net for the poor, elderly and disabled. The draft welfare reform bill, *The Personal Responsibility Act*, proposes drastic changes in the program of cash assistance to poor families with children (AFDC) including replacing important nutrition programs — food stamps and school lunches — with a block grant at a reduced funding level. The result would be to end the entitlement status and unlimited funding for the AFDC and Supplemental Security Income (SSI) programs for the needy, blind, aged, or disabled. It would also cap growth in funding for these programs as well as for child support enforcement, child care for the working poor, and 15 housing programs.

The sweeping reforms underway in Congress are aimed at people of color, the poor, and the most vulnerable in America.

The Republican proposals are based on the premises that (1) welfare spending is out of control and must be curtailed; (2) as long as the programs retain entitlement status, spending cannot be controlled; and (3) states should be given maximum flexibility in administering health and social welfare programs through a block grant structure of funding. The Republican proposals include capped block grants to the states that would replace AFDC; a separate block grant for major child care, child welfare, and

child nutrition programs; restrictions on food stamp benefit increases; eliminating SSI benefits for substance abusers; restricting SSI eligibility for children with disabilities; ending or restricting benefits for most immigrants — documented and undocumented; strengthening child support enforcement; and repeal of the Job Opportunities and Basic Skills (JOBS) program for AFDC families.

During periods of recession, the allocation of block grants may ultimately place greater rather than less burden on the state governments. If states receive insufficient funds to provide health and human services, they will be unable to respond to the changing needs of their constituents and will be forced to cut programs or fill the gaps with state funds.

Communities of color will be most adversely affected by the welfare reform proposals because large proportions of our populations depend on government-assisted programs. The proposals which will deny benefits to immigrants will also negatively impact on our communities since a large proportion of the immigrant population are people of color. While HIV/AIDS programs are not directly affected by the welfare reform proposals, the cuts in SSI, cash assistance and food stamps, to name a few, will also affect poor people with HIV/AIDS. In addition, some members of Congress have floated proposals to restructure HIV/AIDS program funding into block grants.

Now, more than ever, advocates, service providers and consumers in communities of color must organize and unite to protect those programs which have been designed to address the AIDS epidemic.

Intensified Advocacy Needed Now

This new political environment will require a shift in strategies in the AIDS advocacy community including intensified grassroots organizing. Now, more than ever, advocates, service providers and consumers in communities of color must organize and unite to protect those programs which have been designed to address the AIDS epidemic. These include the HIV programs sponsored by the Centers for Disease Control and Prevention (CDC), the Ryan White Care Act (CARE Act), the Office of AIDS Research (OAR), the Housing Opportunities for People with AIDS Act (HOPWA), and the Americans with Disabilities Act (ADA).

As Republicans push for state and local control of domestic programs, the voices of communities of color must be heard in the city councils, state legislatures and congressional district offices. We must make our presence felt in the halls and chambers of Congress through participation in organized lobbying efforts and Congressional hearings. The challenges posed to the health and welfare of communities of color by the ideology embodied in the "Contract with America" is the central focus of this year's policy conference, *Our Place at the Table: The National Meeting*, held May 22-23, 1995 at the National Press Club in Washington, DC.

NMAC has played a critical role in articulating the needs of communities of color impacted by HIV and AIDS during policy formulation and legislative action undertaken by the Clinton Administration and the 104th Congress, covering such issues as the reauthorization of the Ryan White CARE Act, FY'95 rescissions, HIV housing, HIV testing of newborns and pregnant/postpartum women, restructuring of prevention activities at CDC, FDA reform, and welfare reform.

This edition of *UPDATE* provides current information on key issues in HIV/AIDS related public policy. Various legislative initiatives presently being contemplated in the House of Representatives and the Senate, as well as Administration proposals are summarized with background information, status, and impact on communities of color. It is critical that you, as a constituent, voice your opinion to your Representative and Senator. Your voice counts, now more than ever! ■

Update
May/June 1995

Update reports on public policy issues and information on subjects in organizational management, for people in communities of color who work with issues of HIV infection. The newsletter is published bimonthly by the National Minority AIDS Council.

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In the next expanded issue of *UPDATE*, NMAC will analyze recent developments in the debate regarding HIV testing of pregnant and postpartum women and infants and examine its impact on women and children of color. Other issues of importance to our communities which will be addressed in the next issue of *Update* will include: CDC Reorganization; Kassebaum's bill, S 142, to block grant CDC prevention programs; the Administration's counter proposal — Prevention Performance Partnerships; HIV appropriations and budget; and welfare reform.

NMAC Opposes H.R. 1289: Newborn Infant HIV Notification Act

On March 22, 1995, Representative Gary Ackerman (D-NY) introduced H.R. 1289, the "Newborn Infant HIV Notification Act" in Congress. H.R. 1289 will require states to disclose the results of HIV testing of a newborn infant to the biological mother, if she is the legal guardian of the infant. If she is not the legal guardian, then the latter or the appropriate state authority must be notified of the infant's HIV status. The proposed bill requires disclosure in instances where a State requires that the results of HIV testing of a newborn infant be reported to the State. Reporting is also required if the State conducts the HIV test on the infant.

The bill would require that the results of anonymous HIV screening of infants conducted by states, such as the one funded by CDC's *HIV Survey of Childbearing Women*, to be "unblinded," meaning that the children and mothers are identified and the results of the test disclosed to the mother or legal guardian. H.R. 1289 also requires that in disclosing the HIV test results, the state shall bear the responsibility to ensure that appropriate counseling is provided to the individual about HIV.

The effect of this bill would be to tell a woman her HIV positive status but provide no services to assist her in dealing with her condition. Many experts agree, that the best way to engage HIV+ women and their children in on-going treatment and care is to provide health and social services to all women, before and during prenatal care. A recent study conducted by the Health Resources and Services Administration and the National Institute on Drug Abuse indicated that female drug abusers received significantly fewer services than their male counterparts. Of those testing positive for the first time, only 59.6% of the women as compared to 72.4% of the men stated they received help to get services.

Coercive measures will not address the problem of lack of access to health, drug treatment and social services and will only serve to deter women from seeking those already limited services. The National Minority AIDS Council, along with other AIDS, women's and children's advocacy organizations, opposes H.R. 1289.

Coercive measures will not address the problems of lack of access to health, drug treatment and social services and will only serve to deter women from seeking those already limited services.

Impact on People of Color

Rates of HIV infection and AIDS among all women are increasing and women of color are disproportionately affected by HIV. African American and Hispanic/Latina women account for 21% of all U.S. women, yet they represent 75% of the cumulative AIDS cases reported among women. In 1993 (the most recent year for which complete data are available), seroprevalence was highest among women of color, particularly among African American women, who had rates 28 times higher than white women in 21 states. These 21 states accounted for nearly 75% of all HIV infected childbearing women in the United States. In these states, 63% of the HIV positive women were African American.

While NMAC recognizes the importance of identifying HIV infected newborns and providing them with early medical care and treatment, we oppose the means by which H.R. 1289 seeks to achieve this goal. The proposed legislation violates the mother's right to written informed consent and pre- and post-test counseling. A viable alternative would be to provide all pregnant and post-partum women counseling and voluntary testing. Voluntary testing means that after a woman receives appropriate counseling from her health care provider, she is able to make an informed decision about a test for HIV. Studies show that when her health care provider talks with a pregnant woman about the HIV test and what it means for her and her baby, most women choose to be tested and treated as their doctor recommends. NMAC supports this approach along with the provision of access to needed treatment and care.

If H.R. 1289 becomes law:

- A large population of women may be deterred from seeking prenatal care because of this bill, including women who are poor, injection drug users, undocumented immigrants and those who have had negative experiences with the child welfare system and fear the loss of their child's custody.
- No adequate provision is made for the delivery of medical and social services for women and infants who have a positive HIV antibody test. Nor does the bill authorize funds for the counseling it requires states to provide.
- In states where newborn HIV screening is done anonymously and for epidemiological purposes, the effect of the bill would be to mandate testing of mothers without informed consent; require women to learn their HIV status; and jeopardize women's legal right to confidentiality regarding their HIV status.

The bill will not accomplish its goals of identifying and treating HIV infected infants and of preventing the transmission of HIV disease because:

- the tests do not accurately reflect the HIV status of most newborns. At least 75% of all babies born with HIV antibodies will shed them and test negative for the virus after 15–18 months.
- the cooperation of women is essential to the treatment of their infants. The threat of mandatory testing will intimidate and alienate mothers, causing them to avoid the health care system and possibly refuse treatment.

Continued on page 12

FDA Reform

By Moises Agosto
NMAC's Director of Research and Treatment Advocacy

Background

The Food and Drug Administration (FDA) is the agency of the US Public Health Service that regulates foods and drugs sold to consumers. The primary role of the FDA is to ensure that any drug or food item sold to the public has been thoroughly tested for safety and efficacy. The FDA also regulates the labeling of products to ensure that the drugs and food items fulfill the claims and carry all necessary warnings.

During the 104th Congress, proposals have been made to eliminate many regulatory roadblocks to corporate investment. As part of the Republican program, Congress is considering eliminating the regulations over drug development. It has been observed that some of the regulations in place put an undue burden on businesses that produce food and drugs. By liberalizing the regulations over drug development, the Republican leadership hopes to encourage companies to be more cost effective and invest more on developing drugs.

Issues

1. Drug Approval

The regulations in place are to ensure that all drugs submitted for approval for sale are safe to take as indicated and will actually produce the effect advertised on their label. Many of the regulations in place accomplish these goals, although some are burdensome and may take years to fulfill. Under pressure from advocacy groups, the FDA has put in place a shortened version of the process. This accelerated approval process places drugs on the market faster and has been used for many drugs currently used to treat persons living with HIV/AIDS.

While it is desirable that the drug approval process be expedited, removal of too many restrictions may put individual consumers in danger. Letting market forces control whether a particular drug family will be used would leave many individuals at the mercy of the drug companies. NMAC's advocacy efforts are to preserve the necessary regulatory elements that would protect consumers. At the same time, NMAC's position calls for current regulations to be reviewed to allow for greater speed in producing new medications.

2. Business Incentives

It has been argued that many of the restrictions now in place limit the ability of businesses to make profit. With some drugs requiring years to obtain approval, manufacturers argue that their profit motive is lost when they have to deal with many of the regulations currently in place. By removing many unnecessary regulations and accelerating the approval process, manufacturers will be more interested in investing in research and development to produce new drugs.

While we favor the use of market forces to encourage private investment, it should not detract from the need to protect individuals. NMAC supports efforts to collaborate with private industry in finding ways to find new drugs and treatments.

3. Consumer Protection

The most desirable outcome of the reform of regulations would be that the approval process would be streamlined as much as possible. This should consist of a review of regulations that currently prevent accelerated drug research, which should be changed or removed. However, protection of consumers should still be the first priority.

While the accelerated approval process has been beneficial in the case of several drugs, the primary role of the FDA is to protect consumers from unscrupulous individuals and corporations. The safety and efficacy of drugs on the market is essential. Removal of restrictions on the approval of new drugs should never take away from the protection of consumers.

Impact on People of Color

People of color will be adversely impacted if drugs are approved that do not meet all the consumer protection criteria. Many in our communities have already been duped by unscrupulous individuals selling false cures. Removing many of the restrictions currently in place would make it easier for members of our community to fall prey to false claims.

What You Can Do

Contact your Representative, either in person or by calling their office in Washington or your Congressional District. Tell your Representative that the most important thing is that consumers be protected while at the same time drugs must be easily accessible and affordable.

To contact your Representative's Washington Office, call the Capitol Switchboard and ask for your Representative or Senators by name:

Capitol Switchboard
(202) 224-3121

Your Representative can also be reached by writing to him/her at the address below:

The Honorable [name]
US House of Representatives
Washington, DC 20510 ■

While we favor the use of market forces to encourage private investment, it should not detract from the need to protect individuals.

New Congress Proposes $222 Million Cut for FY'95 AIDS Programs

Prevention and CARE Funds Restored; HOPWA Preservation Threatened

The proposed $23 million rescission of CDC funds would eliminate half the increases for the 1995 budget – increases intended by Congress to fund new activities under the HIV Prevention Community Planning Process.

On February 22, 1995, over $6 billion in cuts were approved by the House Subcommittee on Labor/HHS Appropriations to fiscal year 1995 appropriations already in place. The proposed rescissions[1] (taking back funds allocated for the FY'95 budget) include $23 million from CDC's prevention activities and $13 million from the CARE Act. Subcommittee member Nancy Pelosi's (D-CA) amendment to restore AIDS funding that was defeated by a vote of 7–7. Frank Riggs (R-CA), Henry Bonilla (R-TX) and John Porter (R-IL) supported cuts which would result in substantial reductions in funding for HIV/AIDS care and prevention in their states.

CDC Prevention Funding

The proposed $23 million rescission of CDC funds would eliminate half the increases passed in 1994 for the 1995 budget. These increases were intended by Congress to fund new activities under the HIV Prevention Community Planning Process.

Federal funding for prevention is critical to communities of color, particularly for organizations that are not able to access sufficient resources from local, state and federal sources to address the epidemic in their geographic areas. CDC statistics demonstrate that 56% of new cases are in communities of color; yet funding has not matched the need in communities of color. Minority CBOs have been forced to rely solely on direct funding from CDC, since state sources have note been made available. CDC's Community Planning Process provided an opportunity for communities of color to have direct input into the needs assessment and prevention service planning process on the state and local level. This increased participation would ultimately serve to increase resources available to underserved populations and to organizations targeting people of color. Any cuts in funding would mean that any new prevention activities would not be funded. These cuts would prevent new funding for CBOs that were previously not funded — primarily CBOs in communities of color. The restoration of HIV prevention funds for FY'95 was therefore an important issue for the AIDS community, especially people of color.

Ryan White CARE Act Funding

The Labor/HHS Appropriations Committee's proposed cut of $13 million for the CARE Act, which amounted to 25% of the increase over FY'94, would adversely affect new Title I cities slated to receive funding in 1995. The cuts would also impact cities that were contemplating expansion in services to meet increasing caseloads. In either situation, cuts would have prevented services from being provided in new areas and to new populations. Communities of color would be adversely affected because many minority organizations — only recently funded under the CARE Act — would be subject to reductions in their level of funding. In the initial phases of development of HIV care services, these organizations have fragile infrastructures which would be undermined by any loss of funds.

Advocates in communities of color throughout the nation have struggled for many years to gain access to the decision-making process through the Ryan White planning councils. Hard-earned victories in gaining representation and access to Ryan White service funds would also be jeopardized by the proposed cuts. The restoration of the Ryan White funds is a critical issue for people living with HIV/AIDS and especially for communities of color which continue to be disproportionately affected and underserved.

Advocacy Restores Proposed Cuts

Intensive work by national AIDS organizations — including NMAC — and grassroots advocacy from all over the country resulted in restoration of both

Continued on page 4

[1] A rescission is a cancellation of all or part of the budget authority (or unobligated balances of the budget authority) for a budget account. Budget authority is the legal permission for the federal government to spend funds. For discretionary programs, budget authority is provided through appropriations; thus a rescission is a reduction in the appropriation previously provided by Congress.

the proposed cuts of $13 million for Ryan White programs and $23 million for CDC's HIV Prevention Community Planning Program. These FY'95 allocations were restored by a vote of 37–18 on March 2 by the full House Appropriations Committee with strong bipartisan support. Rep. Pelosi offered an amendment to the House rescissions bill to save prevention and CARE funds with an offset from the Energy Department and a federal building project. Fourteen Republicans, including John Porter (R-IL) who had voted to cut AIDS funds at the subcommittee level, and the very conservative Istook (R-OK) and Dickey (R-AR) supported the Pelosi amendment. In addition, 23 Democrats voted to save the programs.

HOPWA Elimination Threatened

On February 23, 1995, the Veterans Affairs and Housing and Urban Development (HUD) Subcommittee voted to rescind $186 million in the Housing Opportunities for People with AIDS (HOPWA) Program, virtually eliminating the entire HOPWA budget for FY'95 and seriously jeopardizing housing programs for people living with HIV/AIDS. On March 2, Representative Louis Stokes (D-OH) led an effort to restore $100 million in HOPWA program funding along with other programs run by HUD. Presented to the full House Appropriations Committee, the Stokes bill unfortunately was defeated along party lines.

Since 1991, HOPWA has provided funding to states and localities on a formula basis, giving local communities the capability to plan and implement the most appropriate housing strategies and related services for persons living with HIV/AIDS and their families. HUD distributes 90% of HOPWA funds to states, with the remaining 10% distributed among various projects on a national competitive basis.

Approximately 60% of people living with HIV/AIDS will need assistance with housing at some point during the course of their illness. Communities of color, with a growing proportion of new AIDS cases (including alarming increases among women, many of whom have children) need HOPWA-supported housing services. Because of the high levels of poverty among people of color and particularly women of color, housing is a critical issue. HOPWA provides a vital safety net for individuals, families and children. The program must be maintained, and restored to its full funding for FY'95. People with HIV/AIDS need adequate and affordable housing in order to prevent the early onset of illness. Affordable housing also assists them in maintaining their quality of life and that of their families.

House and Senate Rescissions at Odds

Eight days later, on March 24, the Senate Appropriations Committee voted to pass a $13 billion rescissions bill leaving intact Ryan White, HIV Prevention, and HOPWA funding. On April 6th, the full Senate passed its FY'95 rescissions bill which did not include any cuts to HOPWA at all.

Then, the House and Senate met in conference to reconcile the differences in HUD funding cuts between the two rescission bills. On May 11, an agreement to rescind a total of $6.3 billion in FY'95 funding for HUD included a $30 million cut in HOPWA funding, bringing total HOPWA funding down to its 1994 level of $156 million. While national and grassroots advocacy efforts to save HOPWA were not totally successful, we did manage to save this housing program — so vital to people living with HIV/AIDS — from elimination. The full House and Senate has yet to vote on the conference report, and President Clinton has the option to veto the FY'95 rescission bill.

What You Can Do

Call or write to President Clinton and urge him to veto the FY'95 rescission bill. Let him know that the importance of HOPWA cannot be underestimated, as adequate housing and support services have been shown to reduce the frequency of hospital stays and their duration. Tell him that tax cuts for the middle class cannot be made on the backs of people living with HIV/AIDS. ■

ministrative costs of grantees to 10% and adds a new provision to cap administrative costs of subgrantees to 12.5% of the total grant. NMAC advocates for the development of mechanisms to provide greater flexibility in the determination of the amount of funding CBOs may spend on administration and program management. Variations in CBO size, capacity, resources and staffing should be considered in making determinations on the proportion of funds used for administrative purposes. CBOs will be doomed to failure without the investment of resources in administrative positions and systems which enable the organization to function effectively. This is particularly true in the case of many minority CBOs, which are struggling to provide services with limited resources which constrain their administrative capacity.

4. Programs for Native Americans

Native American communities are faced with unique challenges in obtaining services for persons living with HIV/AIDS. The Indian Health Service (IHS), the Public Health Service agency entrusted with caring for Native Americans in reservations, has not provided necessary HIV/AIDS related services. To date, the majority of HIV/AIDS services have been limited to seroprevalence studies. The relationships between the tribes and the Federal government have changed substantially in the recent past. Many tribes are now opting to "compact" with the Federal government to provide themselves the medical care that was entrusted to IHS in the past. Since the beginning of the epidemic the Native American non-profit sector has developed systems to respond to the needs of HIV-infected Native Americans. This has been possible through funds provided under the Special Projects of National Significance (SPNS) program of the CARE Act, under Title II, which names Native Americans as one of its target populations. Currently, there are 12 contracts under SPNS serving Native Americans. These include case management, traditional medicine, technical assistance, and infrastructure development for Native American services.

The legal relationship between tribal governments and the United States is directly between the tribe which is a sovereign nation and the United States government. Sovereign nations have no direct legal relationship to state governments. Applications for funding must, therefore, be submitted directly to the U.S. Government not the states. NMAC has joined the National Native American AIDS Prevention Center (NNAAPC) in advocating for the following as part of reauthorization:

a. Ensure that Native Americans are considered by definition a Special Project of National Significance. Projects funded under this rubric must also extend beyond the current scope of health services research and demonstration projects. The needs of Native Americans will be met more effectively by providing a mechanism to ensure continuity of services to this population as well as fair and adequate inclusion in the bill.

b. Establish a mechanism under Title II for tribes to apply directly to the Federal government for funding, giving tribes an opportunity to address the needs of their own populations and design necessary programs. This requires that some formula be devised for subtracting the tribe's portion of the state allocation under Title II. Although S. 641 does not include language to that effect, the bill must be changed to address the needs of Native Americans. As tribes begin to operate their own health care systems, it is very important that all federal health legislation include their interests.

CARE Act Reauthorization: Impact on People of Color

The CARE Act provides funding targeted for persons living with HIV/AIDS. With over 50% of the new cases of AIDS being reported in communities of color, it is essential that targeted funding for HIV/AIDS services continue. It is also critical that the funding go to those areas where there are large numbers of people of color in need of services.

S 641 has limited guarantees in place for the inclusion of people of color. It is critical that the language of the final bill be strengthened to address the needs of people of color.

What You Can Do

It is critical that you contact your Representative so that language addressing the issues described above be included in the House version of the CARE Act. Primary among these:

1. inclusion of people of color in all planning bodies of the CARE Act and change in the language regarding representation on the planning councils;
2. elimination of the single appropriation for Titles I and II;
3. minimize reductions in funding to existing EMAs and highly impacted states, phase in changes over five years to limit the negative impact the new formulas will have on existing service delivery systems;
4. provide funds for infrastructure and capacity building in underserved communities;
5. provide for flexible administrative caps for subgrantees;
6. provide for on-going funding for Native American services under SPNS and the development of a mechanism for direct application for funds from tribes to the Federal government under Title II.

Contact your Representative in person or call their office in Washington or your Congressional District. Call the Capitol Switchboard, 202-224-3121, and ask for your Representative or Senators by name. If your Representative is not available, speak to their legislative aide that works on health issues. These individuals are generally well versed on these issues and will listen to your concerns and relay them to your Representative. You can also write to your Representative at: The Honorable [name], U.S. House of Representatives, Washington, DC, 20510.

Contact both of your Senators and tell them to support the CARE Act as reported by the Labor and Human Services Committee. Call the Capitol Switchboard at (202) 224-3121 and ask for your Senators by name. You can also write to your Senators in their office in Washington, U.S. Senate, Washington, DC, 20515. ■

The bill must be changed to address the needs of Native Americans. As tribes begin to operate their own health care systems, it is very important that all federal health legislation include their interests.

Ryan White CARE Act Provisions *Continued*

PROPOSED CHANGES

Title II

Allows funds to be spent on substance abuse services, treatment education, prophylactic treatments, and for profit entities when they are the only available provider of quality care.

Requires providers of services to children, mothers and families to be part of the Title II networks.

Requires the establishment of a national minimum AIDS drug formulary for use by ADAP programs.

Requires state plans to include a description of how the plan complies with the SCSN.

Requires states to convene at least annually a broad cross section of service and community representatives to develop SCSN.

Provides new guidance for use of state administrative funds.

Requires the development of grievance procedures with enforcement mechanisms to address allegations of violations of each part or the intent of the provisions of each part of Title II.

Creates a single appropriation for Titles I & II for fiscal year 1996. The appropriation is divided between the titles based on the ratio of fiscal year 1995 appropriations: 36 % for Title II.

The Secretary is authorized to develop and implement a method to adjust the set aside for Title I & Title II to account for new Title I cities and other relevant factors in FY 1997 and extending through FY 2000.

Grants are based on an estimate of living AIDS cases weighted over a ten year period modified by the cost of providing services. 50% of the funds are allocated based on all cases in the states (including the EMAs) and 50% are allocated based on cases in non- Title I areas alone.

The funding loss a state could incur from the formula changes over the five year period of the CARE Act is capped at 7.5% (based on current funding levels). This cap would be phased in over a five year period in increments of 2%, 1%, 1.5%, 1.5% & 1.5%, accumulating per year until the 7.5% cap is reached.

Loss caps to states would be proportionally reduced consistent with any reduction in available funding.

SPNS is taken out of Title II and moved to a new Title V.

CURRENT LAW

Title III: Early Intervention Services

Title IIIA was designed to provide grants to states to give to private organizations for counseling, HIV antibody testing, referrals to health and support services, diagnostics and early intervention treatments. This Title has never been funded.

Title IIIB supports outpatient early intervention services for people with AIDS and HIV infection. Funds are granted to community-based clinics and health providers to organize comprehensive HIV services on an outpatient basis. More than half of the Title II grants were awarded to migrant health centers. The other half included awards to health care programs for the homeless, local health departments, family planning providers, comprehensive hemophilia diagnostic and treatment centers, and non-profit organizations.

PROPOSED CHANGES

Title III

Title III B requires that not less than 50% of the funds be spent on the continuum of primary care services.

Allows for profit entities to receive service funding when they are the only available provider of quality care.

Provides $50,000 planning grants for the development of services, with preference given to providers in rural and suburban areas.

Increases to 10% the amount of funds allowed for administrative purposes.

Requires services to be consistent with the SCSN.

CURRENT LAW

Title IV: Pediatric AIDS Research Demonstration Projects

Provides support for comprehensive pediatric, adolescent, and family HIV care programs and coordination of access to clinical research programs. Grants are used to provide case management, referrals to hospitals, drug abuse, mental health, social and support services. Community health centers and other public and non-profit private primary care providers serving a significant number of HIV/AIDS pediatric or pregnant patients also receive support.

PROPOSED CHANGES

Title IV

Requires grantees to provide or arrange for coordinated HIV services for the purpose of supporting or maintaining comprehensive, community-based, culturally competent, family or youth centered HIV CARE systems. Projects facilitate the voluntary participation of children, youth and women in qualified research protocols.

Provides waiver from defunding for non-compliance with the requirement to establish access to research for one (1) year if assurances are given that such noncompliance will be remedied in that period.

Title V

This new title is created.

Funding for SPNS will be provided under this title from a 3% set aside from each of the other four titles. SPNS will continue to address the needs of special populations, assist in the development of essential community-based service infrastructure and ensure the availability of services to Native American communities.

Total funding not to exceed $25 million per year.

Grants will be based on the need to test the effectiveness of a model of care; their innovative nature; or the potential for replication. Native American communities are targeted for support . Other populations include: rural communities; adolescents; homeless persons and families; hemophiliacs; and incarcerated individuals. Proposals must be consistent with SCSN.

AIDS Education and Training Centers (AETCs)

Establishes as a new part of the CARE Act funding for these clinical training programs that were previously supported through a discrete appropriation. ■

Ryan White Reauthorization

Background

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was enacted into law on August 18, 1990, to provide federal disaster relief for AIDS. Emergency assistance is provided to localities that are disproportionately affected by the AIDS epidemic. The CARE Act is divided into four titles that grant federal funds to cities, states and to other public or private non-profit entities both for direct delivery of medical services and for the development, organization, coordination and operation of more effective service delivery systems for individuals and families with HIV disease. The funding goes to cities most impacted by the epidemic (Title I), states (Title II), community health centers (Title IIIb), and pediatric demonstration projects (Title IV). Special Projects of National Significance are also funded with CARE Act funding. The CARE Act is the first comprehensive federal program and represents the largest authorization of federal funds earmarked for HIV health and social services for people living with HIV/AIDS. Authorized for five years, the current fiscal year is the last year for CARE funding. The CARE Act has provided over $2.5 billion in federal funding for services for people living with HIV/AIDS since 1991. In FY'95, total appropriations for the CARE Act were $633 million. Reauthorization of the CARE Act must occur by September 30, 1995, the end of this fiscal year, when the current law expires.

Reauthorization Efforts Fail in Final Days of the 103rd Congress

During the second session of the 103rd Congress, various advocacy groups, including the Four Title Coalition (which represents the grantees under the four titles) spearheaded an effort to reauthorize the CARE Act. NMAC was an active participant in these activities.

The efforts for early reauthorization failed due to action from Republicans, who prevented the bill from being considered by the Labor and Human Resources Committee in the Senate. While there were over 60 co-sponsors in the Senate, the legislation did not come up for consideration before the 103rd Congress adjourned on October 7, 1994.

Reauthorization Efforts in the 104th Congress

Reauthorization of the CARE Act thus fell under the purview of the new Republican leadership. The Senate Labor and Human Resources Committee, chaired by Senator Nancy Landon Kassebaum (R-KS), held hearings on February 22 1995. In her opening remarks, Senator Kassebaum delineated the goals of the hearing and her intention to address the perceived disparities and inequities in the current distribution of CARE Act funding through changes in the funding formula: "...As we will learn this morning, the face of the HIV epidemic has changed since the CARE Act was first authorized in 1990. Once primarily a coastal urban area problem, the HIV epidemic now reaches into the smallest and most rural areas of the country. As the committee considers revisions to the CARE Act, I believe it is important that adjustments be made to take these changes into account."

"Once primarily a coastal urban area problem, the HIV epidemic now reaches into the smallest and most rural areas of the country. As the committee considers revisions to the CARE Act, I believe it is important that adjustments be made to take these changes into account."
— Senator Nancy Kassebaum (R-KS)

GAO Calls for Change in CARE Act Funding Formulas

Senator Kassebaum's call for adjustments in funding distribution were supported by testimony from representatives of the General Accounting Office (GAO). In a report prepared to study current funding formulas for the reauthorization process, the GAO concluded that there were wide disparities in funding on a per case basis across Eligible Metropolitan Areas (EMAs) and states. The report further concluded that the use of the cumulative AIDS caseload as a measure to calculate the formula for Titles I & II was inappropriate because it included counts of persons who were deceased. Because of this factor, according to the GAO, newer EMAs with recent increases in AIDS cases receive substantially less funding than older EMAs. In addition, funding inequities are greater in states where the majority of people with AIDS live in EMAs, since a larger proportion of their caseload is counted for purposes of determining Title I and Title II formula allocation. The GAO concluded that greater equity can be achieved by (1) changing the current structure of the two titles to eliminate double counting of EMA cases, (2) changing the Title I caseload measure to better reflect the service population, and (3) changing both Title I and Title II formulas. As a result of the GAO study and recommendations, Senator Kassebaum expressed support for a change in the formulas for Title I and Title II of the CARE Act.

The proposed formula change, while promoted as a mechanism to create greater equity in the distribution of CARE Act funds to new and emerging areas of the country impacted by HIV/AIDS, does not however take into account the fact that 71% of all AIDS cases are located in large metropolitan areas. By restructuring the funding formulas, cities that still bear a disproportionate burden of the epidemic and continue to experience increases in caseloads will receive reductions in funding.

Following the hearing, committee staff drafted **S 641.** On March 29, 1995, the Senate Committee on Labor and Human Resources, unanimously approved the bill, the **Ryan White CARE Act Reauthorization Act of 1995.** The bill was cosponsored by Senator Nancy Kassebaum (R-KS) and Senator Edward Kennedy (D-MA).

Continued on page 7

Ryan White CARE Act Provisions

CURRENT LAW

Title I: Emergency Relief Grants to Eligible Metropolitan Areas (EMAs)

Title I targets cities that are disproportionately affected by HIV/AIDS with funds for outpatient medical care and support services. Grants are made to the Chief Elected Official (CEO) of the city or urban county that provides outpatient and public health services to the largest number of individuals with AIDS. The CEO appoints a planning council to conduct needs assessments, establish funding priorities and plan services in municipal areas with more than 2,000 diagnosed AIDS cases, or 25 cases per 100,000 people. Planning councils guarantee local community input in creating continuum of care services in their EMAs. Planning Council members must include representatives of health care, social service, mental health service, provider organizations, community-based and AIDS service organizations, individuals with HIV, non-elected community leaders and state government officials.

In FY 1991, 16 cities were eligible. In FY 1995, 42 cities qualified and in FY 1996, 59 cities are expected to be eligible for grants. Half of the funds are distributed according to a formula based on cumulative AIDS caseloads and the other half is awarded through a competitive grant process (supplemental application).

Administrative Caps: Provisions under the CARE Act currently limit the administrative costs of grantees (cities and states), but not those of subgrantees (service providers and contractors).

PROPOSED CHANGES S. 641

Title I

Changes eligibility criteria to require a Title I city to have a population of at least 500,000 and to have 5,000 AIDS cases over the previous 5 years. Existing Title I cities would still be covered under the law, regardless of whether they meet this criteria or not.

Composition of the Planning Councils (PCs) is amended to "reflect in its composition the characteristics of the current and projected epidemic in the eligible area involved (as evidenced in reported AIDS cases, HIV data, or other relevant indicators), with particular consideration given to disproportionately affected and historically underserved groups." Adds to list of PC representatives substance abuse providers, pediatric, youth and women's service organizations. Calls for an open process for nominations of members for the PCs based on delineated criteria including a conflict of interest standard for each nominee.

Requires PCs to establish priorities for allocation of funding based on documented needs; cost and outcome effectiveness to the extent that data exist; priorities of the HIV infected community; the availability of other governmental resources; and the Statewide Coordinated Statement of Need (SCSN). Gives PCs the discretion to assess the effectiveness of services in meeting identified needs. Requires PCs to participate in the development of a SCSN coordinated by the state.

Requires HRSA to give priority consideration under the Supplemental Grant applications to those areas with more severe need based on the presence of sexually transmitted diseases, Tuberculosis, substance abuse, severe mental illness and homelessness. Allows funds to be spent on substance abuse services, treatment education, prophylactic treatments and for profit entities when they are the only available provider of quality care.

Amends the descriptions of costs subject to a 10% administrative cap for grantees and adds an administrative cap for subgrantees (CBOs) of up to 12.5%.

Allows for the use of a single application for Title I funding (formula and supplemental). Creates a single appropriation for Titles I and II for FY 1996. The appropriation is divided between the titles based on the ratio of FY 1995 appropriations: 64% is designated for Title I.

The Secretary is authorized to develop and implement a method to adjust the set aside for Title I and Title II to account for new Title I cities and other relevant factors in FY 1997 and extending through FY 2000.

Grants are made based on an estimate of the number of individuals living with AIDS weighted over a ten-year period and the costs for providing services.

The funding loss a city could incur from the formula changes over the five-year period of the CARE Act, is capped at 7.5% (based on current funding levels). This cap would be phased in over a five year period in increments of 2%, 1%, 1.5%, 1.5% and 1.5%, accumulating per year until the 7.5% cap is reached.

CURRENT LAW

Title II: HIV CARE Grants

Provided to states to improve the quality and availability of existing health care and support services for persons with HIV/AIDS. Title II supports home and community-based care services, drug reimbursement, expensive pharmaceutical treatments and insurance continuation . Title II is designed to establish and support a continuum of AIDS health care, treatment and support services.

Title II establishes consortia which are associations of one or more public and one or more non-profit private, health care support service providers and community-based organizations (CBOs) operating in those areas of the state most affected by HIV/AIDS. HIV care consortia use funds to develop and provide comprehensive outpatient health and support services for persons living with HIV/AIDS. Those states that report one percent or more of all cumulative AIDS cases in the United States are required to use at least 50% of their CARE grants to establish HIV consortia in those areas with high numbers of persons living with HIV/AIDS.

Special Projects of National Significance (SPNS) is designed to award direct grants to to public and non-profit entities including CBOs are funded through a set aside of up to 10% of the funds appropriated to Title II. Organizations proposing to demonstrate innovative models of delivering health and support services to persons living with HIV/AIDS which can be replicated, are eligible to compete for these funds. Target populations include substance abusers, participants in family based care networks, the underserved hemophilia community including minorities in rural and underserved areas, "Indians" with HIV disease and their families, rural communities, incarcerated persons and homeless individuals and their families.

Continued on page 8

S 641 has the bipartisan support of 51 Senate co-sponsors and is currently pending passage by the full Senate. Advocacy efforts are aimed at having the full Senate pass the CARE Act by unanimous consent (without amendments) as soon as possible.

The House of Representative's Committee on Commerce, Subcommittee on Health and Environment, chaired by Michael Bilirakis (R-FL), held hearings on April 5. Currently staff of the subcommittee are drafting the House version of the CARE Act reauthorization bill.

NMAC Testifies Before House Subcommittee *Offers Minority Focused Recommendations*

At the hearings before the House Subcommittee on Health and Environment, Miguelina Maldonado, Director of Government Relations and Policy, NMAC, testified in support of reauthorization of the CARE Act with its existing four-title structure and advocated for inclusion of language in the House bill to address the needs of communities of color. The analysis that led to these positions focused on the issues that are particular to people of color. NMAC continues to spearhead efforts to include legislative language on the following areas:

1. Minority Representation

Language in the legislation must be changed and strengthened to ensure greater representation for people of color in HIV Planning Councils and other decision-making structures. The legislation must include language requiring the inclusion of "historically underserved and disproportionately affected communities and subpopulations, including but not limited to: women, people of color, gay and bisexual men of color, individuals in recovery from drug/alcohol dependency, homeless persons, youth, and kinship or other caregivers".

A targeted allocation should also be provided for the development of infrastructure and capacity building among organizations operating in underserved, high need communities, particularly communities of color.

The language must also allow for participation on the planning council to be determined by other co-morbidity indicators which are closely associated with HIV. These include: tuberculosis and sexually transmitted disease rates, incidence of homelessness, and substance abuse. These indicators are all associated with poverty and poor health, which in turn, relate to the incidence of HIV in communities of color as well as other communities. The legislation must allow for expanded nominations and selection for membership processes on the planning councils based on locally delineated and publicized criteria which reflects the local demographics of the epidemic and ensures diversity and representation.

2. Funding Formulas

The Senate bill includes a single appropriation for Titles I and II. Of this single appropriation, 64% would go to Title I and 36% would go to Title II. The proportionate breakdown in the Senate bill is consistent with the current funding for Titles I and II. NMAC believes that the single appropriation would lock-in this specific percentage breakdown into the legislation and therefore undermine the flexibility to respond to the epidemic supported by the current law. This would mean that if there is a shift in the burden of cases between metropolitan, suburban or rural areas, the CARE Act funding would not shift accordingly. This would prevent advocacy efforts from impacting on the breakdown of funding.

We believe that the single appropriation will also mean a potential funding shortfall for existing Title I cities, if and when new cities become eligible. Title I cities are vulnerable to a reduction in funding every time new cities become eligible. If Congress does not appropriate sufficient additional funds to cover increased costs, existing cities will suffer a reduction in funding. The single appropriation also threatens the structural integrity of the CARE Act, eliminating the distinct appropriation lines for Title I and II. Preserving the targeting of funding to metropolitan areas with large concentrations of people of color is essential to meet the expanding epidemic among people of color.

3. Program Structure

SUBSTANCE ABUSE TREATMENT

NMAC has long supported the programs that provide services to people of color. NMAC's advocacy efforts in the area of program structure have focused on those areas that impact people of color. According to the latest statistics, substance abuse — injecting drug use in particular — is directly responsible for over 40% of all cases among people of color.

The CARE Act language currently does not specify substance abuse treatment as an eligible funding category. Some Planning Councils have funded substance abuse treatment, after demonstrating the need in a particular situation. However, planning councils may not perceive substance abuse treatment to be an eligible service because it is not specified in the CARE Act. NMAC's position is that the language in the CARE Act must be altered to clearly specify substance abuse as a fundable service. The legislation should also include substance abuse treatment as an eligible service that can be funded under Titles I and II; substance abuse treatment programs as entities that should be on Title I planning councils; and supplemental funding priority to Title I cities that have severe need based on rates of substance abuse, tuberculosis, other sexually transmitted diseases and homelessness.

TECHNICAL ASSISTANCE ALLOCATION

The CARE Act must also allow for ongoing analysis of the service needs in a particular population . Planning Councils should be required to conduct, at least on an annual basis, training, orientation, and program review. A targeted allocation should also be provided for the development of infrastructure and capacity building among organizations operating in underserved, high need communities (particularly communities of color). Eligible activities for this funding would include technical assistance to support grant and report writing, program development and administration, evaluation techniques, and fiscal management.

ADMINISTRATIVE COSTS

The Senate bill limits the ad-

Continued on page 9

File AIDS

THE NEW YORK TIMES,
WEDNESDAY, JULY 10, 1996

Clinton Is Criticized by His Own AIDS Panel

By DAVID W. DUNLAP

President Clinton's own AIDS council has called on the White House to show "greater courage and leadership" in taking steps to prevent H.I.V. transmission and to protect people with the virus from discrimination.

"We commend the President's dramatically heightened responsiveness to the urgency of this epidemic," the 30-member council said in a report released on Monday. "However, when compared with what truly needs to be done, this Administration's efforts are still insufficient."

Specifically, the council faulted the Government's failure to push for needle-exchange programs, saying Federal prevention policy is "underdeveloped, lacks focus and is overly timid." And in the area of discrimination, it said the Administration has been "both notably strong and notably weak."

On behalf of the White House, Patricia S. Fleming, the national AIDS policy director, said yesterday that she believed that the report was generally "very positive."

"It makes clear the President's commitment, and it endorses his programs," Ms. Fleming said by telephone from Vancouver, where she is attending the 11th international AIDS conference.

And indeed, the council said it was impressed by the Administration's "strong commitment" to increase money available through the Ryan White Comprehensive AIDS Resource Emergency Act, which has been under attack in Congress, and by its "vigorous resistance to the proposed dismantling" of Medicaid, which pays the health costs of half the nation's AIDS patients.

The council chairman, Dr. R. Scott Hitt of Los Angeles, said yesterday that he was also glad that the Administration would grant waivers allowing foreigners infected with H.I.V. to enter the United States to attend the Olympics, which begin this month in Atlanta, and the Paralympics, which follow the Olympics.

Since 1987, foreigners with H.I.V. have been barred from the country, but the Government has made exceptions for events like the international AIDS conference in San Francisco in 1990, and the Gay Games in New York in 1994.

"There is no evidence of any harm that has come to anyone in the United States," Ms. Fleming said about past waivers. "I think it does greater harm to keep people from coming to this country, greater harm to our image worldwide and to individuals. It perpetuates the stigma and discrimination that people with H.I.V. and AIDS face."

But the new report criticized Federal policy against needle-exchange programs, in which intravenous drug addicts turn in used syringes and receive sterile ones.

The idea is to cut down the transmission of H.I.V. that occurs through the sharing of needles. On the theory that such programs encourage illicit drug use, Congress has barred Federal spending on them. And the Administration has said it cannot overcome the hurdles posed by that legislation.

"When half the new infections in this country are by people using a dirty needle, we clearly need to do a lot," Dr. Hitt said. The council did not go so far as to call outright for Federal spending but said that Government policy was "not consistent with current knowledge regarding the impact of such programs on H.I.V. prevention."

Steve Michael, an advocate for people with AIDS who is running for President under the banner of his own AIDS Cure Party, said the report "hits hard" on the Administration's prevention policies.

"The President could, with a stroke of the pen, lift the ban on Federal funding," said Mr. Michael, 40, who has H.I.V.

But Ms. Fleming said, "Those advocating that Federal funds be spent should turn their attention to the Congress."

Mr. Clinton created the Presidential Advisory Council on H.I.V. and AIDS last year. Unlike previous AIDS commissions, its purpose was not to propose national policy but to identify specific steps that the Administration could take to halt the spread of H.I.V. and mitigate its effects. The panel has issued three sets of recommendations so far.

Among them are that the Government rescind mandatory H.I.V. testing in the Foreign Service, Peace Corps, Job Corps, State Department and armed forces, if there is no public-health justification.

Ms. Fleming said yesterday that the Job Corps policy was being changed and that others were being examined "one by one to determine the rationale."

More national news appears on page B8.

THE NEW YORK TIMES,
WEDNESDAY, JULY 10, 1996

Key Russian Legislator Accuses Leading Military Officers of Graft

A1

By MICHAEL R. GORDON

MOSCOW, July 9 — In an early test of President Boris N. Yeltsin's promise to root out corruption if re-elected, the retired general who heads Parliament's defense committee has accused some of Russia's highest-ranking generals of enriching themselves from the military budget.

The charges, which have become the talk of Moscow, have rocked the military establishment.

They are also shaping, and perhaps are being shaped by, the struggle to succeed the ousted Defense Minister, Gen. Pavel S. Grachev, who has himself been implicated in the scandal.

"While soldiers are on a hunger ration, while officers wait to get a flat for more than 10 years and get no salaries for months, those close to the Defense Minister are literally living it up," said Lev Rokhlin, the defense committee chairman.

Corruption is hardly a new phenomenon within the top ranks of the military. There have been persistent reports of opulent dachas, secret bank accounts and the sale of weapons for private gain, even as Russia's military budget has shrunk and its conscript army has been deprived of basic provisions.

The problem of corruption, as well as the considerable risks in uncovering it, were brought into stark relief two years ago when Dmitri Kholodov, a 27-year-old reporter for the daily Moskovsky Komsomolets, was blown up by a booby-trapped suitcase.

Mr. Kholodov had been investigating graft when Russian troops were stationed in East Germany and asserted that two Mercedes sedans were purchased for General Grachev by selling army equipment.

The newspaper took to calling the Defense Minister "Pasha Mercedes." Nevertheless, during his years as Defense Minister, General

Continued on Page A7, Column 1

Continued From Page A1

Grachev and many of his top aides were immune from serious legal challenges.

But now that Mr. Yeltsin has dismissed General Grachev and appointed Aleksander I. Lebed, a retired general, as his national security adviser, General Grachev has suddenly become more vulnerable.

The allegations are coming from Mr. Rokhlin, a political ally of Prime Minister Viktor Chernomyrdin and also a retired general, who is well regarded within the Russian military.

Mr. Rokhlin charged on Friday that General Grachev, his key aides and other high-ranking officers are "mired in corruption."

No sooner were the charges made than Parliament voted 301 to 0 to demand a legal investigation.

The charges have also created a sensation in the Russian mass media, which originally disclosed some of the most damning allegations.

Associated Press

Ex-Defense Minister Pavel Grachev, accused of illicit enrichment.

Tonight, the independent television network NTV broadcast a report in which a camera crew and investigators from the prosecutor's office descended on a dacha settlement. The broadcast showed army trucks carrying concrete and soldiers building the dachas, which the network said were for high-ranking officers from the Strategic Rocket Forces and the Air Defense Forces.

Mr. Rokhlin's report was far more specific.

In a litany of charges was the accusation that Gen. Konstantin Kobets, a chief military inspector who is among the candidates to replace General Grachev, was part of a plot in which the military gave away a Government building to a construction company in exchange for officers' apartments that were never delivered.

Mr. Rokhlin asserted that General Kobets's son was involved in the company, and charged that the general also urged the transfer of $12 million worth of aircraft engines to the company.

At a news conference today, General Kobets denied that his son had any connection to the company and said that Mr. Rokhlin's charges were a politically motivated attempt to influence the selection of the new Defense Minister.

But much of General Kobets's account of the tangled transactions appeared to raise as many questions as they answered.

In another charge, Mr. Rokhlin asserted that Col. Gen. Dmitri Kharchenko, whose daughter is married to General Grachev's son, pocketed the interest from a $5 million bank deposit of government funds.

In the new Russia, many ousted officials tend to retain their privileges and perks. But the allegations raise the possibility that former ranking officials may be prosecuted.

And since corruption is believed to be widespread within the military and the Government, many are asking how far the anti-corruption drive will go.

In Russia's conspiracy-minded capital, the timing of Mr. Rokhlin's report produced no shortage of speculation.

General Grachev, who has protested his innocence, insisted that Mr. Rokhlin was nothing more than a stalking horse for Mr. Lebed.

"There is a simple reason for this," General Grachev told the newspaper Nezavisimaya Gazeta. "Lebed's supporters worked on him."

Mr. Rokhlin has denied that he working on Mr. Lebed's behalf. But he has endorsed Mr. Lebed's candidate for Defense Minister, Gen. Igor Rodionov, and has acknowledged that he wants to bar the door to corrupt candidates.

For all the storm and fury, some members of Parliament say more sweeping steps must be taken to fight corruption.

Aleksei Arbatov, a military expert and member of the parliamentary delegation led by the liberal reformer Grigory Yavlinsky, said that the Yeltsin Government needed to appoint honest officials and to press the Defense Ministry to disclose more information about its finances.

"That there is unprecedented corruption is not news," Mr. Arbatov said. "The system is not transparent. It is most secretive, and changing it is one of the conditions for fighting corruption."

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– Beth Winship

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Beth Winship writes "Ask Beth," the nationally syndicated newspaper column for teenagers, and is the author of *Ask Beth: You Can't Ask Your Parents* and *Reaching Your Teenager.* She is the mother of four children.

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WORKMAN

THE PARENTS' GUIDE TO RISKY TIMES

A Companion to Jeanne Blake's *Risky Times*

BY

BETH WINSHIP

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