

Proceedings

Action Alliance

The Best of Science and the Best of Program

1991 National STD/HIV Prevention Conference

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
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Centers for Disease Control

CDC
CENTERS FOR DISEASE CONTROL

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ACTION ALLIANCE

The Best of Science and the Best of Program

***1991 National
STD/HIV
Prevention Conference
San Diego, California***

Sponsored By
CENTERS FOR DISEASE CONTROL

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Plenary Session Presentations

Challenge for the Conference

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Welcome to San Diego and the 1991 National STD/HIV Prevention Conference. This is not the largest conference CDC has conducted, but it is the largest that the National Center for Prevention Services has coordinated. As of last week, there were more than 1,100 persons pre-registered, representing 50 state health department STD or HIV programs, 120 local health departments, 28 national or regional minority organizations, 135 community-based organizations, other Federal agencies, and a variety of other professional, service, or advocacy organizations. We represent different races and ethnicities, different cultures, different sexual orientations, and different value systems. We include physicians, nurses, lawyers, teachers, social workers, mental health workers, managers, administrators, community organizers and outreach workers, and volunteers. Some of us have been working in STD prevention and control for many years and have recently become involved in HIV as well. Others were not primarily involved in public health work until the advent of the HIV epidemic and have been totally immersed since then. Still others have a more personal involvement, since they have HIV infection or AIDS.

We are, in short, a very diverse group with widely varying backgrounds, skills, attitudes, and agendas, but we do share a common determination—to prevent transmission of sexually transmitted diseases, including HIV infection. Our challenge is to take advantage of the collective wisdom and experience represented here and develop a comprehensive, integrated approach to STD/HIV prevention. I intend to address briefly each of the adjectives—comprehensive and integrated.

Comprehensive

With passage of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE), for the first time we have a legislative mandate and a funding mechanism (in Title III) to develop and implement HIV prevention programs which include not only primary prevention activities but also follow-up services for those found to be infected. I think we

all welcomed passage of this act as a means of expanding access to, and provision of, services which may be critical to improving the quality of life and extending the life span of persons infected with HIV. Current funding levels, however, do not permit full implementation of all of the activities required by the Title. Several sessions at this conference will be devoted to consideration of the implications of CARE as currently funded so I will not go into detail here. We are hopeful the situation may improve in future fiscal years, but that is not at all clear at present.

Integrated

Please notice that I said **integrated**, not **uniform**, approach. The unabridged *Random House Dictionary of the English Language* defines **integrated** as follows:

1. "Having on a basis of equal membership individuals of different racial, religious, and ethnic groups: an integrated school.
2. Combining or coordinating separate elements so as to provide a harmonious, interrelated whole: an integrated plot. . ."

By contrast, **uniform** means:

1. "Having a single form or pattern; consistently following a definite formula or set of rules; unchanging; consistent over the full range of occurrence: uniform spelling . . ."

We are not talking about a nationally uniform program, with everyone marching lock step. What we are hoping to achieve is a locally, state, and nationally coordinated, integrated STD/HIV prevention program in which we are all working to achieve a common goal but using tools which may vary according to local needs.

In the context of this conference, I refer to integration in several ways: integration of governmental and non-governmental efforts; integration of HIV and non-HIV/STD prevention efforts; and integration of local, state, and national efforts—a true "Action Alliance."

Conditions considered under the rubric of sexually transmitted diseases share several characteristics, most notably that they are transmitted through sexual contact. Consequently, they are most common among persons who are highly active sexually with multiple partners and who do not use risk-reduction techniques such as condoms. Many are also spread from mother to infant and through injection. Beyond these similarities, however, there are many differences. The micro-epidemiology of the diseases may vary greatly—some are more common among men who have sex with men than among men who have sex only with women.

Although many of the “traditional” STDs can be spread through needle-sharing, this is a major mode of transmission of HIV. Some of the infections are self-limited, even without treatment, and thus carry few long-term ramifications; others are readily treatable with antibiotics; still others represent life-long infections with significant long-term implications, both for the individual and for his/her sex partners.

Traditional STD prevention and control programs, based in official health agencies, were developed against syphilis and subsequently gonorrhea, bacterial infections with relatively short incubation periods which were easily and quickly cured with penicillin or other antibiotics. With these conditions, identification and treatment of the patient also had an important primary prevention effect—the patient was no longer capable of transmitting infection to others. Rapid identification, examination, and treatment of sex partners could and did result in interruption of community chains of transmission.

But success led to complacency in some circles. STD programs over the years have undergone major swings in levels of support (from local, state, and Federal levels) and priority, partly reflecting their impact in reducing morbidity levels. At one point, a former Director of the (then) Venereal Disease Control Division at CDC said of the syphilis control program: “They eradicated the program before they eradicated the disease.”

One result of this has been that STD control program managers have been forced to focus on what are considered the core elements of syphilis and gonorrhea programs: selective screening in high-risk population groups; provision of clinical services for rapid diagnosis and treatment, and partner identification; examination, preventive treatment, and treatment of infection. Relatively little attention was paid to modification of sexual behaviors because little was known about successful interventions, because there was no agreement as to the appropriateness of governmental involvement in this arena, and finally, because the conditions were readily

treatable if the individual or sex partners should become re-infected. More recently, the same approaches have been successfully implemented in demonstration chlamydia control programs.

Growing awareness of the incidence, prevalence, and implications of viral STDs in the late 1970s and early 1980s led researchers and public health practitioners to the realization that effective interventions were needed for these diseases also. However, there were no cures available and, for many, an infected individual remained infectious for the rest of his/her life. Clearly, substantial information was needed about sexual practices in the United States and means of affecting them. However, the social/political/economic climate at the time was not supportive of the allocation of significant Federal funding in this direction. At the same time, there was not great enthusiasm for expanding public funding for STD control activities. STD programs were thus left with the realization that much more needed to be done to address viral STDs, that available technologies were insufficient to do the task, and that help was not necessarily on the way. It may not be too great an exaggeration to say that many STD programs have been essentially frozen at that stage until recently, with resources inadequate even to fully carry out “traditional” programs, much less expand to viral diseases. Since these programs were primarily based in official agencies without a great deal of active community involvement, there were not effective advocates to call attention to the needs. However, good relationships were established between many urban STD programs and the gay community as evidenced by cooperative screening, treatment, intervention, and follow-up programs in bath houses and bars. These relationships helped facilitate subsequent close working relationships between gay men and their communities and official agencies in AIDS prevention and service activities.

The appearance of the AIDS epidemic in the early 1980s galvanized several segments of society in addition to the public health system. The greatest initial impact was among gay men in San Francisco, New York, and Los Angeles, cities where there were well-organized gay communities with long-standing records of political activism and a willingness to talk openly about sexual activities. Other community organizations subsequently saw the current and potential impact of HIV infection on their constituents and also became quite politically active. The result was that, from early stages, HIV prevention and control activities have had a degree of active community participation that few STD programs ever achieved and that a new attitude developed generally (although not universally) about the appropriateness of studying and attempting to modify sexual behaviors, as well

as needle-using behaviors, to prevent HIV infection.

In April we convened a group of 19 individuals from diverse backgrounds to discuss the effectiveness of, and suggest improvements in, current STD prevention and control activities; and to discuss additional and alternative strategies that could be applied to further reduce STD transmission. Participants included persons with knowledge and experience in sex research, women's issues, gay issues, drug abuse, school-based education, the sex industry, behavioral science, community-based organizations, etc. Few had extensive experience in traditional STD control programs. Panelists were asked to provide their suggestions individually; group consensus was not sought. A detailed summary of that discussion will be available to all of you soon, but I want to share with you now a few of the comments made by several panel members:

- Strengthen the partnership among public and private agencies and non-governmental organizations involved in STD control at the national, state, and local levels.
- Develop and disseminate flexible guidelines for community-based STD control programs.
- Provide technical assistance to states in adapting guidelines for community-based STD control programs to suit local needs and priorities.
- Assess the effectiveness of current prevention and control strategies.
- Conduct behavioral research to identify alternative prevention strategies.
- Promulgate consistent messages to the public on STD exposure and transmission.
- Tailor public education messages to the target audience.
- Improve coordination and integration of public and private treatment services.
- Improve the counseling received by infected individuals who present for treatment.

These comments and recommendations bear a striking resemblance to activities currently under way in HIV prevention programs and to issues we have been discussing recently in HIV prevention meetings.

Over the past 3 years, we have been making a concerted effort to assure integration of HIV prevention activities between official and non-official agencies and to ensure that we have the best possible access to those in need of services by working through community organizations known to them and trusted by them. We have learned from each other and, I think, have been fairly successful so far. We now wish to ensure that other STD prevention activities are integrated with the HIV prevention programs. This is already the case in many areas, but in some areas the programs are totally

separate, although they deal with much the same populations and address conditions that are transmitted in the same ways. Given the fact that resources will never be adequate to do everything we want in any program, we must try to achieve the most we can with available resources.

This does not mean that we advocate that every single local STD program immediately undertake a full range of HIV prevention activities or that every community-based organization now working with HIV should immediately add a full range of other STD prevention activities. What we do recommend is that HIV education activities should include other STDs and that STD education activities should include information about HIV prevention. Outreach workers should be explaining that condoms can prevent syphilis and gonorrhea as well as HIV transmission. STD clinics and STD health educators should begin talking more about modification of sexual practices and the use of condoms for both HIV and other STD prevention. We should try to bring STD testing and treatment to HIV counseling and testing sites, and we should try to ensure that all facilities dealing with other STDs also offer HIV services.

Our hope is to achieve an STD/HIV prevention program which integrates governmental and non-governmental organizations; which integrates HIV and non-HIV/STD prevention activities; and which is integrated at the local, state, and national levels. Given the striking variation in needs around the country, it would be folly to seek a uniform program. We do hope, however, that the various programs will share important characteristics.

In 1908, Israel Zangwill wrote a play entitled, "The Melting Pot," which included the line: "America is God's crucible, the great melting pot where all the races of Europe are melting and re-forming."

Mr. Zangwill had it all wrong. First of all, he ignored the majority of the world's population, including Asia, Africa, and the rest of the Americas. Secondly, I believe our strength comes not from melting or homogenization, but from appropriate use of our diversity. Speaking on a slightly different topic (foreign policy) in a 1963 speech, John F. Kennedy said:

Let us not be blind to our differences—but let us also direct attention to our common interests and the means by which those differences can be resolved. And if we cannot end now our differences, at least we can help make the world safe for diversity.

In the area of prevention of sexually transmitted diseases and human immunodeficiency virus infection, let us build on our diversity to develop programs which are locally, culturally, and linguistically appropriate and which offer a comprehensive range of integrated services.

AIDS and Sexually Transmitted Diseases

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Today there are over 300,000 **reported** cases of AIDS from over 155 countries, but the **estimated** number is over 1.3 million cases, which includes 500,000 children. Between eight and ten million individuals are infected worldwide and 75 percent to 80 percent are the result of heterosexual spread.

Infection rates are as high as 25 percent to 30 percent of young adults in some sub-Saharan cities (Malawi, Johannesburg, and Uganda). One in 49 sub-Saharan females are infected compared with one in 500 South American females and one in 700 North American females. By the year 2000, 30 million adults and 10 million children will be infected and 10 million uninfected children will be orphaned.

There will be a 50 percent increase in infant mortality in Africa in this decade because of AIDS. (In some cities in Africa today, AIDS is the leading cause of adult deaths.) Deaths from AIDS could equal or exceed the expected adult deaths from all other causes by the year 2000.

In the United States there are over 170,000 cases of AIDS—90 percent between 20 and 49 years of age and 20 percent between 13 and 29 years of age. New York, California, Florida, Texas, and New Jersey lead the list of states with the highest numbers of cases (New York and California = 40 percent) and New York City, Los Angeles, San Francisco, Houston, and Washington, D.C., are cities with the highest prevalence (New York and San Francisco = 24 percent).

Sixty-six percent of the cases are among homosexual and bisexual men, 22 percent among intravenous drug users, 2 percent among transfusion recipients, and 1 percent among hemophiliacs. Over 60 percent were infected through sexual transmission with heterosexual transmission accounting for 5 percent of all newly diagnosed cases and 30 percent of cases among women. Whites represent 55 percent of adult cases, blacks 28 percent, Hispanics 16 percent, but the percentage is different among children. White children represent 21 percent, blacks 50 percent, and Hispanics 25 percent. This means that 75 percent of all children with AIDS are children of color.

Half of all the gay men in San Francisco are infected, half of the drug addicts in New York City, and one-fourth of all medical/surgical beds are occupied by AIDS/HIV cases in

New York City. Over 105,000 have died including 3,000 children. As time progresses, we will see increases among blacks, Hispanics, females, children, and drug users.

Over 250 million sexually transmitted infections are estimated worldwide, including 3.5 million cases of syphilis, 20 million cases of genital herpes, and 25 million cases of gonorrhea. The highest incidence is among youth 15 to 29 years of age.

Although in many industrialized nations, gonorrhea, syphilis, and chancroid have almost disappeared, they have been increasing at epidemic rates in the minority populations of urban America. The causes are many, but **poverty and social disintegration** and sex for drugs appear to be major factors. The racial difference in sexually transmitted disease rates has significantly increased over the past 5 to 7 years with **30-fold** higher rates of gonorrhea among blacks compared with whites and a 129 percent increase in rates of syphilis among black men (192 percent) while **among whites it actually decreased** (largely because of changes in homosexual behavior.) The use of and the exchange of sex for crack cocaine, young age, single marital status, low income, urban residence, and lack of education are all related to the incidence of sexually transmitted diseases among individuals.

Even with the availability of a vaccine and the incredible change in high-risk sexual behavior among gay men, there has been very little change in the incidence of hepatitis B infections since 1982, largely because of the new cases attributable to heterosexual contact and intravenous drug use.

Although sexually transmitted diseases in general have not been of major interest to governments or the public in the recent past, the presence of HIV/AIDS has directed much more attention to them, and this gives us an enhanced opportunity to prevent them. In and of themselves, sexually transmitted diseases are significant because of the problems of sterility, infertility, stillbirths, blindness, brain damage, disfigurement, and cancer that they can cause. Added to this is the growing evidence that some of the sexually transmitted diseases can increase the risk of transmission of HIV up to 300 percent through genital lesions and inflammation

that they cause. Interestingly, some sexually transmitted diseases are less responsive to traditional therapies among persons infected with HIV. Thus, HIV may also increase the spread of sexually transmitted diseases.

It is very evident that the world and the United States are facing two major health problems—sexually transmitted diseases in general, and AIDS in particular. The roots of these problems are similar, as are the necessary actions to deal with them.

Preventive actions against both are hindered because of the relative ease of transmission, the difficulty in changing sexual behavior, the lack of vaccines (except for hepatitis B) and, in some cases, the absence of curative treatments. Add to this the political impediments created by people like Jesse Helms and William Dannemeyer who have tried to make it almost impossible to get the most appropriate information and education to those at greatest risk.

Finally, the demand for public health care and preventive services has outstripped the capacity of many public and community-based programs. Infighting among and between programs has also been detrimental.

The primary mode of transmission of both HIV and other sexually transmitted diseases is sexual, many of the preventive measures are the same, the target audiences are also similar, STD clinical services are an important point of access for persons at risk for both, and there is a strong association between the incidence of HIV infection and other sexually transmitted diseases. These facts make early diagnosis, treatment, and counseling for STDs an effective strategy for the prevention of HIV transmission. All of these factors cry out for the close coordination between HIV and STD programs. This coordination can help minimize the costly duplication of staff activities and services and can increase overall program effectiveness by maximizing technical and managerial expertise.

Obviously, for this to take place, we must have accessible, acceptable, and effective public and private clinical services for diagnosing and treating STDs and HIV. This will require more well-trained staff, improved and enlarged clinic facilities, and more funding for laboratory services. There must also be integration of STD/HIV services with family planning, adolescent clinics, and drug rehabilitation programs, as well as coordination with community programs such as Job Corps, Head Start, housing, and prison services.

We must involve all of these groups and non-governmental organizations in an all-out educational campaign utilizing schools, government, industry, the religious community, and the media. One example of a successful program can be found in Sweden where sex education is compulsory in all schools and is linked to extensive clinical services for adolescents, including the availability of condoms. Gonorrhea and syphilis have almost disappeared.

Rather than separate educational and informational programs for HIV and other STDs, there should be a coordinated approach that also deals with the determinants of behavior and the actions that can be taken to reduce the risk of infection; we know that knowledge alone is insufficient. Common training materials and guidelines for behavior interventions should be developed.

Surveillance of HIV and STDs should be complementary and mutually beneficial. Identification of populations for surveillance, the training of personnel, and the data analysis can all be coordinated, even though the actual epidemiological process may be different. HIV often deals with unlinked anonymous testing of sentinel populations; whereas, STD frequently deals with casefinding, diagnosis, and treatment of often clinically linked cases.

Research should also be coordinated where there is an obvious overlap in the clinical, epidemiological, behavioral and/or health service areas. Obviously, the coordination and actual combining of STD/HIV programs should acknowledge the distinct aspects of HIV disease and STDs such as the opportunistic infections and non-sexual aspects of HIV disease and the STD-related complications such as infertility and cervical cancer.

Finally, we must have the political commitment of this and future administrations; we must have what I call the four "Cs": **Cooperation, Collaboration, Communication, Compassion.**

As I look at this audience and see people who have been working in the trenches for years in STD, and now in HIV; when I realize that monies formerly used for STD have been cut back in many communities because of HIV—instead of being a reason to work at odds with each other—we really need to come together, to work together, to try to bring the scourge of the '80s and '90s, AIDS, to an end. We can only do that with **cooperation, collaboration, communication, and compassion.**

Meeting the STD/HIV Challenge Through Collaboration: Coalition Building

Jane L. Delgado, Ph.D.

Executive Director

Coalition of Hispanic Health and Human Services Organization

Washington, D.C.

It is a great pleasure to be here as well as an honor and a surprise. An honor, because of the gathering that we have here and a surprise because the organization I head, COSSMHO, has an ongoing "love-hate" relationship with CDC. I think inviting me to speak says a lot for CDC. They're probably very surprised that I'm giving them compliments, for it has been a struggle—I'm going to talk about that, because I think one of the things you have to understand is that my topic, "Meeting the STD/HIV Challenge Through Collaboration: Coalition Building," has a lot to do with the struggle that our organization and the organizations that we've worked with have had with CDC. I think there is a lot to learn. I think there are many things that we can all take great pride in. The fact is that I can look around this audience and see many Hispanic, black, Asian, and Native American faces. Even though you think you are very few, many years ago, most of you would not have been here. I'm sure if we went across the street to the Association of State and Territorial Health Officers (ASTHO) meeting, you would see a different diversity.

Anyway, as you know, I'm a clinical psychologist and interested in behavior change, not attitude change. That means, I want to see how organizations change and how they relate to individuals. You don't have to like me, you don't even have to want me, but you do have to treat me in a way which is respectful. That's the basic underpinning for any collaboration—respect for institutions. Remember, my patient is now institutions—I no longer want to do therapy. I tell people that I'm still licensed in the district, but now my patients are the Federal institutions who don't *want* to change, so it is much harder to get them to do some things I'd like them to do. When we talk about collaboration, we have to understand the context in which I speak as head of COSSMHO. COSSMHO is very unique. We started out in California 18 years ago with the idea that, for Hispanics to get ahead, we had to work together as a community. We were founded by two Mexican-Americans and one Puerto Rican social worker back in the early '70s. That kind of thinking of unifying all the communities was very unique. We also started with the idea that we were not going to focus on

everything. We were not going to focus on civil rights as did many organizations of the 1970s. We were not going to do bilingual education or integration. If anything, we were going to focus on mental health. That's how we started. By 1981, our focus had broadened, based on the needs of our members, and became health and human services. When we started to look at our communities, we looked around and saw what was happening, and one of the first things that we decided to do was to work in the area of collaboration, working with other organizations (and our members are organizations). At the national level, what we often do is work with other national organizations.

Back to my clinician skills—one of the things that you have to understand is that process and coalition building is crucial, and coalition building is no more than building relationships with people. When we're talking about STD and HIV it becomes harder, because what we bring to the agenda are personal behaviors and sexuality, topics which are very difficult for diverse communities to talk about—topics which historically even within our own communities, have caused division among members of our communities. When we talk about collaboration, we have to be very careful about three things. One is how we identify our partners, the second thing is how we negotiate our terms, and the last thing is how we are going to implement whatever we say we're going to do.

In identifying partners, remember I said coalition building is forming relationships. If you look at data on America, you can tell that, as a country, we are dismal in forming relationships. It's probably why a lot of our coalitions don't work either. We transfer a lot of the behaviors over to coalition building that we have in our own personal lives. We need to look at a person's history, an organization's history—how was that organization founded, who founded it, what was the event that caused it to occur? We have to understand that without looking at our own bias. I think what happens too often when we look at an organization we want to work with, we see them as fitting into a niche, Hispanic female, head of a health organization. That's one "check-off." But, if we're going to collaborate with people, we have to go beyond that, and I think that becomes very important. So, when you are

identifying partners for collaboration, look at the history.

The second thing is, look at the resources of that organization in terms of finances, diversity, staff, and expertise. One of the things that happens very often is that Hispanic organizations, community-based organizations, are invited to meetings, but there are no resources for them to get there. People say, "Well, we invited you, but you didn't show up." That does not get you off the hook just because you invite someone. If you really want to form a collaboration, you've got to get the people there. I think that's where we sometimes miss in identifying our partners, because we invited them and they didn't come and the people say, that means they really didn't want to be there or that wasn't an important issue for them, when in fact, their resources were limited and they could not attend.

The third thing is identifying the constituency which an organization represents. That is very important. You have to understand who that organization is talking for. COSSMHO speaks for our members and those people who consider themselves our members. We can't say we speak for all Hispanics. Anyone who tells you that their organization speaks for everyone, believe me, I know that someone is going to get up in the audience of that group and say, "But they don't speak for me." That's all right; you have to understand who people represent.

The last thing you have to understand when identifying your partners is history, resources of that constituency, why they're involved in a certain problem. This is a very delicate subject because in no subject have I seen more experts jump up than I have in HIV. When I worked in Health and Human Services in 1983, the Secretary I worked for, Margaret Heckler, announced that AIDS was the major health problem for the United States. Many people don't remember her fondly, partly because she did come out and make that statement. She lost a lot of supporters in the White House and other places. The other thing that people sometimes don't realize is that in those early years, many people did not want to be active in AIDS. When I got to COSSMHO in 1985, they had already held their first AIDS workshop (in Los Angeles in 1984) and seven people showed up. In 1986, one of my staff people staffed a booth to give out information about AIDS at the National Hispanic Journalists' Association. Many people would go up to her and say, "Get out. Don't talk about this. Why are you stigmatizing our community?" Over the years, I have softened. I used to get angry at the "AIDS banditos," but I don't anymore. I sort of feel that there is a voice, a place for everyone and some of you (and I hope your consciences are really on), I hate doing this, but AIDS is something very important and it's not something that people

should just see as a way to make money, and I know many of you don't. It's something that people have used to fund a whole variety of things. That has been an ongoing struggle and an ongoing problem. So, when we look at why people are involved in AIDS, please understand, "how come?"

I understand that there are people who like to divide those people who are HIV-positive into those who are "innocent" and those who are not. That is the worst—that tells you who that group really is. You have to be very aware of them. I think that when people are HIV-positive, we have to serve them. When people have STDs, we have to serve them, too. If we're going to be looking at who I would identify as partners in our collaboration, we have to know who they are by their history, not by our own stereotypes of them. We have to know what resources they have, the constituencies they serve, and their involvement in the topic.

The next thing we have to look at is how we negotiate terms with organizations. As one who is always asked to collaborate on a whole host of things, the most important thing to remember is when you collaborate with me, and I know Gary Noble is going to laugh, you don't get acquiescence. That's not what you are getting; you are getting someone who is going to give input. And, like my husband would say, "Sometimes she agrees and sometimes she doesn't, but you always know what she thinks," and that is what collaboration is about.

Too often people want to include a group, be it a gay group, a Hispanic group, a black group, and even among our own community, people are invited in because they want their silence. That is not how we form coalitions. That is a way that we get little "check-offs" and in the end it comes back and bites you. How do you negotiate terms with people? Well, if you are going to have a coalition with real collaboration, you have to exchange things. You know what community-based organizations need—money! They need money! It is very hard for them to do the work they do with the limited resources they get. It is very hard for you to do the work you get with the limited resources you have. But, you also have to be very careful of where you expend your energies, and I am going to say something that many of you may not know. A lot of people say, "Well, let's not have a stealth bomber, then we'll put it on AIDS." Actually, those people want you to waste your energy, because Gramm/Rudman was passed years ago and Congress, a Democratic Congress, passed this law and the way it passed, you cannot take defense dollars and put them in health and human services. They have to change that law, they have to go back to that, so that when people tell you, do something, go back to this Gramm/Rudman Law, that's where the problem starts. Don't

think that if you say, "Well, how come they didn't change things?" They structured things in a way that you can't change things that easily. I'm not too sure if that's the answer. I have other answers for saving money. When you negotiate terms, you have to put cash on the table.

We're a national organization, but trust me, we are poor. We have a total budget of \$2 million dollars; we have 23 staff members, but we give 35 percent of our dollars to community-based organizations. Look at national organizations and see how many of them give money to CBOs. Look at government and see how many of them give money to CBOs. Look at major contractors who work for profit and see how much money they give to CBOs. Community-based organizations—I'm sorry but that's not the local health department to me. It is not. I love the local health department. We've worked with you, we're supportive, but you have a very strong advocacy group in Washington that supports you. Our CBOs who represent other people do not, and it is harder for them to get money. When you give money, many of you don't give it to our CBOs, so it's hard for us to support you when you are not supporting our agencies.

Negotiating terms—who will do what? What will they bring to the table? Where will the sites be? I had a major national volunteer organization that wanted to do work with COSSMHO in the Hispanic community in Los Angeles. Their site was going to be out in Westwood. Good intentions, but, it's not going to meet our needs. We as organizations have also got to learn to say "no" to certain things and it's very hard. I tell you that we need money, it's very hard for us. For example, COSSMHO does not take tobacco or alcohol money or money from their subsidiaries. We as an organization have to say that sometimes we're not going to collaborate with people, and I think that's very hard because we're needy, but when we start taking money from people, I think it becomes harder to be as outspoken as we could otherwise. Fortunately for COSSMHO, we have a history of being outspoken, so people know that if we're not included in things then other people wonder why we're not there, so it is better for us to compete and to get awards and things like that than for us not to be there. If we're not at something, don't think we weren't invited, you should call some of us and ask why we're not there. There is usually a very good reason.

Let's say that you have built a coalition that you have never worked with before. You have to make sure that you have identified the partners and that you have a good idea that you've negotiated terms. Don't tell me what to do, I'm not big on obedience, let's work things out. So, the same thing with our communities you do in a good relationship. If you have a good relationship with someone, you don't tell them, "Do the dishes, do this, walk the dog, do the garbage." No, you negotiate. So, when you are collaborating, negotiate with people.

The final thing is, know that people and organizations are dynamic. Can you believe people like to stereotype? It's amazing to me, but people do this and they'll form a relationship with you because of a certain stereotype, sort of like thinking that you are always going to be the same, not recognizing that your needs and the needs of your constituency are fluid, changing, and if you are a good leader, what you are going to advocate is also going to be fluid and changing. So, whatever you do in building a coalition, you have to keep in mind that those members and what they represent are going to be changing, and you have to have a process in place that will allow for change. You know from your own personal lives that rigidity is not something that stimulates growth. When you think of building collaborations, when you think of coalition building, remember that the kinds of things important for personal relationships are also important for relationships between institutions. If you don't, you will have an abusive situation, a divorce, or you'll have one partner walk out. I look forward to working with many of you. I want to make sure that you'll realize that COSSMHO's relationship with CDC is something which we're proud of, and we're proud because even though we've battled with them, and believe me we have battled, we've also grown with them in that they have grown and become much more. How can I say it? When we first started working with CDC, their main agencies were state and local health agencies. In a very short time for government, they have changed and now include community-based organizations, not as much as we would like, but much more than many other agencies. I want you to know that coalition building is a process. We expect you all to be a part of that challenge, but also, like they used to say in the 1960s, be a part of that solution. Thank you.

The Impact of HIV on STD/Public Health Infrastructure

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Today, I would like to talk to you about the impact of HIV prevention programs on the public health system. Strengthening the public health infrastructure is one of CDC's most important goals. But before I talk about specific efforts to accomplish this goal, I believe we need to talk a little about why programs for the prevention of HIV infection and AIDS are so important.

AIDS has established itself as a leading cause of death in the United States. As early as 1987, it was the 15th overall leading killer of Americans. In 1988, AIDS was the third leading cause of death among U.S. men 25-44 years of age (which is 34 percent of all males); in 1989, it had moved to second place, causing 14 percent of all deaths among men in this age group—surpassing heart disease, cancer, suicide, and homicide, in fact, all causes except unintentional injuries.

For women 25-44 years of age, AIDS was the eighth leading cause of death in 1988. In 1989, 4 percent of all deaths of women in that age group (which constitutes 46 percent of all females) were caused by AIDS, and estimates based on current trends indicate that in 1991, AIDS will be among the top five leading causes of death for women in this age range.

CDC estimates that approximately 1 million people are currently infected with HIV in this country alone. Approximately one in 100 adult males and one in 600 adult females in the United States are infected. According to projections, the cumulative number of deaths from AIDS will approach 200,000 by 1993.

One of CDC's primary missions is to prevent HIV infection and reduce associated illness and death. In fighting AIDS, there are four important goals: 1) Assessing risks, 2) developing prevention technologies, 3) building prevention capacities, and 4) implementing prevention programs.

What we have learned in dealing with the HIV epidemic will help us when other health crises strike, because these lessons have strengthened our nation's public health system. The urgency of fighting AIDS has in many instances added impetus or substance to programs or research already underway.

Goal One of CDC's plan is to assess the status and

characteristics of the AIDS epidemic and the prevalence of HIV infections; the risk of HIV infection associated with behaviors, practices, and occupations; and the impact of HIV on other health conditions. CDC and its partners in the state and local health departments and national and community organizations have undertaken a number of activities to achieve this goal.

AIDS case surveillance activities, supported by CDC and conducted by the states, have strengthened the capacity of state health departments to conduct and evaluate surveillance for all diseases. AIDS surveillance has demonstrated the effectiveness of using multiple data sources for disease monitoring (for example, case reporting, surveys, analyses of medical-care records and other vital records). These activities have also set nationwide standards for the timely collection and dissemination of surveillance data.

Innovative surveillance methods for evaluating timeliness and completeness of reporting can be applied to surveillance for other diseases. Advances in statistical methodology for analysis of AIDS surveillance data, including analysis of trend data and projections, as well as expanded computer applications and software, will benefit other surveillance programs.

HIV seroprevalence surveys and related studies have catalyzed collaborative disease prevention and research efforts in other areas. For example:

- Implementation of seroprevalence surveys in a variety of clinical and nonclinical settings (e.g., STD and tuberculosis [TB] clinics, drug treatment centers, Planned Parenthood and other clinics serving women, jails and prisons, and clinics for the homeless) has required the formation of new, in many cases unprecedented, liaisons between health departments and outside agencies and groups. Health departments and collaborating agencies are taking advantage of the data by using them to design programs and target resources toward those at highest risk.
- Implementation of the seroprevalence surveys has afforded training opportunities to health department staff in data collection and analysis that are applicable to work with other public health data systems. Supplemental training in the design of research studies, the conduct of interviews,

and the development of study protocols has enabled experienced personnel in health departments to function effectively in multiple positions, strengthening and broadening the research capacities of health departments in general.

- The survey of childbearing women, which is based on already existing newborn screening programs for metabolic diseases, has focused attention on newborn screening and has fostered new collaborations between health department epidemiologists and those providers responsible for screening.

The second goal in the plan for preventing HIV infection is, "Developing Prevention Technologies," an area in which we have all been active.

The application of polymerase chain reaction (PCR) technology for the rapid, sensitive, and specific diagnosis of HIV infection has been the impetus for more widespread use of this technique. This methodology has now been applied to the detection and diagnosis of a variety of infectious agents that are difficult to detect and analyze by standard means. These include other viruses (human papillomavirus, HTLV-I/II, etc.), bacteria, and parasitic agents.

Donor deferral and heat treatment of factor concentrates have led to a safer blood supply with major declines not only in HIV transmission, but also of other bloodborne agents, especially hepatitis B and C.

Increased focus on the use of universal precautions, engineering controls (e.g., needle-less systems, anti-needlestick devices), and personal protective equipment (gloves, masks, eye and face shields) reduces the risk of occupational transmission of HIV and other bloodborne pathogens.

Studies to characterize aerosols produced during surgical settings have been initiated. This will lead to a better understanding of the capacity for aerosols to transmit other pathogens, as well as HIV.

The suddenness with which AIDS appeared on the world scene in the last decade has necessitated the development of a health communications system that is unprecedented in public health history. Effective public health programs require the support of an informed public.

During a time when deregulation was reducing the broadcast industry's contributions to public service time, the *America Responds to AIDS (ARTA)* public service advertising (PSA) campaign, in its first 3 years of activity, was able to generate more donated air time than any previous publicly funded PSA campaign in history. Development of the ARTA campaign has relied heavily on collaboration with our state

and local health partners, as well as national, minority, and community-based organizations.

CDC's National AIDS Information Clearinghouse is demonstrating the type of cost-efficiencies and public health benefits that can accrue through deploying contemporary technologies for data collection, storage, and dissemination techniques. CDC's National AIDS Hotline has answered over 5 million calls during the past 3 years—approximately four times more calls than any public health helpline in history. This hotline was the first federally supported health line to provide national information service to hearing-impaired callers, opening communication with more than 21 million Americans with severe or total hearing loss, for whom much of standard English and the spoken word are ineffective for communicating health messages. The state AIDS hotlines have been equally important in delivering important information and education, and the collaboration between CDC and the states on these efforts has strengthened this activity.

The AIDS crisis has also enabled us to break new ground in the field of health communications research. We are testing new evaluation instruments and technologies to improve our ability to know what will be most effective in influencing populations of interest, and under what conditions. Lessons learned about evaluations, technologies, designs, and so forth, as well as lessons learned about communication channels for special audiences will provide immediate, beneficial information that will be applicable to other health programs.

Laboratory support services have been enhanced as a result of the HIV epidemic. The National Laboratory Training Network (NLTN) was implemented to provide information and training to laboratorians performing HIV-related laboratory testing, but has become a nationally recognized training model which can be applied to a variety of other public health training needs.

The National Laboratory Training Network serves to promote interaction between state and local departments of health and the private sector in the assessment, delivery, and evaluation of laboratory training services. It encourages information and resource sharing, and increases the visibility of the public health laboratory sector among private sector laboratorians. The NLTN provides a network for quickly disseminating laboratory training in new technologies, e.g., Western blot, HIV antibody testing using blood spots dried on filter paper, and PCR. The network strengthens the collaborative training relationships and opportunities between CDC, ASTPHLD, and other professional and scientific organizations.

The Laboratory Performance Information Exchange System (LPIES) is an electronic bulletin board developed for laboratorians performing HIV-related testing so they may collaborate among themselves to identify problems in testing and work together for rapid self-resolution. It provides a system for quickly relaying information about performance evaluation results, improvements in testing, new technology, and sources for laboratory training and education that could be applied in other laboratory testing situations.

The Model Performance Evaluation Program (MPEP) enables states to compare their laboratory performance on HIV-1 and HTLV-I/II antibody testing, and serves as a model for evaluating laboratory performance and for identifying and resolving problems that may be occurring throughout the testing process.

Our third goal is to build or strengthen HIV prevention capacities and promote collaboration among governmental, public, and private agencies. Again, this is an area which involves all of us.

In addition to the increased collaboration among CDC and state and local health agencies, strong linkages have been forged between CDC and national organizations (including those addressing minority HIV issues) and community-based organizations (CBOs) through HIV prevention funding and technical assistance. Development of prevention capabilities in CBOs is nurtured through the transfer of new scientific findings and technical information from demonstration projects to programs. For example, community outreach programs for AIDS education have wider application:

- Hard-to-reach populations are often at risk for a myriad of other medical and social problems that could be effectively addressed through outreach programs.
- Street outreach serves several important functions: First, it is a way of providing health messages to persons who are not being served or who are not accessing health information from public or private physicians and other health professionals. Second, outreach is also a major vehicle for connecting persons with needed services throughout the public health and social services arena. Third, as a result of the first two functions, street outreach has the potential to greatly improve the status of dysfunctional individuals and communities through the individual empowerment that information and access provide which, in turn, can lead to more informed and responsible decision making about health, social, and economic issues.

HIV prevention programs have reinforced the importance of behavioral science in the infectious diseases arena, which has been very beneficial for STD and family planning programs. HIV and AIDS prevention efforts have also, in many

instances, promoted integration of services at one site, such as STD, TB, and HIV services in drug treatment centers.

Efforts to communicate important public health messages to all of the many populations that may be at risk, in a country that has prided itself on the diverseness of its population, have enabled us to forge partnerships with many organizations and individuals that are uniquely capable of delivering public health prevention messages to particular segments of the population—many of whom have often fallen outside of the health care mainstream. Partnerships with racial and ethnic minority organizations, for example, have brought our program people into frequent contact with a diverse range of health professionals that had been previously “unknown” to CDC and to our state and local public health partners. In addition, these efforts have encouraged state and local health departments to deal with a broader range of constituents.

Unique networking through national organizations may set a model for future prevention programs in other areas. For example, through a partnership with CDC, eight national organizations (such as the National PTA) were instrumental in the implementation of a CDC-based national Youth Risk Behavior Surveillance System; these surveys have provided important baseline information on sexual and drug use behaviors of high school students throughout the country.

CDC is currently providing state and local public health personnel with specific training and consultation assistance in the skills associated with health communications using the mass media. As these skills become firmly implanted throughout the United States, CDC's ability to mobilize the public health community, as well as the public, through rapid transfer of public health intelligence will be vastly superior to what was in place prior to the HIV and AIDS epidemic. CDC is working to forge a new alliance of public information officers from all of the state departments of health. This new organization has already used its new communications' network to transmit vital public health information to one another on many non-HIV-related issues.

We are working with writers and producers and with TV program standards personnel at the major networks to increase avenues for delivering HIV/AIDS prevention messages. These efforts should also benefit family planning and STD programs.

Prior to 1988, all three major networks had policies against use of the word condom in public service advertising messages. As of October 1988, the networks publicly announced removal of this prohibition. Condom “spots” now are carried by all three networks. And, beginning with the fall 1991 TV season, numerous popular situation comedies and dramatic series have incorporated dialogue into sexually

suggestive scenes that reflect a new sense of sexual responsibility—a new norm—that has been AIDS-generated, but if successful in changing public practices will also contribute to reductions in STDs and unplanned pregnancies.

Our fourth goal, which is built upon the other three, is “Implementing Prevention Programs.” We can all cite numerous examples of prevention programs that contribute to a stronger infrastructure. Let me mention just a few.

HIV/AIDS prevention programs have helped to improve the safety of the nation’s blood supply through collaboration with blood collection agencies, such as the American Red Cross and the Food and Drug Administration (FDA), in using HIV surveillance data to evaluate routine blood collection procedures.

These programs have improved public health communications with the general public, including more widespread use of, and more frankness in, media such as newspapers and the entertainment industry.

CDC has been working with its partners to improve the health of the nation’s school-age youth by helping schools provide comprehensive school health education programs, and providing financial and technical assistance to national organizations, states, territories, and local departments of education to develop HIV/AIDS curricula.

These programs help to establish a foundation for understanding the link between personal behaviors and health, especially sexual behavior and health. They help youth avoid or reduce behavioral risks associated with leading causes of illness, death, and disability, including behaviors associated with unintentional and intentional injuries; tobacco use; drug and alcohol use; sexual behaviors associated with HIV infection, other sexually transmitted

diseases, and unintended pregnancy; health-related physical activity; and dietary behaviors.

The entire substance abuse issue has been heightened and increasingly addressed through the public health arena as the HIV epidemic has brought it, and other social problems, into clearer focus. While CDC and ADAMHA have often collaborated in the past, the HIV/AIDS epidemic has strengthened CDC’s relationship with ADAMHA, and other Federal agencies, through a realization that HIV and substance abuse issues cannot be addressed independently. These efforts have brought together drug abuse and health programs in the process of trying to integrate activities.

In conclusion, the HIV/AIDS epidemic has placed enormous strains on the public health system of our nation. Although I have outlined primarily CDC’s prevention activities that contribute to our public health infrastructure, we recognize the tremendous contributions that state and local health departments and national, minority, and community-based organizations have made in this area, particularly with regard to counseling, testing, referral, and partner notification; early intervention; and promotion of clinic-based services.

One more item should be addressed, and that is how this epidemic, in stretching our public health system to its limits, has exposed weaknesses and fragmentation throughout the system. However, armed with this knowledge, we should be able to turn this situation around and make the system better.

There are probably many other examples of ways HIV/AIDS has strengthened the public health system that we haven’t included, and I’d like to encourage others to contribute during the discussion period.

Women and Adolescents and STD/HIV

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It is a real pleasure for me to be here today to speak to this conference, *Action Alliance, The Best of Science and The Best of Program*. I think you should be congratulated for being able to bring together such a large group, not only those who care, but those who are willing to share.

Today, I will discuss an important issue that we all must deal with. You've been on the front line. You know that our people and our children, especially our women, have been out there in the ocean surrounded by the sharks of drugs, alcohol, homicide, and suicide, while we have been sitting on the beach sipping at the fountain of, "Just Say No. Just punishment!" *Read my lips! They are morally wrong!* We know we've got a problem, and I think it is time to put our shoulders to the wheel and decide we're going to deal with it.

We all felt good about what happened to our syphilis and gonorrhea problems during the 1970s and '80s. We thought we could get rid of syphilis, GC, and even tuberculosis, but now we wake up and find them back. We felt good because we thought we had penicillin shots and good drugs for tuberculosis to help eradicate the diseases, and yet, even with all of that, we didn't eradicate the diseases. We need to ask ourselves *why*, because I think one of the things that we know about HIV and AIDS: we don't have a penicillin shot or isoniazid (INH) in our back pockets that we can pull out and use. Can you imagine what would have happened to our country if we had not had these wonderful drugs to make a difference?

Now, we're dealing with the fact that we've got to educate, we've got to motivate, and we've got to convince people to change their behavior. If we had taken our heads out of the sand 20 years ago and begun to educate our people and established a framework on which we could build, we would not have had such a hard problem dealing with AIDS. We've made a lot of progress, because at first we were dealing with a group of white, educated, homosexual males, and we could put an ad on TV, we could talk about AIDS in the newspaper, and we could make a difference. But, suddenly we discover that now we're dealing with people who can't read, people who don't watch the ads on TV, and we're finding that our problem is growing larger and larger all the time, especially when we look at our minority populations and our adolescents. I'm appalled! We should have known that this would

happen! All we had to do was look at our problem with teenage pregnancy to realize that we didn't have a working system. We in health departments must learn to look at problems in different ways. One way is as acute crisis, and I think AIDS and teen pregnancy have gotten to be acute crises. They are both related to sexual issues, and we don't talk about sex! We're **going** to talk about it, because it's going to break our backs and make us talk about it. The second way is to look at those chronic and enduring problems that sit out there all the time, like tuberculosis, and that ticking time bomb that's about to explode in regard to our environmental health and other issues. I'm saying that we've got to begin to come together and work together to deal with problems as we know them and as we see them.

When we look at what is happening to our young people and our children, we find that since 1970 in a country that "loved little children," we've gone from one in seven of our children being poor to one in four! One in four of all the children in America today is poor, and when we look at our black children, one in two is poor. When our children are poor, they're less likely to get the kind of education they need, more likely to engage in earlier sex, more likely to be infected with sexually transmitted diseases, more likely to be involved with drugs, and that means that they're more likely to be at high risk for HIV and AIDS or to experience marked increases in syphilis. Yet, we've not decided we're going to deal with that problem as it presents itself. I consider that this is something that we've got to do if we want to make a difference.

When we look at our children and adolescents, they're involved in drugs and alcohol. We find that 66 $\frac{2}{3}$ percent of high school seniors have tried illicit drugs. Thirty-four percent use them regularly. Fifty percent of our 12- to 17-year olds have tried alcohol or consumed more than a six-pack of beer a week. You know and I know that one in six of our adolescents has a sexually transmitted disease every year. One in ten of all of our female children from 10- to 19-years of age has a pregnancy every year. Four out of 10 will be pregnant before the age of 20, and yet we still deny that our children ever engage in sex. We know that adolescents are the group at greatest risk. AIDS has increased more among adolescent women than in any other age group, especially among black

women. Fifty-seven percent of AIDS among women are among black women, and we only make up 15 percent of the population. That to me is a real problem! When we look at babies with AIDS, who do you think they are—they're the black infants with AIDS. It isn't just because they're black, it's because of all the other social factors that we refuse to deal with, that we must deal with, if we want to make a difference. I feel that we have a golden opportunity with this AIDS virus to use the crisis to make a difference—to make our government, to make our people, and to make our country deal with the problem of providing a system to take care of our citizens. We know we don't have a system; what we have rather than a system of health care is a patchwork of providers and a patchwork of programs—no system—but, if we could get a system out of AIDS, then it would be worth the fight and worth the battle. I think that is what we should be about, and that's what we should work toward if we want to make a difference. Each year in this country, we have more than a million teenagers who become parents before they become adults, and women spend more than half their lives trying not to get pregnant; and yet our country, this United States, refuses to invest in contraceptive research. That says something about how much we care about people and how much we care about women. Less than 10 percent of all research money is spent on women. That says to me very clearly how we think, and I think it's part of the whole problem. If we could come together—AIDS patients, poor people, blacks, women—then, we could become power brokers and make a difference and make things change.

We look at our prison system and we find in our prisons primarily a lot of black men. Only one in five of the young black men in America is surviving—one in five! Two out of five have been out on drugs, one will be killed by homicide or suicide, and another one out of the five will be in our prison system—one out of five! We're eating up our seed corn, and we refuse to respond. That causes me grave concern. If we develop a system to take care of those people, we will have a system to take care of our problems related to AIDS. In this country we don't mind spending \$25,000 a year for each prisoner we "warehouse" in our prison system, and yet we refuse to spend \$4,000 a year for early childhood education. These are real concerns for me, and I feel that what this conference should do is really think about where we are—and you know better where we are than I do. You and I know all the statistics regarding the increase in AIDS cases. I know that we're not where we thought we wanted to be, but I think now is the time for us to think about solutions.

I think we've got to think about solutions, but not just for AIDS. However, we can use AIDS to build a system, but not

just to take care of AIDS. As you put together your alliance, I want you to think about the word, *SOLUTION*. I want you to think about the "s" in solution for "strategy." What are the strategies we need to take to make a difference? We have to think of short-term strategies and long-term strategies and, as we think of short-term strategies, we have to think in terms of health care, medication, education, and how we are going to reach the people to keep them from getting AIDS. These are some of the things I think we have to do. And, in our long-term strategies, I think we have to think about early childhood education. We know if we're going to make a difference, we've got to start early. We can't wait to walk in and try to teach them in junior high and high school, because they've already got part of the problem. The second part of the strategy that I feel we've got to have is comprehensive health education programs in our schools from kindergarten through twelfth grade. We can't get there without that. People always say, "Well, Dr. Elders, what do you teach kindergartners?" You can teach kindergartners there are certain places nobody is supposed to touch, and if they do, to tell somebody. Sexual abuse has increased two- to threefold, and we know that children who have been abused may grow up to be abusers themselves. If we do nothing about it, what do we think is going to happen? I tried to get some laws passed addressing that and I was told, "Well, what if a 12- or 13-year old was lying?" What we do is protect the abusers and we accuse the children, so I'm saying that we've got to address those issues as we go along.

For the "o" in solution, I chose the word *"opportunity."* I want you to know you've got to use every opportunity you get, at the state level, the Federal level, and in your community, your churches, your businesses—everybody. I always tell people that opportunity is like a hair on a bald-headed man—it only goes around once, and you've got to grab it when it's there. I'm always talking about teen pregnancy and so one day when I was in a grocery store, a man came up and said, "You're Dr. Elders, aren't you?" I said, "Oh yes, and you support me, don't you, you're about what I'm about." By the time I got through, I'm not sure whether the man would have supported me or not, but he said, "Yes ma'am." I'm saying we have to be aggressive! We've been silent too long and we've got to go out and fight for what we want. We know that the squeaky wheel gets the grease and we've not squeaked loud enough. There are enough of us that if we all decided to save one child, I want you to know that there wouldn't be any more children left in our country to save!

For the "l" in solution, I chose the word *"leadership."* We've got to start making sure we've got leaders who are willing to get out in front and lead. We've been "taillights" too long;

it's time we decided we're going to be the "headlights"; it's time we decided we're going to grab leaders who are willing to *get* in front, rather than *jump* in front when they see which way the wind is blowing, to get out in front and say, "Well, I'm the leader and if we've allowed that to happen, it's our fault." This is our government. You know we talk about what the government didn't do, but we're the government—we elected the people that are there. Well, we need to start telling them, "We elected you and we can bring you home, too." I think that those are some of the things that we've got to do if we want to make a difference and if we want to get the things done that we need done.

For the "u" in solution, I chose the word "*unity*," and you know and I know that we've got to come together. If we're together we're very powerful, but if I'm over here and you're over there and you're saying this and I'm saying that—we'll be here 10 years from today trying to make a list that all of us can agree about. Don't even think about that! Let's decide on some of the things that we can agree on. Let's work on that and then the next time we'll get the next thing and if we take things one by one, we might be where we want to be in 10 years. We've got to start talking to each other. You know, in some of our states, and even in Arkansas (but I want you to know we changed), the STD people and the AIDS people and the drug people and the teenage pregnancy people don't even know each other. You know, we were sending somebody out one night to talk about drugs and another night to talk about teenage pregnancy, another night to talk about STDs, and another night to talk about AIDS. You know and I know, we're talking to the same people who have the same problems, but we get hooked up on our funding stream; we've got all this money over here to fund the drug program, and they said we couldn't use all of ours, and they were sending the police in to do all the drug education in schools. I am begging for a comprehensive program. I have been telling our people at the health department that we're part of the problem. If we say we aren't going to come in and waste our time anymore doing a 1-hour lecture talking about sex, talking about AIDS, it's because we need a comprehensive program. If we pull out, we might get it; but as long as we go on fooling people that they've had their sex lecture, they've had their AIDS lecture, they've had their STD lecture, we become part of the problem. We should demand that they have comprehensive programs for our children, because to me when we don't do that, we are using the backs of the most viable resource we've got to support our program. We should say to the Federal government that we're tired of all these straight-line funding streams—we want to deal with the

problem. Let's look at *outcome* rather than look at just, "Well, what did you do with the money?"

The other thing in unity, I feel, is that we've got to collaborate—we've got to start looking at "one-stop shopping." We should know we've got a problem when only 39 percent of the 2-year-olds are immunized, and we know immunization works. If we can't give immunizations, what can we do? I'm saying, we've got to start looking at how we're funding health and looking at health. One of the things that's been most appalling to me is that we spend more money on health than any other country—12 percent of our gross national product, \$660 billion dollars a year. But, do you know how much is spent on prevention—**0.8 percent**—less than 1 percent! We spend all of our money, 90 percent of our health care dollars, on the last month of life. We aren't paying for wellness, we're paying for a very expensive dying! So, I'm saying we need to start taking care of our children and of our families. We've got to start forming partnerships at working together. There are enough of us that if we unify, it's kind of like having a puddle—if we are united, that puddle runs into a creek, and that creek keeps going and it gets into a river, and soon that river runs into the ocean. Just think of how powerful an ocean is, if it comes out and stands up to the politicians and says, "Wake Up," and they see this "ocean of people" coming toward them. I can tell you things would change! The military budget has increased 150 percent in the past 10 years and the budget for our children has increased 15 percent. Why do you think that happened? Lobbyists work for the military. They have power brokers, but our children do not. So, we need to start becoming power brokers for health and for the things that we should do.

For the "t" in solution, I chose "*tenacity*." We've got to stick to it. I know you have been working hard on AIDS, and you feel sometimes it's kind of slipping away from you; and you look at syphilis and you think, my God, it's coming back. But we've got to have the tenacity and follow through to make it happen and to keep going. We can get there. We can make it, but we can't get there the way we're going. I feel there are things we've got to do.

For the "i," I chose the word "*infrastructure*." We've got to get the infrastructure out there, and a part of that infrastructure is early childhood education or comprehensive health education or educating parents and families. We've got to educate them. We've got to teach our young men responsibility. One of the things we addressed in Arkansas is that we're putting the social security number on the birth certificate, and we're going to take 17 percent off the top for the babies, and that will take away bragging rights if you've got to pay

17 percent of your salary for 18 years. I'm saying, we've got to have two people concerned about the problem.

For the "o" in solution, I chose the word "*open*." We've got to open up the system so we can take care of everybody, so that we can make health care available to everybody, not just to those who can afford to pay for it.

And last but not least, for the "n" in solution, I chose the word "*now*." We've got to do it *now*. Time is running out and things are getting very difficult. I think you already know that the track is right for getting it done. The jockey is ready,

the thoroughbred is ready, and the jockey is capable. We're capable of doing this. We know how and we have the resources. What we need to do is to make commitments to the most valuable resources we have, our people. We've got to save our people. We've got to save our communities. It's up to us. I feel the challenges before you and I'm very pleased that you are having this meeting, that you are working for *SOLUTIONS* to educate and empower all of our people to do the things they most need to do to get the job done.

Epidemiology of Drug Abuse in the United States

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The problems related to the epidemiology of drug abuse-related-HIV infection in the United States are "half" problems of science, figuring out what we should be doing, and at least "half" problems of the lack of political will to take the scientific knowledge we already have and act upon that knowledge. In the time I have this morning, I will be giving you "everything you need to know about drug abuse epidemiology" without having to take learning-enhancing drugs.

One of the important factors in drug abuse epidemiology in the United States and other countries is the age factor. Data from the last National Institute on Drug Abuse (NIDA) household survey about use of marijuana and cocaine in the previous year by different age groups in the United States show a strong age gradient for both drugs, with highest use rates in the early adult years. Also, very importantly, the data show substantial use rates among young people in the 12- to 17-year age group. Once you get into the older part of the population, you actually see that the estimates can't be reported because the reported drug use is so low. One additional important aspect of this age gradient is that people who start at younger ages to use both legal and illegal drugs tend to have much more drug-related problems throughout their lives. A person who is starting with alcohol or marijuana at the 12 to 13 age level or cocaine at the 12 to 13 age level is much more likely to have drug-abuse-related problems throughout life than someone who postpones that initial drug use until they are 18 to 21 years of age.

A second important concept in drug abuse epidemiology in the United States is that drug abuse tends to correlate with social problems such as syphilis, sexually transmitted disease, unemployment, lack of access to health care, single parent families, and poverty. Drug use is not a problem that exists in isolation from other social problems. Indeed, other social problems tend to cause drug abuse just as drug abuse may also cause some of these social problems. Data about people coming into drug abuse treatment programs and people coming into hospital emergency rooms with drug-related problems show a high over-representation among ethnic minorities. People of color, African American, and Latino

Americans are greatly over-represented. This is not a matter of skin color as much as a matter of socioeconomic class and of discrimination against people of color in this country.

The third important factor in drug abuse epidemiology is change over time. Data about marijuana and cocaine use rates from 1974 through 1990 in the NIDA National Household Survey show that both drugs follow a peak and then a decline. This decline actually surprised some of the Federal experts who were formulating our national policies. They didn't realize that over the last 5 years (with the important exception of crack cocaine), we've been seeing a decline in illicit drug use in this country, particularly for leading drugs such as non-smoked cocaine and marijuana. This does not mean that either our illicit or legal drug use problems are going away, but it means that we do have patterns that we have to pay attention to. In terms of political action, we have to pay attention to these problems as illicit drug use declines within middle class populations. Public support for doing something about the problem may become much more problematic, and we may find that our concentration of drug problems among people who face multiple social problems and multiple discrimination in our society will become more intense as the general population perceives drug abuse affecting them at reduced rates; so, political support for doing something about the nexus of drug-related problems, sexually transmitted disease, and health care for the poor may actually decline as drug use in the population as a whole declines.

To summarize this section, if we want to think about drug abuse epidemiology, we can think in terms of fashions. Some drugs come and some drugs go. They don't necessarily go away, but they do have cycles of popularity. In thinking about social problems, drug-related problems tend to correlate highly with other social and health problems.

Finally, we need to think in terms of irreversible technological innovations—things like the invention of the hypodermic syringe, the discovery that you can smoke cocaine and derive a very intense psychological effect. These "inventions" don't go away, rather they stay around and become applicable to other drugs. Some very preliminary

findings report possible smoking of heroin in this country. We have such technical innovations as "designer drugs." If we should ever be able to stop the importation of heroin or cocaine into this country, we would still have to confront the fact that there are many "bathtub chemists," who can supply narcotic and stimulant drugs just by taking ordinary industrial chemicals and using them to produce very, very powerful drugs. These designer drugs and the basic biochemistry needed to produce them also will not go away.

Finally, I would like to spend some time addressing the specific problem of HIV infection among injecting drug users. This is clearly one of the major sources of HIV transmission in the United States. Data collected in a detoxification treatment program in New York City provide a record of blood collected going back to 1978. The data show the time when HIV was first introduced to heterosexual drug injectors somewhere around 1975 or 1976. We saw a very rapid expansion of transmission in the late 1970s and early 1980s. We have been seeing a leveling off of seroprevalence among drug injectors in New York City. This type of leveling off has been seen in a large number of other cities including San Francisco, Amsterdam, Bangkok, and Stockholm. We've been collecting data from 1990, again showing current seroprevalence among drug injectors. It is still at about 50 percent; it really has not gone up from our 1984 data.

One thing that has happened is that drug injectors who are HIV-positive now tend to be much closer to clinical illness. Their CD4 count has declined significantly over this period of time. So, even though we've seen a stabilization of HIV seroprevalence, our need for medical resources to take care of people who are infected with HIV is probably going to be increasing as more people approach clinical illness. One of the reasons HIV stabilizes among drug injectors in various cities is the substantial death rate among drug injectors who are HIV-positive. When we followed up our 1984 sample, almost sixteen of them have died in the last 6 years and the death rate among the HIV-positives is approximately twice the death rate among the HIV-negatives. This indicates that one of the bad things that contributes toward stabilizing HIV infection rates is that people who are HIV-positive are lost to the population of drug users simply because they're dying.

We've also seen the emergence of an AIDS gradient in HIV seroprevalence. In that 1984 sample, relatively small difference in HIV prevalence existed by age 56 versus 61; whereas in 1990, we've seen a much larger difference in seroprevalence—52 percent among subjects under 30 and 59 percent among subjects 31 years of age or older. Basically,

these young injectors are often new injectors. In our current 1990 sample, approximately 20 percent of the people we're seeing now began injecting drugs after 1984. Essentially, everybody in New York knows that sharing needles spreads AIDS. Unfortunately, knowledge about AIDS is not a sufficient deterrent to keep people from starting to inject drugs anymore than knowledge about AIDS will keep people from starting to have sex. It may be a nice fantasy that some people have that knowing about AIDS will scare people away from behavior we don't like, but it's not happening.

In these new injectors, the seroprevalence rate was only 25 percent. That sounds relatively low. Certainly, it is much less than the more than 50 percent we see in the group as a whole. But, you also need to remember that these people are new injectors. They've only started within the last 6 years, and when you look at the seroconversions per 100 years of drug injection, it is eight seroconversions per 100 years of drug injection, so that they are actually becoming infected at a relatively high rate, even though their absolute level of infection is still modest. Their rate of new infections is rather high. If you start injecting drugs in a city like New York with a high HIV seroprevalence rate, the chances are fairly high that you are going to get infected in a moderate-to-long period of time. We now have 14 or so years of information about the spread of HIV infection among people injecting drugs in New York. We now have a model for what certainly could happen in other cities with the HIV epidemic among drug injectors.

But, we know that stabilization of seroprevalence can occur in that it doesn't have to reach the 90 percent plus rate of infection for hepatitis B. Drug injectors will change their behavior because they are concerned about HIV infection, and you can get a stable seroprevalence rate at 50 percent or possibly even less. We do know that as stabilization occurs, there will be an increased demand for health services because people who are HIV-positive are much more likely to be closer to clinical illness. They will need not only immediate medical care, but they'll need social support for themselves as individuals and for their families. As you know, HIV infection among drug injectors tends to occur not in isolated individuals, but in family units with the mother, father, and perhaps half the children being HIV-positive. We also know that there will be special problems with new drug injectors. As long as we have large numbers of people starting to inject drugs, we're never really going to be able to solve the HIV infection problem among drug injectors.

While we have had various programs like bleach distribution for preventing HIV infection among drug users, we do not have a national program about," What are we going to

do to stop people from starting to inject drugs?" We know that the fear of AIDS will not be sufficient, but until we do something to reduce the large numbers of new people coming into the population of drug injectors, the problem really can continue indefinitely. For a city like New York and other cities like Chicago and Miami, we really can be in a situation of an endemic problem with large numbers of HIV-posi-

tive drug users who are not only becoming ill, but who are also transmitting the virus heterosexually and perinatally. Until we find some way of trying to attack the larger problems of new people starting to inject drugs, we can see this sort of stable seroprevalence level with its multiple problems essentially continuing indefinitely.

CDC Strategic Plan for HIV Prevention

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Good morning. It is a pleasure to be here and to have the opportunity to address you. Assembled here are many of the principal members of this nation's HIV and STD prevention programs. As CDC Director, I know that your efforts are critical to the health of the nation. This morning, I would like to review briefly for you what we at CDC have developed as our long-range HIV prevention plan.

Since 1981, when the first five patients with *Pneumocystis carinii* pneumonia were reported in the *Morbidity and Mortality Weekly Report (MMWR)*, we have made great strides in understanding HIV infection, its clinical outcomes, and its epidemiology. Guided by this, we have launched effective national HIV prevention programs, forging new partnerships and strong linkages between CDC and national, regional, and community-based organizations.

The challenges of the 1990s will require even greater efforts. All of CDC's HIV/AIDS efforts are directed towards the prevention of HIV infection and the reduction of associated morbidity and mortality. To help us in accomplishing this mission, CDC has developed a blueprint for action in the 1990s. This plan is strengthened by the knowledge and experience gained in working with many new partners to meet the challenges of the HIV epidemic during the 1980s and from CDC experience in previous prevention efforts with STD, polio, tuberculosis, smallpox, and other diseases.

To establish the appropriate context for the plan, CDC considered a number of assumptions. From these assumptions, we selected certain essential principles and facts, and the plan was drawn up based on these underlying principles. Let me review some of these.

HIV Causes a Lifelong, Persistent Infection, Usually Leading to Progressive Illness and Death.

The time between infection and onset of life-threatening disease varies from person to person and can range from about 6 months to 10 years or longer. Prevention must be a continuing priority throughout the years of infection and illness.

No Vaccine or Cure is Currently Available.

When a safe and effective vaccine or curative treatment is available, CDC will immediately revise its strategic plan. In the meantime, some therapeutic agents have been shown to prolong the life of some people with AIDS, and recent evidence suggests that certain drugs can delay the onset of HIV-related illness. It is important that persons with HIV infection benefit from these early intervention drugs and services.

HIV is Transmitted in a Limited Number of Ways: Sexually, Parenterally, and Perinatally.

It is not transmitted through the air, by mosquitoes, or through casual contact with an infected person.

Transmission of HIV Infection Can Be Prevented.

Prevention efforts should be guided by the best available scientific knowledge. Surveillance, laboratory, behavior, and epidemiologic studies will provide the basis for our actions.

Behaviors are major determinants of the transmission of HIV infection. Individuals can change their high-risk sex and substance abuse behaviors and sustain safer behaviors. In addition to the many studies documenting behavior change among adults, shifts toward safer behaviors have also been measured within subpopulations of adolescents, college students, and selected inner city populations. Studies, such as those done among homosexual men in San Francisco, have shown that changing to safe or safer sex practices can significantly reduce the incidence of HIV infection. The challenge is to reach those people who continue to practice risky behaviors and to assist persons who have initiated change to avoid relapse into high-risk behaviors.

Preventing the initiation of high-risk behaviors is preferable to attempting to change these behaviors once they have been adopted. It is difficult to change behaviors once they are established. Ideally, HIV education should reach children before they develop lifelong patterns of high-risk behaviors. School-based STD/HIV education programs are

essential to long-term success in curbing the epidemic. In this setting as well, our HIV Prevention Plan is quite specific. We are encouraging the integration of education about STD and HIV for any state or local organization or agency that may influence curriculum choices in the schools.

Occupational transmission can be prevented through modification of work practices, the work environment, and use of protective equipment. The blood supply can be protected through self deferral of persons at risk, by ensuring the availability of counseling and testing services for those who wish to learn their antibody status, by testing all donated blood and plasma, and by appropriately treating blood components. Prevention is an important, cost-effective component of the control of HIV infection.

HIV and AIDS are a growing threat to the health of the nation and the world, and will continue to make major demands on health and social service systems for many decades. Assisting one person in preventing HIV infection is far less expensive than the cost of treatment services and premature mortality related to HIV or AIDS.

Public Opinion May Influence which Prevention Activities Can Be Supported with Public Resources.

Comprehensive HIV prevention efforts must address sexual practices, injecting-drug use, and reproductive decisions. These are highly personal and sensitive issues on which our society holds diverse opinions. These differences add complex dimensions, and sometimes serious obstacles, to the implementation of prevention efforts. We must enlist the support of a large number and a variety of organizations to educate and thereby increase support and acceptance of HIV prevention programs and services.

The HIV Epidemic is Made Up of Multiple Subepidemics. Successful Public Health Prevention Programs Must Be Appropriate to the Population Groups They are Addressing.

Special efforts are needed to prevent HIV infection among those populations that have been disproportionately affected by it, such as racial and ethnic minority populations and persons whose behavior places them at risk, including men who have sex with men and injecting drug users who share drug paraphernalia. It is essential that groups disproportionately affected by this epidemic be involved in the planning and implementation of HIV prevention programs. To be effective, intervention efforts must be planned and implemented by people who understand how to communicate with or gain acceptance of audiences to be served.

Successful Prevention Efforts Require Confidentiality and Freedom from Discrimination.

Discrimination and fear of discrimination may deter at-risk individuals from seeking early detection of HIV infection and other needed medical services.

Prevention Activities Will Be Enhanced By the Availability of Medical and Social Services.

An individual's knowledge of HIV serostatus is important for both prevention efforts and the individual's well-being. Individuals who know their HIV serostatus is negative can take steps to ensure they remain uninfected; individuals who know they are seropositive can take steps to prevent the spread of infection to others and can seek appropriate medical care and management to delay the onset of HIV-related illness.

This principle is particularly apropos in light of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act that authorizes grants to states, territories, and eligible local health departments in order to improve the availability and the quality of services and care provided to individuals with HIV infection. I know that several workshops are offered at this meeting on the implications of CARE, so I won't go into any further detail, except to say as an aside, that we are aware of the potentially negative fiscal impact of CARE on current state and local HIV prevention programs. We have communicated our concerns within the executive and legislative branches of government. We will, of course, assist you as much as possible to prepare for implementation in 1992.

Successful Prevention of HIV Transmission Requires Individual Effort and the Collective Effort of National, State, and Local Governmental and Non-Governmental Organizations.

Preventing the spread of HIV infection requires mobilizing all Americans, our collective resources, and our institutions. Society must foster the standards that prevent the initiation of risky behaviors and sustain the change from risky to safe or safer behaviors by persons at risk or already infected.

Program Needs Can Be Expected to Continue Growing at a Pace That Will Probably Exceed Available Resources.

Plans like this one become essential as needs begin to outpace resources. We must approach our planning with a desire to make the most effective use of available resources. We recommend that all HIV prevention programs develop a long-range plan to ensure the best use of resources.

With these essential principles serving as its foundation, the CDC plan employs a broad strategy that is common to virtually all preventive public health programs. Simply put, these strategies are:

- Assessing risks.
- Implementing prevention programs.
- Developing prevention technologies.
- Building prevention capacities.

Assessing Risks

We define **assessing risks** as assessing over time, and in a variety of settings and populations, the status and characteristics of the HIV/AIDS epidemic and the prevalence of HIV infections; the risk of HIV infection associated with behaviors, practices, and occupations; and the impact of HIV infection on other health conditions.

In its early response to the public health threat from HIV, CDC focused on epidemiologic studies to identify the characteristics and define the extent of the problem. In the 1990s, active surveillance of adult and pediatric AIDS must be maintained, trends in both AIDS and HIV infection monitored, and the incidence, prevalence, and distribution of HIV infections more precisely determined.

Implementing Prevention Programs

In **implementing prevention programs**, we must design, support, and evaluate intervention activities that reduce risky and promote safe behaviors, that prevent HIV transmission, and that reduce associated morbidity and mortality among persons with HIV infection. These prevention programs must be based firmly on behavioral science, in addition to the microbiological and epidemiological bases that have long been the cornerstones of CDC's public health efforts.

In the 1990s, the availability of improved therapeutic measures will require further expansion and evaluation of counseling, testing, referral, and partner notification services in community health centers, and STD, drug treatment, women's health, TB, and other clinics and facilities, especially in high seroprevalence areas. TB screening and preventive therapy need to be expanded to individuals in drug treatment centers, correctional institutions, and any other facilities providing services to individuals with HIV infection. Also, the relationship between HIV and other STDs, especially those which produce genital ulcers, calls for the close coordination and integration of services at sites where HIV and STD prevention services are provided. Persons may rationalize their risky sex or drug use behavior by saying, for example, that they are not at risk for HIV because they don't inject drugs or associate with men who have sex with

men. We now know that acquiring other STDs may significantly increase a person's risk for HIV infection. We strongly support state and local efforts to integrate STD and HIV prevention activities to promote quality, efficiency, and patient acceptance.

Developing Prevention Technologies

We must **develop** and test diagnostic and **prevention technologies** for HIV, promote the rapid transfer of appropriate methodologies into clinical and public health practice, and promote the use of a scientific knowledge base in the development of public policy related to HIV.

In the 1990s, new laboratory tests to detect and monitor HIV-1 infection will become increasingly important for prevention and early intervention efforts. New or improved tests for HIV-2 and other diseases, including TB and syphilis, will be needed. Procedures for developing and evaluating measures to reduce the risks of occupational exposure, including drugs for use in postexposure prophylaxis will be expanded. Behavioral science interventions will be developed and tested, as will channels and systems for health communication.

Building Prevention Capacities

To **build** or strengthen **HIV prevention capacities**, CDC will promote collaboration among governmental, public, and private agencies at local, state, regional, national, and international levels. Particular emphasis is needed to strengthen prevention capacities and promote collaboration with groups serving populations disproportionately affected by HIV, such as racial and ethnic minority populations.

As the HIV epidemic expanded in the mid-1980s, CDC began to direct increased attention and resources toward strengthening the institutional capacity of agencies to develop and implement HIV prevention programs. This approach was based first on the longstanding partnership with state and local health departments. It has also involved enhancing our relationships with national, regional, and community-based private organizations serving individuals at risk and others in society, such as racial and ethnic minorities, who are disproportionately affected by the HIV epidemic. In the 1990s, it will be important to assess and monitor the effects of the epidemic on state and local health departments and on their abilities to respond to the epidemic. Special emphasis will be placed on non-governmental organizations and on providing technical and financial assistance to enhance their institutional capacities to participate fully in the HIV prevention effort. As the worldwide epidemic grows, collaboration with WHO and other international organizations

will continue. In short, to meet the prevention challenges of the 1990s, we must improve efforts to:

- Prevent sexual transmission.
- Prevent transmission through blood, primarily through the sharing of contaminated drug paraphernalia.
- Prevent perinatal transmission from an infected woman to her fetus or newborn.
- Reduce the disproportionate impact of the epidemic on racial and ethnic minority populations.
- Increase collaboration among national, regional, state, and local governmental and non-governmental organizations.

- Promote and sustain changes, not only in the behavior of individuals at risk of HIV infection, but also in the social environment in which those changes must occur.

The plan I have described to you will guide CDC's efforts in accomplishing its mission to prevent the spread of HIV infection. These strategies can be modified as the face of the epidemic changes and as new problems, opportunities, and information develop. As a nation and a world joined in a common effort, we must all work together to interrupt the transmission of HIV infection.

Sexual Behavior in the United States

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Our nation has a long and, and let's face it, unenlightened history of dealing with syphilis, "the Great Pox," and the sexual behaviors which are responsible for its transmission. Thirty years ago when I entered the Public Health Service, a Task Force on the Eradication of Syphilis met to consider what it would take to finally bring the "Great Pox" under control.

Six recommendations were made to the Surgeon General, including one that is responsible for my being here today. Members of the Task Force observed, "There is a critical lack of knowledge of the characteristics, attitudes, and habits of the venereal disease-prone population." The Task Force proposed that, "Research in adolescent and young adult sex behavior should be greatly expanded." They concluded, "A great potential for the elimination of syphilis in the United States lies in the answers to the many, as yet unsolved, problems in human sex behavior."

Unfortunately, very few answers were forthcoming in the 1960s and 1970s because, in spite of dramatic changes in the sexual behavior patterns of young people in the United States, systematic research on this most important aspect of human behavior was hampered by antediluvian beliefs that would not have been tolerated in any other branch of science. It was only when a mysterious and apparently acquired immunodeficiency syndrome (AIDS) began to be detected among men who had engaged in sexual intercourse with other men that social scientists were allowed to thoroughly examine some of the determinants and consequences of human sexual behavior. The purpose of my presentation is to describe some of the research that social scientists have been able to conduct about sexual behavior patterns in the United States in the decade before and the decade after the discovery of AIDS in 1981. I shall focus on two questions in particular: 1) have sexual behavior patterns changed in the United States in the past 20 years (1971-1991); and 2) what does it take to change patterns of sexual behavior?

Adolescent Sexual Behaviors

The first question is easier to answer than the second because we have some data that were collected from

representative samples of young women in the United States, 15 to 19 years of age, in 1971, 1976, and 1979, and other data that were collected from young men and women in the 1980s (Table 1). Retrospective analysis of the answers given by a nationally representative sample of 8,450 women, 15-44 years of age living in households in the United States in 1988, showed that the proportion who reported having had premarital sex **increased steadily** from 28.6 percent in 1970 to 51.5 percent in 1988. Increases in premarital sexual intercourse since June 1981, when the first five cases of AIDS were reported in the *MMWR*, were **greater for white women**—from 41.4 percent in 1980, to 43.1 percent in 1985, to 50.6 percent in 1988, than for black women—58.1 percent in 1980, to 55.4 percent in 1985, to 58.8 percent in 1988 (Table 2).

Data are also available on reports of sexual intercourse in two comparable samples of never-married men 17-19 years of age living in metropolitan areas of the United States. In the National Survey of Young Men conducted in 1979, 64.5 percent of white, 71.1 percent of black, and 65.7 percent of all never-married men 17-19 years of age reported ever engaging in heterosexual intercourse. In the National Survey of Adolescent Males conducted by the same research organization in 1988, 73 percent of white, 87.7 percent of black, and 75.5 percent of all never-married men 17-19 years of age reported ever engaging in heterosexual intercourse. Thus, increases in premarital sexual intercourse reported by women 15-19 years of age parallel **increases** in heterosexual intercourse reported by never-married men 17-19 years of age living in metropolitan areas of the United States. In contrast to observations made for women, increases in the proportion of never-married men who reported ever engaging in heterosexual intercourse were twice as great for black men living in metropolitan areas (from 71.1 percent in 1979 to 87.7 percent in 1988) as they were for white men living in metropolitan areas (from 64.5 percent in 1979 to 73 percent in 1988) (Table 3).

Male-female differences in reports of ever having sexual intercourse are narrower among white adolescents 15-19 years of age (52.4 percent for women and 56.8 percent for never-married men in 1988) than among black adolescents

(60.8 percent for women and 80.6 percent for men in 1988). Because of increases in the proportion of white adolescent women reporting premarital intercourse in 1988 (52.4 percent) compared with 1982 (44.5 percent), over half, or approximately 4.9 million of the 9 million adolescent women in the United States, may be at risk of exposure to HIV and other STDs. Furthermore, data from the National Survey of Family Growth and other sources suggest that the **age of first sexual intercourse** is declining for adolescent women and men in the United States, and the **number of different sex partners** reported by sexually experienced adolescent women and men is increasing.

Sexual behavior trends in the United States over the past 20 years have grown increasingly more favorable for the transmission of HIV and other STDs. Nationally representative data of adolescents living in households indicate that **larger proportions** may now be at risk for HIV infection and other STDs **than before we knew about AIDS**. The so-called "sexual revolution" that began in the U.S. in the 1960s continued throughout the 1970s and 1980s, in spite of warnings about genital herpes, AIDS, and other STD (Table 4).

Although sexual behavior patterns reported by adolescents have been moving in a direction that might facilitate HIV/STD transmission, health behaviors, such as more frequent condom use, have been running counter to sexual behavior trends. Reported condom use at last intercourse by women 15-19 years of age more than doubled between 1982 and 1988 (from 22.6 percent to 47.4 percent); these increases occurred in all groups of young women. Similarly, increases in reports of condom use at last sexual intercourse more than doubled for never-married men 17-19 years of age living in metropolitan areas of the United States (from 21.1 percent in 1979 to 57.5 percent in 1988). Increases have also been reported for condom use at first intercourse. Analysis of trends toward frequent condom use among never-married men suggests that most of the increase in reports of condom use occurred shortly after November 1986, when the Surgeon General of the Public Health Service strongly recommended the proper and consistent use of latex condoms for the prevention of AIDS.

Number of Sex Partners and Condom Use

But, there is more bad news. Never-married men who reported that they or their sex partners had injected drugs intravenously, that they had sex with a stranger or someone with multiple partners, or that they, themselves, had multiple partners, were significantly **less likely** to report condom use at last intercourse than other sexually experienced young men. Never-married men with one or more of these risks

represented 42 percent of the sexually active male population 15-19 years of age (Table 5). Furthermore, as the number of different sex partners increased from one to more than four, the proportion who reported using a condom at last intercourse decreased from 63 percent to 37 percent, suggesting that those at **greatest risk** may be the **least** likely to take **adequate precautions** to prevent HIV/STD transmission.

Finally, some good news from the 1989 CDC-sponsored Secondary School Student Health Risk Survey (Table 6). High school students who are most knowledgeable about AIDS are least likely to report multiple partners and most likely to report always using condoms. For example, John Anderson and others have shown that, as the number of correct responses to questions about AIDS increases, the proportion of high school students who report two or more different sex partners decreases, and the proportion who report always using condoms increases (from 23.2 percent to 36 percent). Anderson, et al., conclude, "HIV/AIDS education may have an indirect effect on risk behaviors by increasing relevant knowledge."

Men Who Have Sex with Men

Mathematical models developed to predict trends in HIV and other STDs require reliable estimates of the number of new sexual partners acquired in a given period. Early estimates for men who have had sex with men were based on crude estimates suggested by Kinsey, Pomeroy, and Martin in their 1948 report on the sexual outlets of a nonrepresentative sample of white men. More recent estimates from more representative samples of men have become available, and they indicate that the proportion of men who have had sex with men is lower than previously assumed. For example, data collected by the National Opinion Research Center (NORC) in 1970 suggested that 20.3 percent of American men had ever had a sexual experience with another man, compared with the estimate of 37 percent made by Kinsey, et al., in 1948. Furthermore, the NORC-Kinsey data suggested that only 6.7 percent of American men had a sexual experience with another man after the age of 19, and about 2 percent had an experience with another man during the previous year.

The National Opinion Research Center added questions about sexual behavior to their General Social Survey in 1988. In a report published in *MMWR* in 1988, NORC-GSS estimated that 3.2 percent of American men had a sexual experience with another male during the preceding 12 months. The National Center for Health Statistics conducted a pilot study of HIV seroprevalence among a representative sample

of 1,724 household residents in Dallas County, Texas, in 1989 (not 1988) and asked participants to complete a self-administered questionnaire. An estimated 4.4 percent of men in Dallas reported having sex with another male in the last 12 months, and 2 percent reported having receptive anal intercourse in the last 12 months (Table 7). More precise estimates of the number, risk behaviors, and other characteristics of men who have sex with other men are becoming available to help focus HIV/STD intervention efforts.

San Francisco City Clinic Cohort

Profound changes in the sexual behavior patterns of men who have had sex with other men have been reported in many cities since 1981. For example, in the San Francisco City Clinic cohort study, the median number of nonsteady male partners reported for the 4-month period before interview by a sample of 126 men fell from 16 in 1978, to three in 1984, to one in 1985 as the median number of steady partners remained low.

San Francisco Men's Health Study

An on-going population-based study of men who have had sex with men in San Francisco has been following HIV-positive men for reports of insertive anal intercourse with two or more partners and HIV-negative men for reports of receptive anal intercourse with two or more partners every 6 months since mid-1984. The proportion who tested positive for HIV and reported insertive anal intercourse with two or more partners fell from almost 40 percent in 1984 to less than 10 percent in late 1987; the proportion of HIV-negative men who reported receptive anal intercourse fell from 14 percent in 1984 to less than 5 percent in late 1986. Two reasons have been given for reductions in high-risk sexual practices among men who have sex with men: 1) perceptions that norms governing acceptable sexual behaviors have been redefined by members of the gay community, and 2) very meaningful interpersonal experiences with persons with AIDS.

Ray, Spring 1984

Many of us are here today because we have been touched by persons we have known who have died from AIDS, and some of our friends, relatives, and companions have insisted on telling their own stories. After Ray was diagnosed with AIDS in February 1985, he decided to tell his story to other members of the gay community through Lisa Keen, a reporter for the *Washington Blade*.

Ray was an attorney in the District of Columbia. He had served as a senator's aide. On his 36th birthday, he noticed a purplish lesion that was later diagnosed as Kaposi's sarcoma.

Just before he died, Lisa Keen wrote, "If people had talked more about AIDS, if Ray had understood the gravity of the illness sooner, he might have changed his sexual activity before he became ill, he says."

One of the reasons that adolescents have not changed their sexual behavior is related to their feelings of invincibility. They feel that AIDS is something that cannot happen to them. To confront these perceptions, it is extremely important for Ray and other people with AIDS and HIV disease to speak directly to us about their experiences.

Commercial Sex Workers

Commercial sex workers in many parts of the world are rapidly becoming infected with HIV. In the United States, HIV infection among female prostitutes is primarily found among women with evidence of intravenous drug use, but we are beginning to find HIV infection in women who exchange penetrative sexual services for money to buy "crack" cocaine. For example, in the San Francisco Bay area, among women with no evidence of ever injecting drugs intravenously, the proportion infected with HIV has gradually increased from 0 in 1986 and 1987, to 2.7 percent in 1988, and to 3.9 percent in 1989.

Reported Patterns of Condom Use

Data collected in 1986 and early 1987, as part of the CDC multicenter study of commercial sex workers, showed that female prostitutes were significantly less likely to report ever using a condom during vaginal intercourse with their boyfriends or husbands than with their clients. Over 90 percent of study participants said that they had a boyfriend, husband, or other nonpaying steady partner; 84 percent never used a condom when having vaginal intercourse with this man. This was cause for considerable concern because 34 percent of those with a steady male partner knew that their steady partner had a history of injecting drugs.

Cal-PEP

To increase proper and consistent use of condoms among women at risk, community-based programs, such as the California Prostitute Education Project (Cal-PEP), have been conducting outreach to identify and enroll women at risk in educational workshops where information can be exchanged, and social and technical skills for improving condom use can be practiced. The Division of STD/HIV Prevention at CDC is extremely interested in learning about the effectiveness of these intervention efforts, and the Behavioral and Prevention Research Branch intends to continue our support of multicenter studies designed to evaluate and enhance interventions which target women at risk, men who have sex

with men, youth in high-risk situations, injecting drug users and their sexual partners.

Summary and Conclusions

Those of us working on STD/HIV prevention have many good reasons for understanding the determinants and consequences of human sexual behavior:

1. The proportion of adolescents who have ever had sexual intercourse has continued to increase over the past 20 years.
2. The proportion of adolescents in the United States who report two or more partners has also increased.
3. The average age at first sexual intercourse has decreased, in spite of warnings about AIDS and other STDs.

Adolescent Health Behaviors

While self-reported sexual behavior trends among adolescents have been moving in a direction that might promote STD/HIV transmissions, health behavior trends have been moving in a direction that should prevent STD/HIV infection:

1. The proportion of adolescents who report using a contraceptive, but particularly a condom, at first sexual intercourse has increased considerably.
2. The proportion who report using a condom at last sexual intercourse has more than doubled in the past few years, and at least one report has linked increased condom use to the Surgeon General's Report on AIDS published in November 1986.
3. Importantly, several studies have shown that higher levels of knowledge about AIDS are associated with reports of fewer sex partners and more frequent condom use.

Men Who Have Sex with Men

Significant changes in sexual practices have been observed among men who have had sex with men. Although

instances of "risky relapse," often associated with alcohol and drug use, continue to occur, and high levels of "unsafe" sexual practices may persist with steady sex partners, and in some groups and in some areas:

1. The proportion of men who report multiple nonsteady male sex partners has decreased remarkably.
2. The proportion who report high-risk sexual activities with nonsteady partners has also decreased.
3. Behavioral changes have apparently occurred because of changing perceptions of social norms and meaningful experiences with persons with AIDS (or HIV disease).

Commercial Sex Workers

Among commercial sex workers in the United States, HIV infection is four to five times more prevalent among women who have injected drugs than among women who have never injected drugs, but now we are finding women infected with HIV, early syphilis, and other STDs who have exchanged sex for money to buy "crack" cocaine. Condoms are more frequently used with clients than with husbands, boyfriends, or other nonpaying partners, so community-based programs, such as Cal-PEP, are attempting to improve patterns of condom use. Preliminary reports suggest that persons enrolled in these programs increase their frequency of condom use and reduce their risks of HIV/STD infection.

The kind of rigorous research on human sexual behavior we needed in the 1980s to fully address the epidemic of HIV and other STDs in the United States is now beginning to be conducted in the 1990s. We must continue our efforts to assess trends in sexual and health behaviors, understand why changes occur, and assist persons at risk of STD/HIV to reduce or eliminate their chances of acquiring or transmitting disease. By combining the best of science with the best of our intervention programs, we should be able to demonstrate our effectiveness with even more definitive data.

Table 1. How many women 15-19 years of age have had premarital sexual intercourse?

Year	White (%)	Black (%)	Total (%)
1970	26.7	46.0	28.6
1975	35.4	50.8	36.4
1980	41.4	58.1	42.0
1985	43.1	55.4	44.1
1988	50.6	58.8	51.5

Source: National survey of family growth, Cycle IV, *MMWR* 1991;39:929-32.

Table 2. How many never-married men 17-19 years of age living in metropolitan areas of the United States have had sexual intercourse?

Year	White (%)	Black (%)	Total (%)
1979	64.5	71.1	65.7
1988	73.0	87.7	75.5

Source: Zelnik M, Kanter JF. National survey of young men—1979. Fam Plann Perspect 1980;12:230-7.
Sonenstein FL, Pleck JH, Ku LC. National survey adolescent males—1988. Fam Plann Perspect 1989;21:152-8.

Table 3. How many women and men 15-19 years of age report ever having sexual intercourse?

Year	Women			Total (%)
	White (%)	Hispanic (%)	Black (%)	
1982	44.5	50.6	59.0	47.1
1988	52.4	48.5	60.8	53.2
Men (never-married living in contiguous United States)				
1988	56.8	59.7	80.6	60.4

Source: Forrest JD, Singh S. National survey of family growth, Cycles III and IV. Fam Plann Perspect 1990;22:206-14.
Sonenstein FL, Pleck JH, Ku LC. National survey adolescent males—1988. Fam Plann Perspect 1989;21:152-8.

Table 4. How many sexually active adolescents report using a condom at last sexual intercourse?

Year	Women (15-19 years of age)			Total (%)
	White (%)	Hispanic (%)	Black (%)	
1982	24.9	12.8	18.7	22.6
1988	51.1	41.8	34.8	47.4
Unmarried men (17-19 years of age)				
Year	White and Hispanic (%)		Black (%)	Total (%)
1979	20.5		23.2	21.1
1988	56.5		62.0	57.5

Sources: Forrest JD, Singh S. National survey of family growth, Cycles III and IV. Fam Plann Perspect 1990;22:206-14.
Sonenstein FL, Pleck JH, Ku LC. National survey young men, 1979; National survey adolescent males—1988. Fam Plann Perspect 1989; 21:152-8.

Table 5. Number of sex partners and condom use during last sexual intercourse reported by never-married men 15-19 years of age.

No. Partners	Condom Use (%)
1	63
2	56
3-4	45
>4	37

Source: Sonenstein FL, Pleck JH, Ku LC. National survey young men, 1979; National survey adolescent males—1988. Fam Plann Perspect 1989;21:152-8.

Table 6. Knowledge about HIV/AIDS, number of partners, and condom use reported by high school students.

No. Correct Items	≥ 2 Partners		Always Use Condoms (%)
	Ever (%)	Past Year (%)	
< 10	49.7	35.7	23.2
10-13	42.0	31.4	32.5
14-15	40.7	29.1	33.5
16-17	37.7	24.4	36.0

Source: Anderson JE, Kann L, Holtzman D, Arday S, Truman B, Kolbe, L. HIV/AIDS knowledge and sexual behavior among high school students. Fam Plann Perspect 1990;22:252-5.

Table 7. How many men have had sex with men?

1970	NORC-Kinsey Survey	Minimal Estimate (%)
	Ever (lifetime)	20.3
	After age 19	6.7
	In previous year	1.6-2.0
1988	NORC-GSS (MMWR 37)	Estimate (%)
	In Past 12 months	3.2
1989	NCHS-RTI (MMWR 40)	Estimate
	Dallas Householders	18-54 Years (%)
	In Past 12 months	4.4
	Anal Intercourse	2.0

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An End to HIV Exceptionalism: AIDS in the Next Decade

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That HIV infection is a blood-borne, communicable, and sexually transmitted disease is a biological fact. But the question of whether policies and practices designed to contain and control STDs should be applied to the epidemic of HIV infection could never have been answered simply by invoking the traditions of public health, by insisting on a kind of biological determinism.

And, indeed, as public health officials at local, state, and Federal levels confronted the AIDS epidemic in the early and mid-1980s, they were forced to face the concerns of white middle class gay men and their political allies who were fearful of how efforts to control AIDS might involve recourse to intrusive and coercive measures, those that would entail invasions of privacy (so recently accorded legal protection) and restrictions on liberty. For those who had become accustomed to the routine professional practices of STD control, the challenges posed may have seemed unreasonable. But to gay men, who had suffered and who continued to suffer the consequences of homophobic public policies—homosexual acts were still illegal in 24 states—and social practices involved crucial matters. Among the questions that shaped the public debate in the mid-1980s were the following:

- Would there be widescale compulsory testing?
- Would the names of those infected be recorded in public health registries?
- Would such registries be used to restrict the rights to work, travel, obtain insurance?
- Would efforts be made to quarantine, if not all, at least some of those with HIV?

In short, would the effort to enforce public health norms result in a profound loss of freedom?

What is most remarkable about the first decade of the epidemic is how the traditional perspectives of public health were deemed inappropriate in the context of HIV. What is most striking is how the perspective of HIV exceptionalism—that HIV should be treated differently from other STDs and communicable diseases—came to dominate public discussions and public practices, especially in those states

where the epidemic had been so brutally felt (1). It also came to dominate policy in most democratic countries.

Because AIDS was incurable, afflicted populations with historically rooted fears of government agencies, carried with it great stigma and the risks of discrimination, required difficult-to-undertake and more difficult-to-sustain modifications in the most intimate behaviors, and was transmitted in contexts that involved well-defined sexual acts or the sharing of drug injection paraphernalia engaged in by consenting adults, a new approach to prevention was, many argued, required. The strategy of HIV prevention had to entail measures that would not—in a phrase that would be used by public health officials from local offices to the Surgeon General—“drive the epidemic underground.”

If the epidemic's first decade was dominated by HIV exceptionalism, that will not be the case in the next 10 years. The old alliances forged among gay leaders, public health officials, clinicians, and their professional organizations have begun to rupture under the impact of the changing epidemiology of HIV infection and important advances in the prospects for managing the clinical manifestations of HIV infection.

These changes can be seen in three areas involving the traditional approach to the control of STDs: 1) screening, 2) reporting, and 3) partner notification (2).

Screening

From the beginning in 1985, the test designed to identify antibody to HIV has been mired in controversy. Gay leaders, particularly concerned about the social and psychological burdens that could be associated with a positive diagnosis, often urged that individuals at risk avoid the test and, instead, undertake behavioral changes. Public health officials, by contrast, typically saw the test as a vital tool for encouraging the needed behavioral changes. Out of the controversies emerged a public norm—sometimes enacted into state law—that HIV testing be undertaken after the specific informed consent of the individual was obtained. This standard represented a marked departure from the conventions of clinical practice where consent to blood tests was often

assumed to exist once the patient extended his or her arm.

Over the past year, the standard of specific informed consent has been subject to increasing challenge. Thus, for example, four medical societies (unsuccessfully) sued the Commissioner of Health in New York State to compel him to declare HIV and AIDS sexually transmitted diseases, in large part to make possible the more routine use of testing. In December 1990, the American Medical Association (AMA) House of Delegates voted to have HIV infection treated like an STD, a designation that would permit routine screening for HIV. And on May 23, 1991, Dr. Marcia Angle, Deputy Editor of *The New England Journal of Medicine*, wrote an editorial calling for the routine screening of all hospital admissions and all physicians for HIV infection.

Calls for the routine screening of newborns for HIV have come from pediatricians for some time, despite the rejection of this course by the Institute of Medicine. The debate on this matter has been made more complicated by the indeterminate significance of newborn screening (HIV infection cannot be detected by the antibody test in infants until they are 12 to 18 months of age). In the absence of a definitive therapy for asymptomatic children, such screening is, in fact, maternal screening. All of this has begun to change. In mid-March 1991, the *Morbidity and Mortality Weekly Report (MMWR)* published recommendations for PCP prophylaxis in infants 1 month of age with a CD4 count of less than 1500. These recommendations will inevitably lead to newborn screening along the lines that now exist for other congenital conditions such as phenylketonuria (PKU).

Reporting

AIDS has been a reportable condition in every state since 1983. But when the possibility of diagnosing HIV infection emerged in 1985, a great debate began over whether it, too, should be made reportable. Despite the fact that the logic of AIDS reporting should lead to HIV reporting, most states have not followed that course. In large measure that has been the case because of concern that reporting would dissuade individuals from undergoing voluntary testing. This has been demonstrated most notably in states where the prevalence of HIV infection is highest.

But here, too, there have been fissures in the alliance that initially opposed reporting. The Presidential Commission on the HIV Epidemic recommended such a course in 1988. In 1990, the suit brought by four medical societies in New York State also called for reporting. At the end of 1990, the House of Delegates of the AMA reversed its earlier position and endorsed such an approach. Finally, in November 1990, the CDC called for reporting in an editorial note in the *MMWR*.

Partner Notification

The move toward reporting has been intimately linked to the question of partner notification—contact tracing. Despite its long-established role in STD control programs, contact tracing has been the subject of great conflict in the context of the HIV epidemic. Lay persons have misunderstood how it functioned and have expressed fears that it would be employed in a coercive manner. Some public health officials who should have known better have also, at times, referred to “mandatory partner notification.”

During the past 2 years, there has been a greater willingness to consider this standard STD control practice for reaching out to those who may have been exposed to HIV. Such change has been fostered by CDC which has made the existence of partner notification programs a condition for the states to receive funds from HIV prevention programs. But, despite the fact that all states now claim that they have such programs, the reality is far more complex. Local epidemiological, political, and fiscal considerations have played a crucial role in determining the extent to which partner notification programs have been put into place.

Each of the changes described above represents a movement toward the reintegration of HIV infection with traditional approaches to the control of STDs. Although I believe that consent to testing by competent adults is ethically required—as I believe that competent adults should retain the right to determine which diagnostic tests and medical procedures they should undergo—the use of often traditional public health practice should not obscure the fact that we have learned a great deal in the last decade because of AIDS. These lessons, most importantly the crucial role of involving community-based groups in the planning and implementation of public health efforts targeted at the modification of behavior, must not be lost as HIV and STD are reintegrated.

There is an even more crucial matter, however, that requires critical attention at this juncture. Much of the change described above is linked to the important advances in the treatment of HIV in the past 2 years. But, theoretical advances do not always translate into available treatment—especially in the central states where 30-40 million Americans have no health insurance, and where most pharmaceuticals must be paid for “out-of-pocket,” even by those who have insurance.

If the end of HIV exceptionalism means that HIV infection will be treated like other medical conditions, it also means that the impetus for providing special funds for the care of those with this lethal condition will be lost. The fate of the Ryan White Act is instructive. In the very year when the Congress so overwhelmingly endorsed the Act, less than 20 percent of the promised funds were appropriated.

We can do more now for those with HIV infection than at any moment since the onset of the epidemic. But whether we will do more will ultimately be dependent on the willingness of politicians—and ultimately the American public—to provide the necessary funds. It was the grim situation that now confronts many individuals with HIV that led Marcia Angel to call for a Federal program to cover the full cost of caring for those with HIV disease on the model of the End-Stage Renal Disease Program, the only Federal effort that covers the full cost for the treatment of a single disease.

In a period of fiscal crisis and retrenchment, when “cost containment” is virtually the only matter that draws political attention, it is hard to be sanguine about the prospects of such a proposal. Under such circumstances, it is the professional and moral responsibility of those committed to public health in general, and the control of HIV more specifically, to make clear the cost—in human and moral terms—of failing to respond with the needed resources.

In the early 1970s, Americans learned of the shameful episode that we have come to know as the Tuskegee Syphilis Experiment in which federally funded scientists deprived poor black men in the rural south of treatment for their disease, even after effective treatment became available. They did so in order to track the natural history of untreated syphilis. Will we look back on the 1990s as a period within which an increasingly black and brown and poor class of individuals with a sexually transmitted disease—this time a

lethal disease—went untreated? I hope not. But hopes are not enough.

On the 24th of May, 1991, it is impossible to conclude without taking note of the Supreme Court's decision on May 23rd, upholding the authority of the Federal executive to prohibit agencies that receive Federal family planning funds from even mentioning the option of abortion to women, or referring them to clinics where they might terminate their pregnancies. This decision, by a sharply divided court, represents a blow against the freedom of clinicians to offer full and open information to their clients. It represents a blow against the right of women to information about their still legally protected reproductive options. It represents, finally, a blow against efforts to limit the perinatal transmission of HIV infection by women who might choose to abort on learning of their capacity to transmit a lethal virus to their children.

Lady Liberty, who stands as a symbol of justice in many of our courts, stands bowed today. If statues could weep, I am certain that tears would flow from behind the blindfold that stands as a symbolic assurance of impartial and equal justice.

Hygeia, the goddess of public health, would be appalled.

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Never Say Never

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City of Houston
Houston, Texas

"Thus the sum of things is ever being renewed, and mortals live dependent one upon another. Some nations increase, others diminish, and in a short time and space the generations of living creatures are changed and like runners pass on the *torch of life*" (Lucretius, *On the Nature of Things*, Book I).

"A great flame follows a little spark" (Dante Alighieri, *The Divine Comedy*, Canto XXII) and "There is in most Americans some spark of idealism, a spark which can be fanned into a flame" (Justice Louis D. Brandeis, 1953, one of the better justices on a former court). "Let the word go forth from this time and place. . . that the torch has been passed to a new generation of Americans" (John F. Kennedy, Inaugural Address, January 20, 1961).

"To you from failing hands we throw/the torch; [it's] yours to hold high" (John McCrae, "In Flanders Field").

Never say "never" to dedicated health professionals like you.

Never tell yourselves. . . **never** let **anyone** else tell you that you cannot make a difference.

Never let **anyone** dissuade you from a sound idea just because it has never been tried.

I am told that this week you have heard about "the best of science and the best of program" as we all learn more about dealing with the devastation of AIDS and HIV.

If you ask, what is science to us? Our minds might immediately conjure up images of the scientist in the lab surrounded by heated test tubes, beakers, and electronic instruments. But science **could** be symbolized by the **flame**.

What is program? We might picture an office or at best an administrator, at worst a bureaucrat. However, program **could** be symbolized by the **torch**, which places sensible limits on the **flame** and keeps it from burning out of control. . . the torch makes the flame useful. **Flame. . . torch. Science. . . program.**

The **flame** can also symbolize **creative energy**—1) the ceramic artist uses a kiln to bake the ceramic piece, 2) the

sculpting artist wields the welding torch to fashion a metallic vision, 3) the welder wields a similar blow torch to assemble a project, 4) a glassblower uses an open flame to shape a delicate crystal creation, 5) a chef uses a range or oven to cook a gourmet dish. All these illustrate the use of controlled flames.

Similarly, 1) from the flame of inquisitive energy, a researcher creates useful knowledge or 2) a line worker proposes useful new ideas. But, the information or the idea is raw/rudimentary until it is refined, controlled, and implemented.

The **torch** can symbolize control—like the skilled juggler learns to control many dissimilar items at once, including balls, rings, Indian clubs, knives, even **torches** (firebrands).

Similarly, a bureaucrat (administrator) learns to balance many demands and problems with the available resources. The demands may be for additional kinds of services, service at additional sites, mobile services, more effective health education, better treatment. The resources will likely include personnel, equipment, funds, facilities, and cooperative services (available in-kind or under contract from other agencies or organizations).

The **flame** — creative energy; the **torch** — control. Neither is useful without the other.

We **need** the creative energy of the **flame** to fuel new discoveries in the fields of prevention, diagnosis, and treatment. We **must** have the creative energy to apply the new discoveries.

We need the control of the **torch** to marshal our resources to address the many challenges of dealing with these devastating diseases.

Never say never — not when **you** can take that **energy** and that **control** and make a difference!!

Sometimes we can't prolong one patient's life, or soothe another patient's pain, but we can help each one deal with his or her own life in a way that makes it possible to face the worst that any STD or even HIV can bring.

If a **flame** under control can be such a powerful tool, what of a flame out of control? An uncontrolled flame could destroy a home, a forest, a country. It could burn a person to the point of pain, disfigurement, disability, and even death.

Our own flame can burn out of control. We can let our creative energy run rampant, thinking up all manner of new ideas and new approaches with or without merit. That's all right as long as we take a considered approach, evaluate the pros and cons, and implement new programs only after adequate planning.

On the other hand, unbridled control could **stifle** creativity. Too much control could **prevent** that important new idea from ever being heard—(our U.S. Supreme Court's May 23, 1991, decision limiting counseling about abortion).

If someone has a new idea and we "put it down" too quickly without a fair hearing, we could overlook a valuable contribution to the field. You know how **you** would feel, if someone squashed **your** idea. Have **you** squashed someone else's creative imagination lately?

That **torch**, that **flame** can also be used to cast light on a mystery. In our case, it might help us discover a cure, a better means of prevention, or at least a better treatment.

Never say never.

If you are dealing with AIDS, especially with people and families with AIDS, then you are engaged in one of the most stressful pursuits that I can imagine. When you find yourself wishing you were elsewhere, but not really wanting to leave, how do you keep yourself going? Here are a few ideas I have heard, and I encourage you to continue networking with each other to share ideas further.

- Seek out support groups. If you can't find one that works for your needs, help someone else form one. I say, "Help someone else," because as soon as you take that step, you will have started your support group. Find a location, set a date and time, and put an announcement in the newspaper.
- When the news programs make you anxious or depressed, don't watch, don't listen. When the newspaper is too much to think about, turn to the comics, sports, entertainment, or whatever helps you to relax. When the telephone adds to your stress, don't answer (treat the doorbell the same way).
- At the office, if you have any control at all over your schedule—and you may be surprised to learn that you have as much control as you demand. Set aside a quiet period of half an hour to an hour each day to catch up on paperwork, phone calls, etc. Make it clear to the other staff that you will not accept phone calls (except emergencies) or visitors (without an appointment).
- Try doing some volunteer work in a field far removed from your vocation. Look for something you really love doing.

This may seem like more work, but it won't be if you really love it.

"Dissatisfaction with the world . . . and determination to make it be better" gives us a reason to keep going even when times get tough (Goldsworthy Lowes Dickinson, *The Greek View of Life*, Chapter 5). I step out before the way is entirely clear, because my younger brother or sister must come this way.

"A great flame follows a little spark" (Dante Alighieri, *The Divine Comedy*, Canto XXII).

And, "There is in most Americans some spark of *idealism*, which can be fanned into a flame" (Justice Louis D. Brandeis, 1953). "Let the word go forth from this time and place . . . that the torch has been passed to a new generation of Americans" (John F. Kennedy, Inaugural Address, January 20, 1961).

"To you from failing hands we throw/the torch; [it's] yours to hold high" (John McCrae, "In Flanders Field").

As we approach the end of this conference, let us decide ways we can implement the ideas of the "Action Alliance: The Best of Science and the Best of Program," the theme for this week.

- I believe we can do it.
- I believe we can marry (meld) science and program.
- I believe we can link knowledge and behavior.
- In the matter of prevention, knowledge is necessary, but not sufficient. Only behavioral change will do.
- In the matter of serving the people, science is necessary, but not sufficient. Only program can meet the need.
- I believe that an action alliance requires science and program.
- In an analogous vein, you can be a good scholar without being a good practitioner; but you cannot be a good practitioner without being a good scholar.
- I believe that action demands a link between scholarship and practice.
- I believe that action demands an alliance between science and program.
- I believe that one day we will serve people on the basis of their health behavior rather than treat them according to the profile of their medical insurance.
- I believe that one day we will spend \$100 per person/year preventing HIV infection rather than spending \$500 per person/year managing HIV.
- I believe that one day we will help anxious teenage girls by the breadth (comprehensiveness) of their individual need and not by the narrowness of their counselor's creed.

- I believe that one day we will treat teenage boys by the etiology of their stress and not by the bravado of their duress.
- I believe that one day innocent little girls and inquisitive little boys will be served according to the hazards of their health and not just by the signs and symptoms of their disease.
- I believe that one day HIV will be treated as if it is an STD and not as if it is a Democrat, an Independent, or a Republican.
- I believe that one day we will have a system that is not only available, but affordable.
- I believe that one day we will have a system that is not only acceptable, but adaptable.
- I believe that one day we will have a system that is accessible and effective.
- If you can help our nation reach these goals, your participation in this conference and in your profession will have been worthwhile, because you will have demonstrated the "Action Alliance." You will have demonstrated the "best of science and the best of program."
- *Never say never!!*

National STD/HIV Prevention Conference Summary

Windell Bradford
Deputy Director
National Center for Prevention Services

I have the difficult assignment of summarizing in 20 minutes what has occurred here since Sunday (Saturday for many of you).

I have been asked to do this on behalf of Alan Hinman who is unable to be here. He has been following the conference daily and sends his greetings and his respect for the work you are doing.

The theme of this conference is the **Best of Science – Best of Program**. The many people who organized the program sought out those who had stories to tell about both—the latest science (there is some) and exciting programs (there are many).

The clear **sub-themes** of this conference have been coalition building and integration of programs: integration of STD and HIV programs, integration of prevention and early intervention services, and integration of STD/HIV programs and drug abuse programs.

Coalition building and integration of activities are clearly the challenges for our programs—and these were the challenges for the conference planners. In many ways, this conference was theater within theater. In planning the conference, each of us had a mental agenda which would have consumed the entire week and more. Conference planners from CDC and each of the groups represented here had the extremely difficult task of distilling, focusing, and giving and taking. Their success (your success) in doing this has resulted in an incredibly exciting achievement—and I, on behalf of Alan Hinman, Gary Noble, and Bill Roper, thank you. Many people are responsible for this, but I would like to mention Jack Kirby, Pegi Brooks, the chairpersons and committee members who developed each track, and the support staff who have put in many long hours.

The heart of this conference, in my opinion, was the workshops. Many of the workshop coordinators have summarized their discussions and recommendations for me to pass along to you, but even when summarized there is more than can be covered in 20 minutes. I will address the high points.

Community-Based Organization Workshops

CBO Workshops addressed:

- Women and HIV.

- Working with culturally diverse populations.
- Substance abuse and HIV.
- Youth and HIV.
- Outreach and educational strategies.
- Program development and management.

Highlights of these workshop discussions included programs addressing needs of **women**. These must:

- Involve women in planning and conducting programs.
- Acknowledge women as a group at risk.
- Recognize diversity among women in terms of cultural realities, religious beliefs, sexual lifestyles, and socioeconomic status.
- Address access to services. This includes review of the AIDS case definition and the need for support systems tailored to women.
- Focus on individual empowerment of women within society, and recognize the great need for research in the area of women and HIV.

Programs addressing needs of a culturally diverse population must consider the following points:

- First, cultural diversity must be acknowledged.
- People from racial and ethnic communities must be involved in planning, carrying out, and evaluating public health programs.
- Cultural diversity should be reflected in CDC staffing.
- Diversity among individuals should be recognized in research and surveillance programs, looking particularly at such variables as education, socioeconomic status, participation in the labor force, and urban/rural residency.

CBO workshops also discussed the particular needs of the visually impaired and persons with mental retardation.

With regard to **substance abuse** and HIV, CBO workshops suggested that we focus on:

- The need for more accessible treatment services.
- More effective outreach with regard to alcohol and substance treatment services.
- Better support systems, case management services, and referral systems.

With regard to **youth and HIV**, we should:

- Involve youth in planning and carrying out programs.
- Emphasize peer education.
- Recognize and incorporate the priorities which youth have (not ours).
- Acknowledge the valid and logical reasons why young people leave home.
- Be prepared to pay youth for their work in public health programs.

With regard to **outreach and educational** strategies, workshops addressed:

- Worker safety.
- The need for CBOs to communicate with and seek support of media representatives, businesses, and civic groups in carrying out programs.
- Education programs which are linked to the availability and delivery of services.

CBO program development and management workshops addressed particular needs for:

- Employee development and training.
- Evaluation plans which are realistic and responsive to program objectives.
- More extensive use of volunteers.

National and Regional Minority Organization Workshops

These workshops developed recommendations related to:

- Organizational leadership and development.
- The role of NMOs in collaborating with local community organizations.
- Public policy and advocacy about HIV prevention issues.
- Coordination of HIV and STD prevention services.

A few nuggets from these workshops included:

- Discussion of six important points in developing rapport with staff and ten key points to good management of CBO programs.
- Suggestions that in developing evaluation plans, we should keep it simple, look to the future, and use outside help.
- Discussion of:
 1. What has **not** worked in collaboration with local community organizations.
 2. What CDC can do to support collaboration.
 3. How to manage turf issues.
 4. Involvement of local elected officials in collaboration.

Use of Seroprevalence Survey Data in Targeting and Evaluating Prevention Programs

This workshop looked particularly at survey data about:

- Childbearing women.
- Persons receiving drug treatment.
- Persons attending STD clinics.

Six small groups discussed individual application of data in their areas. Examples included:

- Using data in collaborating with CBOs to target resources.
- Using data in working with the media and with health care providers.

STD Surveillance Workshop

This workshop emphasized:

- Standardized methodologies using standard case definitions.
- Local control and local analysis of surveillance data.
- The current transition in reporting from aggregate paper forms to line-listed electronically transferred data.
- Emerging surveillance systems for congenital syphilis and chlamydia.

STD/HIV Prevention Workshop

This workshop addressed:

- Outreach and intervention for hard-to-reach populations.
- Prevention opportunities through supervisory involvement (training and education).
- Providing alternative clinical and referral services with limited resources.

In these sessions, several common themes and take-home messages emerged:

- Understand that AIDS should be viewed in terms of "families affected by AIDS" instead of "persons infected with AIDS."
- Understand that women have unique HIV prevention needs (versus the concept of women as vectors of disease).
- Strong prevention activities are still the key in early intervention.
- Efficient models for interventions need to be inventoried and shared with the family of disease prevention players (health departments, CBOs, NMOs, etc.).
- Standards and guidelines need to be developed and shared.
- Technical assistance needs are many.
- HIV/AIDS and STD programs must work together. This means more than infrequent communication, collaboration, and coordination. Some players are providing a

disservice because they focus only on HIV/AIDS or STD.

- The most used words in these workshops were: integration, collaboration, communication, coordination, access, assess, models, guidelines, standards, early intervention, CARE, CARE, CARE.
- Research findings need to be transferred to health care providers at the local level. CDC must do or sponsor research that helps answer operational problems.
- With regard to STD/HIV services in correctional institutions, workshops spent time identifying problems and issues before turning to proposed solutions. Nuggets from these discussions included:
 1. The potential importance of peer education within institutions.
 2. CBOs have a major role in HIV/STD education for ex-offenders — programs are needed in institutions to link programs for persons re-entering society.

3. STD/HIV programs should “ride the coattails” of other services being provided in correctional institutions — e.g., TB and Alcoholics Anonymous programs.

In addition to these workshops, creative and topical presentations and discussions took place in the wide variety of special topics seminars, general sessions, and poster sessions. To those of you who took time to make these possible, all of us owe our gratitude.

It has been a week of messages delivered, messages heard, and messages debated. Hopefully, each of us participated in all three. It has been informative, exhilarating, and exhausting.

Shortly, Ron Valdiserri will help us put this week into focus as we leave to get back down to business.

Thanks to all of you.

How to Build on What We Have Learned

*Ronald O. Valdiserri, M.D., M.P.H.
Deputy Director (HIV)
National Center for Prevention Services
Centers for Disease Control
Atlanta, Georgia*

I have been asked to bring this conference to a close by talking about "how to build on what we have learned." But, before we can talk about the "how to," I'd like to spend some time on the "what."

What exactly have we learned this week? Speaking for myself, having an opportunity to meet so many different people with such a diverse range of experience and perspective has been truly educational. And throughout the course of talking with you, listening to your presentations, and sharing my own opinions and ideas with you, I have been struck by a number of recurrent themes that have appeared and reappeared in many of our activities this week. I would like to present these to you now as my interpretation of some of the important lessons we have learned at this conference.

First on my list is the observation that, although disease prevention activities may be funded categorically, people's health needs are rarely separated into neat little packages. Much has been said this week about the importance of integrating HIV and STD prevention services. What we are really saying is let's not forget that services are intended for people—not for diseases. Because sexual and drug use behaviors can place people at risk for a number of infectious diseases, as well as unintended pregnancy, it is important that we take a "holistic" view of our prevention activities rather than a purely disease-specific orientation.

Following up on the observation that prevention services should be for people and not for diseases, let us keep in mind a second extremely important point; gender, race, ethnicity, and social circumstance are powerful influences on health-related behaviors and should be given careful consideration in the design and implementation of prevention services. If we expect people to view our services as beneficial and to use them, we have to understand our clients: who they are, what values are important to them, how they communicate among themselves, and what they think of the services that we offer to them. It is naive to assume that people will come flocking to our programs merely because they are free of charge and available. The low return rate for HIV posttest counseling reported by some STD clinics is a perfect case in point. We assume that anyone who is at risk for HIV

disease would want to know whether or not they are infected, especially now that early medical intervention can delay the onset of illness and improve the quality of life. But this is not always the case. And, it is those persons who do not return that we need to learn more about. Not because we want to keep track of everyone who is infected, but because we care about them and we want to help them and their families.

In order to develop HIV/STD prevention services that are in tune with the variables of gender, race, ethnicity, and social circumstance, we have expanded our prevention team to include many new players. And this is the third of my observations: the components of the public health infrastructure for HIV/STD prevention are heterogeneous. We are not of one face and sometimes we are not of one mind, but we do share common goals. Speaking specifically of HIV disease for the moment, I can safely say that all of us, regardless of our gender, race, ethnicity, or sexual orientation, want to prevent the pain and suffering that result from HIV infection. In order to do this, we have recruited new prevention partners. Community-based organizations, national minority organizations, schools, churches, businesses, and professional groups are among the many non-governmental organizations that have joined forces with state and local health departments in mounting a national prevention campaign. More and more we realize that in order to be successful in our fight against STDs and HIV infection, we must mount a broad-based societal response.

In the same way that different kinds of organizations have been asked to join in our STD/HIV prevention efforts, so too have we sought the input of different scientific disciplines. Our prevention programs have been strengthened by input from our colleagues in the social sciences. We have profited by their concepts of social marketing, by their theories which view behavior change as a multiple step process, and by their ethnographic techniques for studying members of groups who are in need of HIV/STD prevention services yet are hard to reach by traditional means. This brings me to my fourth and final observation, that biomedical solutions, by themselves, are not always the final answer to disease prevention.

Consider for example, two sexually transmissible diseases for which we have effective biomedical interventions: syphilis and hepatitis B. In one case we have a drug and in the other we have a vaccine—two perfectly good biomedical solutions to these infections. Yet neither disease has disappeared. Neither disease has been removed from the medical textbooks. And in the case of syphilis, incidence of infection is actually increasing in certain population groups. This doesn't mean that we don't believe in biomedical solutions—but it does remind us that even when curative drugs and vaccines are at hand, prevention efforts will still require the advice and guidance of the social sciences. It means that disease is more than the infection of an organism by a microbe. Disease is also a reflection of how we live as a society, what values are important to us, how well we plan and allocate resources, and how well we understand the needs and circumstances of people. It means that those of us who work in the field of HIV and STD prevention must develop prevention programs that treat the person—not just the microorganism.

So, how do we build on these observations? Where do we go from here? The operative word is “build.” As any crafts-person could tell us, building means to bring together different parts and to assemble them into a whole. And that is exactly what we must do with our HIV and STD prevention efforts. It is not enough to have a diverse array of organizational partners providing HIV and STD prevention services. It is not enough to enlist the support of varied scientific disciplines. And it is not enough to develop programs that address the special needs of populations and groups. Without coordination and integration, we will be left with only the pieces of a prevention program. And although many of these individual pieces may be exceptional in their performance, unless we can bring them together in a cooperative and mutually supportive way, we will fall short of our goal. This is clearly not an easy task. But, it is one that is possible to achieve as long as we are willing to do the following: Listen, Share, and Learn.

There is an old proverb that advises “from hearing comes wisdom.” I would agree with that adage. Each of us has something important to say, a contribution to make toward solving the prevention puzzle. Listening to one another is probably one of the best ways we have of building effective organizational relationships. I know it seems an awfully simple approach, but if we don't listen, we cannot share information. And, if we cannot share information, we won't be able to learn from one another.

In both our HIV and STD prevention programs, we have made a conscious decision to expand their scope to include

more and more non-governmental organizations. This is not because we are dissatisfied with the job of health departments. In fact, I agree with the statement made by the Institute of Medicine in its 1988 report, “The Future of Public Health,” that, and I quote, “The wonder is not that American public health has problems, but that so much has been done so well, and with so little.”

We have expanded our public health infrastructure to include non-governmental organizations in recognition of the fact that prevention activities have to extend beyond the clinic and into the homes, neighborhoods, and communities of the persons we wish to serve. We have enlisted the support of other prevention partners because we are aware of the fact that our clients may need more from us than we can deliver in a single clinic visit.

Of course, this expansion is not without its difficulties. Different organizations bring different values and perspectives. Take for instance “partner notification.” While partner notification is a time-honored, well-proven method for preventing the spread of syphilis and other sexually transmitted diseases, some of our new prevention partners may be wary of it. Perhaps they do not come from an STD background and are unfamiliar with the role that partner notification has played in syphilis control. Or perhaps they represent a minority group whose experience with government has not always been positive.

It is not my intention to digress into a discussion of partner notification. But it is my intent to support the importance of sitting down to talk about issues on which we may not hold the same opinion. That is how we can learn from one another and how we can ultimately improve our programs. I realize that this isn't always easy. But, giving birth to an infant with syphilis, or coping with the knowledge of HIV infection isn't easy either. The reality is that we have chosen a tough way to make a living, but I also know that the effort we put into cooperation will be well worth the payoff in terms of benefit to our clients.

What is the role of CDC in all of this? Obviously, we are accountable to Congress and to the American people for the resources that we receive to fund HIV and STD prevention programs. As part of that responsibility, we want to ensure that we are making the best use of our prevention resources—that we are putting those dollars where they will do the most good. But our role in “helping to build” a national HIV and STD prevention strategy is much more than disbursing resources and tracking their use. Our role is also one of providing leadership and developing guidance, of setting standards and providing technical assistance when technical assistance is needed. As America's national

prevention agency, CDC is responsible for providing the "glue" that holds together all of the unique and diverse components of the prevention puzzle. This doesn't mean that we have all of the answers. Nor does it mean that we develop prevention programs in a vacuum.

Our recent experience in developing the program announcement for the implementation of Part C of the CARE Act is a good example of how CDC conducts business with its "prevention partners." After our own professional staff developed a preliminary draft of the program announcement, based on the requirements outlined by Congress, we invited nearly 30 external consultants to review the draft and to provide us with guidance and input. These consultants were from many different organizations, including: professional societies, national minority organizations, other Federal agencies, and community-based providers of medical and psychosocial care for persons living with HIV infection and AIDS. Their comments helped to craft a revised draft which was then reviewed by another group of 28 consultants from state and local health departments. The health department representatives had a different, though equally valid, perspective about early intervention services. Their comments

helped us to improve the draft even further—and it is that multiple-revised document which we have shared with you this week.

Now certainly, a good program announcement—and I think we have one—does not necessarily ensure a good program—but that's where all of you come into the picture. If CDC is the glue for the national prevention program, you are the program parts that make it work. You are the men and women on the front lines whose experience and know-how translate abstract national HIV and STD prevention objectives into something tangible and worthwhile—HIV and STD prevention services to people. Hundreds of times each day, your efforts touch the lives of those in need. Without you, our objectives and guidance are only words on paper. You make them real, and for that you are to be congratulated.

There are those pessimists who question our ability to gain the upper-hand in dealing with diseases like syphilis and HIV infection. But, we know that they are wrong. We know that it is possible to make a difference. And, it is because of people like you that I can say that.

Keep up the good work and have a safe trip home.

Annotated List of Special Topics Seminars

Substance Abuse: *What Everyone Should Know*

Moderator: Alberto Mata, Ph.D., National Institute on Drug Abuse, Rockville, Maryland. *Coordinator:* Richard T. Conlon, Rich Voigt, DSTD/HIVP, NCPS, CDC. *Presenters:* Jan Howard, Ph.D., National Institute of Alcohol Addiction and Abuse, Rockville, Maryland; Gloria Rodriguez, Paterson Health Behavior Project, Rahway, New Jersey; Dan Gleason, Orange County Health Care Agency, AIDS Outreach Project, Santa Ana, California; Harry Haverkos, M.D., National Institute for Drug Abuse, Rockville, Maryland.

Gloria Rodriguez spoke about "Engaging the Addict and Improving Compliance." In her presentation she:

- Identified the most commonly abused opiates by the drug name, generic label, and street name.
- Discussed characteristics and effects, duration of effect, potential for physical and psychological dependence as well as for drug tolerance.
- Elaborated on signs and symptoms of narcotic withdrawal, and the effects of withdrawal on pregnancy.
- Gave step-by-step guidance for health care workers who work with addicted individuals.
- Emphasized the importance of speaking directly to the patients' concerns, listening to them, and being very clear and straightforward when giving them instructions.

Jan Howard's special topic was, "Alcohol and Health." Dr. Howard:

- Addressed the epidemiology of alcohol abuse in the U.S. and the link to sex, STD, and HIV, the fact that alcohol lowers resistance to avoiding unsafe behaviors.
- Documented the patterns of abuse among teens and adolescents as well.
- Described a number of attempts to educate youth, but stressed how such efforts were futile in the face of the glamorization of alcohol in the music, movies, and television programs which bombard the American public. The only **effective** programs are those which are legislatively enacted, i.e., banning liquor ads from TV, strict enforcement of DUI laws, etc.

In Harry Haverkos' talk about "Crack Pipe as Pimp," he focused on:

- Patterns of cocaine abuse in the United States based on data collected through the Drug Awareness Warning Network (DAWN).

- Described the sharp increase in cocaine abuse during the 1980s, largely due to the reemergence of crack cocaine in poor inner cities across the U.S.
- Emphasized that the marketing of crack at such a low cost, plus the extreme "high" that could be attained, made this drug extremely popular.
- Described preliminary observations of seven ethnographers who were studying the role of crack in prostitution in seven urban areas. This has particular implications for syphilis and HIV control efforts.

During Dan Gleason's presentation, "Drug Treatment & HIV," he discussed:

- Drug abuse in Orange County and the many steps it has taken to make drug abuse treatment more appropriate for clients at increased risk of HIV infection.
- Drug treatment professionals must participate in an HIV in-service training within 6 months of being hired.
- All drug treatment clients are provided HIV education, which is followed by voluntary confidential HIV antibody testing and counseling.
- Antibody testing is important in that HIV-positive clients can be identified. These clients are referred for psycho-social and financial counseling, an immune system work-up and consultation with a physician.
- HIV street outreach is directed toward IV drug users in parks, shelters, missions and meal programs. The HIV street outreach includes HIV education and antibody testing.

Integration of Substance Abuse Services with STD/HIV Prevention Services

Moderator: T. Stephen Jones, M.D., Office of the Deputy Director (HIV), NCPS, CDC. *Coordinators:* Eva Margolies and Rich Voigt, DSTD/HIVP, NCPS, CDC. *Presenters:* Fred Felch, Project Trust, Boston, Massachusetts; Frank McCorry, Ph.D., Division of Substance Abuse Services, AIDS Resource Unit, New York City; Douglas Morgan, AIDS Prevention and Control, New Jersey Department of Health, Trenton, New Jersey; Linda Samost, Family Planning Council, Philadelphia, Pennsylvania.

This seminar presented information about:

- Reducing perinatal HIV and other STD through integration of onsite family planning and HIV/STD/TB prevention services in drug treatment facilities.

- Successful case management coordination of substance-abusing clients through integration of community-based services with other medical facilities.
- Integration of substance abuse counseling; HIV/STD prevention and primary care services in a community health center setting through a joint agreement between CDC and the Health Resources and Services Administration (HRSA).
- The value and need to integrate primary care and HIV/STD/TB prevention services in drug treatment facilities.
- The injecting drug user and the transmission of HIV/STD and the responsibility for notifying partners.
- Integrating substance abuse counseling in an STD Clinic.
- Alcoholism and its prevalence among STD clinic clients.

Outreach to Substance Abusers

Moderator: Imani Thompson, Office of the Deputy Director (HIV), NCPS, CDC. *Coordinators:* Tim Quinn and Rich Voigt, DSTD/HIVP, NCPS, CDC. *Presenters:* Fred Felch, Project Trust, Boston, Massachusetts; Harvey W. Feldman, Ph.D., Youth Environment Study, Inc., Oakland, California; Al Mata, Ph.D., Rockville, Maryland; Frank McCorry, Ph.D., Division of Substance Abuse Services, AIDS Resource Unit, New York, New York; Yolanda Serrano, ADAPT, New York, New York.

- A description was given of Project Trust, a model for providing HIV education and prevention services to intravenous drug user (IVDU) clients who are not in treatment.
- A presentation was given of how to develop an effective street-based model for early intervention in drug prevention and prevention of HIV among injection drug users and their sexual partners.
- The issues and problems faced by those who provide HIV outreach to "out of treatment" IV drug abusers were discussed.
- A presentation was given about some of the measures, actions, and procedures used by some National AIDS Research Demonstration Grant Programs and AIDS Targeted Outreach Models Programs. The implications of these efforts for current and future planning and programming were also discussed.
- A review was given of current practices used by outreach programs and the need to develop an outreach model with a repeated contact capability in order to influence the reduction of relapses among substance abusers to reduce HIV transmission.

- An overview was presented of a multi-strategy outreach program for reaching IVDU populations in several settings.

Early Intervention for Persons with HIV Infection

Presenters: Don Francis, M.D., San Francisco, California; Bernie Branson, M.D., DSTD/HIVP, NCPS, CDC; Rals Leven, California State Department of Health, Sacramento, California; Betsy Jones, AIDS Program State Health Office, Tallahassee, Florida; Randall S. Pope, Michigan Department of Public Health, Lansing, Michigan.

- Early intervention has often been seen as delivery of medical services. While medical services are important, **strong prevention messages** must be a critical part in delivering medical as well as psychosocial and social services to HIV-infected individuals.
- HIV antibody counseling was discussed.
- Provide referrals to: health and support services (CARE Act Funds) community-based organizations, research facilities/drug treatment trials.
- Provide clinical and diagnostic services and periodic medical examinations.
- Therapeutic approaches to HIV infection were discussed.
- Outreach.
- Case management.

Syphilis Epidemic and Its Impact on Programs

Presenter: Dennis Murphy, STD Control Program, New York State Health Department.

- Clustering and screening are productive, but are resource dependent—not enough dollars.
- Information was presented about the expanded screening and preventive treatment measures taken in New York because of increasing syphilis morbidity.

"Modern Day" Approaches to Disease Intervention: The Best of Program

Moderator: Kathy Cahill, PHPPO, CDC. *Coordinators:* Rich Voigt and Gene Williams, DSTD/HIVP, NCPS, CDC.

Presenters: Edwardo Alcantar, M.D., M.P.H., Maricopa County Department of Health, Phoenix Arizona; Kenneth Bromberg, M.D., Kings County Hospital, Brooklyn, New York; Sheila Dooley, Philadelphia STD Program, Philadelphia, Pennsylvania; Mark Henrickson, Hartford Health Department, Hartford, Connecticut.

- It is possible to reduce syphilis morbidity and associated congenital syphilis and stillbirths by offering clients voluntary preventive treatment according to specific zip codes.

- Alternative casefinding methods were offered in a crack-related syphilis epidemic. A high-risk population was reached—those who would not normally interact with the health delivery system.
- A mobile unit was used for HIV and syphilis testing and provided a more productive service delivery approach than at sites offering traditional health delivery.
- The need for voluntary immediate treatment services based on state rapid plasma reagin (RPR) results or high-risk patient profiles in select health delivery settings was discussed.
- Allied in action for syphilis testing services at HIV anonymous counseling and testing sites (CTS): an STD and HIV/AIDS program protocol for testing patient specimens for HIV and syphilis.
- HIV-positive autopsy results were linked with partner notification services.

STD/HIV: Crosscutting Issues for Community-Based Organizations

Summary not available.

Integration of STD/HIV Counseling, Testing, Referral, and Partner Notification Services at the Clinic Level

Presenters: Patricia Cory-Doniger, R.N., F.N.P.C., Department of Infectious Diseases, University of Rochester, Rochester, New York; Penny Weismuller, Ph.D., Orange County Health Department, Santa Ana, California; Gene Wiley, R.N., Drug Abuse Services/AIDS Outreach Project, Santa Ana, California; James R. Novotny, Division of STD Control, Department of Health and Mental Hygiene, Baltimore, Maryland.

- A need for CDC technical assistance for staff training indicates the need for a specific course to implement and problem-solve the integration of services.
- HIV/AIDS programs and STD programs (**where separate**) **must** collaborate and coordinate prevention activities. Current communications in some areas are counterproductive and end up being a disservice to those we should be serving.
- Integration of HIV counseling, testing, and sex partner referral presents problems to the county STD clinics:
 1. Who bears the responsibility for CTS?
 2. Who trains the personnel?
 3. How will the changes in clinic flow be handled?
 4. How much increased time is required?
 5. What are the feelings of the staff?

- The potential positive outcomes of integration are:
 1. The feeling of accomplishment.
 2. The knowledge that you have helped patients through traumatic experiences.
 3. You may have effected behavior change.
 4. You have intervened in disease transmission.
 5. Positive attitudes from CTS may be transferred to other areas.

Legal Issues Related to HIV/STD Prevention Activities

Moderator: Brian Willis, L.L.B., Office of the General Counsel, CDC. *Coordinator:* Russ Havlak, DSTD/HIVP, NCPS, CDC. *Presenters:* Carmen Quintana, J.D., Indiana State Board of Health, Indianapolis, Indiana; Lisa Bowleg, AIDS Policy Center, The George Washington University, Washington, D.C.

Federal Anti-Discrimination Laws and AIDS

Since there is no single Federal anti-discrimination law, one must rely on existing laws which are specific to the alleged discrimination, be it in housing, employment, education, etc. An overview of three Federal anti-discrimination laws which may apply in cases brought by those with AIDS or who are infected with HIV is presented. State and local anti-discrimination laws should also be considered by those advising individuals with AIDS or HIV infection.

• Impact of discrimination

Discrimination, or the fear of discriminatory action, can have a profound impact on services, especially if they involve testing for HIV. According to the Presidential Commission on the HIV Epidemic, discrimination has been one of the most significant barriers to reaching high-risk groups and implementing effective interventions. Also, the fear of discrimination and resulting delays in testing and treatment may lead to gaps in other public health initiatives to slow the epidemic, such as AIDS and HIV surveillance.

• Scope of discrimination

In a survey of social agencies conducted by the American Civil Liberties Union (ACLU), 260 agencies reported 13,000 complaints of HIV-related discrimination from 1983-1988; reports of HIV-related discrimination rose 50 percent in 1988 alone (ACLU, *Epidemic of Fear*). The most common complaints involved employment discrimination followed by housing complaints.

• Federal Anti-Discrimination Laws

The three Federal laws which may apply in cases of discrimination against people with AIDS or HIV infection

are: Section 504 of Rehabilitation Act, the Fair Housing Amendments of 1988, and the Americans With Disabilities Act.

- **Section 504 of the Rehabilitation Act of 1973**

This law is commonly referred to as "Section 504." Under the Act "no otherwise qualified individuals with handicaps . . . shall, solely by reason of her or his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. . . ."

The purpose of Section 504 was articulated in *School Board of Nassau County v. Arline*, 107 S.Ct. 1123 (1987), where the Supreme Court said, "[t]he basic purpose of Section 504 [is] to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or ignorance of others." The Court also held the definition of handicapped individual under Section 504 includes a person with a contagious disease, making it applicable to HIV infection.

Under Section 504, an employer may exclude an employee or applicant if there is "a significant risk of communicating an infectious disease to others" *Chalk v. United States, et al.*, 840 F.2d 701 (1988). If the significant risk of communicating an infectious disease to others in the workplace cannot be eliminated by reasonable accommodation, the person will not be otherwise qualified for his or her job.

- **Fair Housing Amendments Act of 1988**

This Act, which amended Title VIII of the Civil Rights Act of 1968, became effective March 12, 1989. In addition to prohibiting discrimination based on race, religion, national origin, or gender (under 1974 Amendment), the Act now also prohibits discrimination based on disability in the sale or rental of private housing.

Under the Act, it is illegal to discriminate in the sale or rental of a dwelling because of the disability of: the buyer or renter; a person who will reside in the dwelling after it is sold or rented; or any person associated with the buyer or renter. However, it is not illegal to refuse to sell or rent to a person, regardless of whether he or she has a disability, "whose tenancy would constitute a direct threat to the health or safety of other individuals" or "whose tenancy would result in substantial physical damage to the property of others."

- **Americans with Disabilities Act (ADA)**

The ADA was passed in July 1990, and becomes effective over a span of years beginning in July 1992. The Act applies the prohibitions under Section 504 to the private sector in employment, public transportation, public ac-

commodations, and services operated by private entities, and telecommunications.

Regarding employment, the ADA provides that "[n]o covered entity shall discriminate against a qualified individual with a disability because of the disability" in such things as: hiring; advancement; discharge; job applications; employee compensation; job training; and other terms, conditions and privileges of employment. The ADA provides employers with several defenses to a charge of discrimination under the Act, with one defense specific to foodhandlers under Section 103(d).

The ADA also provides that no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, or accommodations of any place of accommodation by any person who owns, leases, or operates a place of public accommodation.

HIV Partner Notification Services

Moderators: Carl Campbell, Beth Dillon, DSTD/HIVP, NCPS, CDC. *Presenters:* Richard Wimberly, Virginia State Health Department, Richmond, Virginia; Sherrie Bruce, Broward County Health Unit, Lauderhill, Florida; Rebecca Jordan, Colorado Department of Health, Denver, Colorado; Nick Farrell, DSTD/HIVP, NCPS, CDC.

- The focus of this session was to discuss partner notification as a prevention strategy. Information was presented about CDC's perspective, as well as preliminary data from the partner notification evaluation currently underway in Broward County, Florida.
- Perspectives from a fully confidential setting, an anonymous setting, and a confidential setting were presented (philosophies, methodologies, evaluation, etc.) Each presenter showed that evaluation can work if presented to the patient in a positive manner.
- Guidelines are needed to provide more information about how to build clients' skills.
- Training is needed for non-DIS counselors—a separate course about the role of partner notification and how to provide this service.

HIV Counseling and Testing Services

CDC Perspective

Presenters: Mary Benyo, Indiana Board of Health, Indianapolis, Indiana; Wesley Ford, Los Angeles STD/HIV Program, Los Angeles, California, Rebecca Cabral, Ph.D., DSTD/HIVP, CDC, Atlanta.

- Guidelines and tools (i.e., risk assessment) are needed.
- Clinic population-based risk assessment surveys are valuable for identifying patterns of risk behavior among those served. They help to target priority subpopulations for HIV counseling and testing, to prepare appropriate prevention messages, and to help allocate resources more efficiently.
- Waiting room videos to address STD/HIV prevention messages, especially components of pretest counseling for HIV would be useful.

Outreach to Adolescents

Speakers: Gary Remafedi, M.D., M.P.H., Youth and AIDS Project of the University of Minnesota Hospital, Minneapolis, Minnesota; Helen Mehrkens, Alaska Department of Education, Juneau, Alaska; Michele Hansen, Alaska Department of Health and Social Services, Anchorage, Alaska; Jack Campana, San Diego School District, San Diego, California; Carlton Duncan, DASH, CDC.

- Public Health officials are often frustrated when they try to work with schools. Yet any attempt to improve health education and/or affect the health status of Americans must involve school-age youth. Thus, the recommendations of the Centers for Disease Control are that HIV/STD prevention and substance abuse prevention become part of a comprehensive health education program in all schools. However, to work effectively with schools, public health officials need to understand how schools are structured: responsibility for public education is shared by local, state, and Federal governments. The relationship between them and the ways they react to sensitive but serious health problems like sexually transmitted diseases and drug abuse are extremely complex.

Outreach to Men Who Have Sex With Men

Presenters: Joe Fera, San Francisco; Ceverro Gonzalez, Seattle, Washington.

Summary not available.

Outreach to Women

Coordinator: Sue Dietz, DSTD/HIVP, NCPS, CDC.

Presenters: Kathleen Stoll, Center for Women Policy Studies, Washington, D.C.; Moher Downing, PHREDA Project, San Francisco, California; Mildred Williamson, Cook County Hospital AIDS Program, Chicago, Illinois.

- Of the many issues discussed, two were emphasized:
 1. Need to understand that women have unique HIV prevention needs rather than seeing women as "vectors of disease."

2. Need to view AIDS in terms of "families affected by AIDS" instead of just "persons infected with AIDS."
- Also presented were approaches to women, identifying barriers to reaching women, and successes as well as wishes for the future.

HIV/STD Prevention Activities in the Criminal Justice System

Moderator: Charles Alexander, M.D., Texas State Department of Corrections, Huntsville, Texas. *Coordinators:* Don Cowne, STD Program, Downey, California and Rich Voigt, DSTD/HIVP, NCPS, CDC. *Presenters:* Cheryll Bissell, National Institute of Justice AIDS Clearinghouse, Rockville, Maryland; Deborah Bohanon, STD Program, Houston, Texas; Tim Gagnon, Massachusetts Department of Correction Health Services, Jamaica Plain, Massachusetts; Ron Howell, Over the Hill, Inc., Houston, Texas; Joyce Hughes, AIDS Institute, Albany, New York.

- An overview of an HIV/STD/TB epidemic in the Massachusetts Department of Corrections was presented. This illustrated the need for including the criminal justice system in state or local HIV/STD prevention efforts.
- The successful collaboration between the Departments of Health and Correction Services in New York State was discussed.
- Correctional institutions provide challenges for providing services in settings with rapid turnover, limited access to new entrants, and lack of space.
- Current plans include the intention to introduce partner notification services into the overall prevention effort.
- It is essential that public health programs continue to assess program needs and look for ways to introduce new disease prevention strategies.

Initiating and Sustaining Behavior Change

Joanne Valentine, Dallas, Texas; Jim Sacco, Atlanta, Georgia; Roger Rothman, Seattle, Washington; Lisa Gurland, Massachusetts Department of Health, Boston, Massachusetts; Chris Keefe, Massachusetts Department of Health, Boston, Massachusetts; Ceverro Gonzalez, Seattle, Washington.

- Sexual and drug-related behavior is extremely difficult to change and providers must acknowledge this in order to effectively promote health behavior change.
- The ultimate goal must be long-term maintenance of healthy behaviors.
- Interventions can occur at both the individual and the community levels.

STD Update

Moderator: Robert E. Johnson, M.D., DSTD/HIVP, NCPS, CDC. *Presenters:* Joan Knapp, Ph.D., CID, CDC; John Moran, M.D., Polly Marchbanks, Ph.D., Jim Newhall, Ph.D., and Stuart M. Berman, M.D., DSTD/HIVP, NCPS, CDC.

- It is time for a more aggressive chlamydia prevention strategy based on declining costs of diagnostic technology. Laboratory and surveillance support for such a strategy were discussed.
- New drug therapies and diagnostic approaches for gonorrhea were discussed in the context of current treatment recommendations.

STD Update

Moderator: George Schmid, M.D., DSTD/HIVP, NCPS, CDC. *Presenters:* Bill Kassler, M.D., Mary Kamb, M.D., Mac Otten, M.D., Stu Brown, M.D., and Bernie Branson, M.D., DSTD/HIVP, NCPS, CDC.

- A variety of controversial HIV prevention issues, including the counseling in counseling and testing programs and the importance of identifying risk factors in known seroconvertors generated the following questions:
 1. Should we be doing counseling at all?
 2. How widely should we be testing since many known seroconvertors currently do not recognize their risk?
- As the HIV epidemic evolves, a lower proportion of gay and bisexual men have been reported to be acquiring HIV infection, while transmission in IV drug users and their heterosexual partners has been reported to be increasing. Although we know this is true from looking at several national surveillance systems, we currently lack a sensitive indicator to measure the changing demographic characteristics of the HIV epidemic.
- AIDS surveillance, which is based on reporting of AIDS cases, is one way of tracking the epidemic. However, the median time from the acquisition of HIV infection to the diagnosis of AIDS has been estimated to be 10 years. Because AIDS is a late manifestation of HIV disease, reported AIDS cases do not accurately reflect current levels of HIV infection. Thus, reported AIDS cases provide limited information about the magnitude of the HIV epidemic, and are insensitive to changes in transmission patterns.
- As a result of the need for information concerning HIV infection, a national HIV seroprevalence surveillance system was developed to complement AIDS reporting. This surveillance for HIV is carried out through the family

of HIV seroprevalence surveys, consisting of studies in specific population groups. The family of seroprevalence surveys is a sentinel system involving the collection of seroprevalence data from different sentinel populations. Sentinel populations represent groups that are considered to be either at increased risk of acquiring infection, such as men who have sex with men; groups that are representative of specific communities, such as racial and ethnic minorities; or groups that are of special public health importance, such as pregnant women.

STD Update

Moderator: Stuart M. Berman, M.D., DSTD/HIVP, NCPS, CDC. *Presenters:* Paul Zenker, M.D., Oklahoma State Health Department, Oklahoma City, Oklahoma; Kenneth Bromberg, M.D., Kings County Hospital, Brooklyn, New York; Cherie Boyer, Ph.D., University of California, San Francisco School of Medicine, San Francisco, California; George Schmid, M.D. and Elsa Villarino, M.D., DSTD/HIVP, NCPS, CDC.

- Congenital syphilis, asymptomatic STD, and adolescents: they really do fit together and maybe we can do something about them:
 1. Congenital syphilis: screening in the emergency room.
 2. Asymptomatic STD: the most common infection?
 3. Screening adolescents for asymptomatic chlamydial and gonococcal infections by noninvasive methods.
 4. Asymptomatic transmission of hepatitis B: a vaccine we should use.
- Patients most at risk of acquiring STDs may not be part of the normal health care delivery system; emergency rooms may be the sites to identify such individuals. Among 550 patients attending a busy inner city emergency room 32 (6%) had positive rapid plasma reagin tests (31 of whom subsequently had positive fluorescent *Treponema pallidum* antibody-adsorbed tests); 26 received treatment. This yield highlights the utility of searching for alternative and innovative sites to perform STD casefinding.
- A successful multidisciplinary skills-building intervention in a classroom-based program of sexual education and risk-reduction behavior for 9th graders was described. This program showed beneficial changes in the levels of knowledge and, importantly, skills for avoiding high-risk sexual behavior and drug use.

Showcase of Collaborative Efforts

Speakers: Wendy Craytor, Alaska Department of Health and Social Services, Anchorage, Alaska; Marianne Ashby, Alaska Native Health Board, Anchorage, Alaska;

Howard Hess, D.S.W., Indiana Department of Health, Indianapolis, Indiana; Donna Dodson, Damien Center, Indianapolis, Indiana; Harold Rasmussen, Department of Health Services, Sacramento, California.

- Collaborative efforts between health departments and community-based organizations (CBOs) are not easily achieved. CBOs are not ordinarily service oriented; they serve their communities as advocates. As advocates they often find themselves in conflict with health departments of which they are critical over the level and quality of services being provided. For health departments, the greatest barrier to collaboration is the history of conflict. For CBOs, it usually is a fear that by providing services, they would lose their advocacy role. However, successful collaborative efforts exist; in each case, the parties recognize that one can do what the other cannot. Collaborative efforts do not just materialize. Both sides need to communicate with one another. The CBO cannot be asked to begin providing services without the regular support and consultation of the health department. Collaborative efforts are, by their nature, ongoing alliances—relationships that need nurturing.

Overview of Behavioral Research in DSTD/HIVP

Moderator: William W. Darrow, Ph.D., DSTD/HIVP, NCPS, CDC. *Coordinator:* Richard T. Conlon, DSTD/HIVP, NCPS, CDC. *Presenters:* Sevgi Aral, Ph.D., Kevin O'Reilly, Ph.D., John Anderson, Ph.D., Linda Dahlberg, Judith Greenberg, Ph.D., and Stuart Seidman, M.D., DSTD/HIVP, NCPS, CDC.

- Research findings need to be transferred to health care providers on the local level in order to make them operational. Also, we need to recognize biases inherent in some research.
- Interventions should be behavior theory-based, targeted, evaluable, and feasible for broader application.

Impact of CARE

- This workshop provided an explanation and "show and tell" for the CARE amendment. No recommendations were given.

Title I

- Formula and supplemental grants to metropolitan areas with substantial need for services.

Title II

- Formula grants to states for:
 1. HIV care consortia.
 2. Home and community-based care.
 3. Continuum of health insurance coverage.

4. Provision of treatments.

Title III

- Formula grants to states for early intervention services.
- State matching funds requirement.

Title IV

- Pediatric demonstration projects.
- Research priorities.
- Emergency response employee notification guidelines.

STD Surveillance Update

Presenters: Joel Greenspan, M.D., Allyn Nakashima, M.D., Linda Webster, Ph.D., Mary Lyn Gaffield, John Moran, M.D., Ruth Ann Dunn, M.D., and Polly Marchbanks, Ph.D., DSTD/HIVP, NCPS, CDC.

This workshop presented current issues in STD surveillance systems.

- STD surveillance at the local level is the cornerstone of national STD surveillance.
- Emphasis was given to standardizing methodologies, using standard case definitions, and allowing local areas to analyze their own data. Surveillance programs are moving toward local control of local surveillance data.
- Surveillance has entered a transition phase in reporting from aggregate paper forms to line-listed electronically transferred data.
- The two newest systems being revised and developed are those for congenital syphilis and chlamydia.
- The current status of the Gonococcal Isolate Surveillance Project and policies concerning other surveillance systems for resistant gonorrhea was reviewed.
- The future of electronically transmitted STD surveillance data was discussed.

Building Effective Relationships Between National and Community Organizations

Speakers: Paul Kawata, National Minority AIDS Council, Washington D.C.; America Brascho, M.D., Latino Family Services, Detroit, Michigan; Ronald O. Valdiserri, M.D., Deputy Director (HIV), NCPS, CDC. *Coordinator/Facilitator/Recorder:* Veronica Hartwell, Jackson State University National Alumni Association, Jackson, Mississippi.

- Discussed the individual strengths of CBOs and NMOs and their capabilities and recommended strategies about how national and regional minority organizations and CBOs can effectively work together.
- Presented a Federal perspective about future directions of HIV and STD prevention activities leading to why the two types of organizations must work together in these important areas.

America Responds to AIDS (ARTA) Media Campaign

Presenters: Staff from National AIDS Information and Education Program (NAIEP):

- America Responds to AIDS Media Campaign Staff
- AIDS Hotline Staff
- National AIDS Clearinghouse Staff
- Communications Technical Assistance Staff
- Partnership Development Staff

This workshop focused on the ARTA campaign from the state and local perspective:

- Previewing ARTA.
- Tailoring national materials to supplement local efforts.
- Looking for implementation opportunities.

STD/HIV Clinical Research Report

Presenters: George Schmid, M.D., Ken Schulz, and Bob Rolfs, M.D., DSTD/HIVP, NCPS, CDC; Gary Oxman, M.D., Multnomah County Health Division, Portland, Oregon.

- The evidence that STDs influence the transmission of HIV is strong, but there is not strong evidence that HIV influences the course of STDs. Currently, insufficient information is available to recommend changes in treatment for syphilis in light of HIV, but innovative control measures such as those used in Oregon should be considered.

STD and Family Planning: Strange Bedfellows?

Moderator: Ward Cates, M.D., M.P.H., EPO, CDC. *Coordinators:* Dorothy Gunter and Sue Dietz, DSTD/HIVP, NCPS, CDC. *Presenters:* Deborah S. Reed, Planned Parenthood of the Capital Region, Harrisburg, Pennsylvania; Edward W. Hook, III, M.D., The Johns Hopkins Hospital, Baltimore, Maryland; David Fine, Ph.D., The Center for Health Training, Seattle, Washington; Susan DeLisle, The Center for Health Training, Seattle, Washington.

- An overview was presented of STD services in family planning clinics with examples of a family planning clinic integrating STD services and an STD clinic integrating contraceptive services into clinical care. Data was presented from a national questionnaire about the integration of STD services into family planning programs. Also discussed were specific benefits and obstacles to STD and family planning program integration.
- The group suggested broadening the concept of reproductive health to include males in order to meet their reproductive health/contraceptive needs and to include them in the equation of contraception. Making contraceptive services available to men may help us to recognize that contraception is not just a women's issue.

Community-Based Organization Workshop Tracks

CBO-1: Women and HIV

Workshop A: Issues of Sex and Reproduction as Related to HIV Prevention for Women

Moderator: Carmen Perez, Planned Parenthood of Essex County, Newark, New Jersey. *Speakers:* Shirley Walker, Dallas Urban League, Dallas, Texas; Awilda Pena, Congreso, Philadelphia, Pennsylvania; Sabrina Sojourner, National Organization for Women, Washington, D.C.

The workshop participants identified several specific issues of sexuality and reproduction as it relates to HIV prevention for women.

- HIV prevention efforts targeting women are often not responsive to the cultural, racial, and ethnic values of women.
- Women are not acknowledged as a group at risk for HIV infection in and of themselves, but are still identified as vessels and vectors of transmission to males and infants.
- Participants identified the need for CDC to include women in the case definition in order to better address the needs of women.
- The need for the expansion of the case definition to include women will help to provide better access to services, child care, referral services, case management, general assistance programs, and will expand awareness of the risks of HIV infection to women.
- Programs targeting women should be developed, implemented, and evaluated with the full involvement and participation of women from all the populations to be served.
- On a nationwide basis, school-based programs need to identify human sexuality as a priority and begin education at the elementary level.
- Women need the skills necessary to attain an empowered state of being so that they can be mentally and physically healthy in order to face life's daily challenges.
- Lesbian women should be identified and tracked in all health care issues.

Workshop B: Accessing Services for Women Infected/Affected by HIV

Moderator: Janet Hernandez, C.U.R.A. Inc., Newark, New Jersey. *Speakers:* Dr. Judith Cohen, Project AWARE, San Francisco, California; Gloria Rodriguez, Paterson Health Project, Rahway, New Jersey.

- Women who are HIV positive should be counseled to make their own decisions in terms of childbearing.
- All women need a safe environment to address HIV and other health issues.
- The area of women and HIV needs additional research.
- HIV-positive women experience great difficulty in coping with HIV without a support system in place.
- Establishing a voluntary provider network has proven to be an effective way to enhance collaboration and result in successful referrals from agency to agency.

Policy as it relates to HIV prevention:

- Women who have been abused need special attention when establishing policy.
- Policies are changing, allowing women to be part of clinical trials.
- Focusing on changing the CDC case definition for HIV is not an effective way to attain accurate clinical diagnosis. Additionally, the change in the CDC case definition may not have influence on the criteria used to determine disability and obtaining services and financial assistance.
- The legal system continues to experience strain due to the challenges brought about by HIV/AIDS.

Workshop C: Educational and Behavioral Strategies Targeting Women

Moderators: Philippa Lawson, Genesis House, Chicago, Illinois; Irma Maldonado, National Hispanic Education and Communication Project, Washington, D.C.

- The interactive workshop format allowed participants to share their ideas, knowledge, and experiences about effective HIV educational and behavioral strategies targeting women. At the beginning of the workshop, the group identified questions they wanted answered during the group, then broke up into focus groups to develop educational and behavioral strategies to answer those questions. After discussion, participants regrouped and shared ideas.

Workshop D: Public Policy as it Relates to STD/HIV Prevention Programs for Women

Moderator: Nancy Rosenshine, NOVA Research, Inc., Bethesda, Maryland. *Speakers:* Mary Clarno, Attorney-at-law, San Diego, California; Janet Arrowsmith-Lowe, M.D., Department of Health and Human Services, Agency for Health Care and Policy Research, Washington, D.C.

- The panel provided an overview of public policy issues related to women and HIV. A question and answer session was a part of this interactive workshop. Also discussed were clinical trials, symptomatology, the CDC case definition for women, and legal and social services issues related to the guardianship of children, disability and public aid, and new legislation.

CBO-2: Working with Culturally Diverse Populations

Workshop A: Racial and Ethnic Populations

Facilitators: Yvonne Graham, Caribbean Women's Health Association, Brooklyn, New York; Chris Sandoval, San Francisco AIDS Office, San Francisco, California. *Panel Presenters:* Tony Whitehead, Ph.D., Department of Anthropology, University of Maryland, College Park, Maryland; Nga Nguyen, Indochinese Community Center, Washington, D.C.; Armida Ayala, Joint Efforts, Inc., San Pedro, California; Mary Russell, Action for Boston Community Development, Boston, Massachusetts; Deborah Fraser-Howze, Black Leadership Commission on AIDS, New York, New York; Ron Rowell, National Native American AIDS Prevention Center, Oakland, California. The workshop participants identified several issues and proposed recommendations which include the following:

- Class systems, traditional cultural values, religious beliefs, and personal ethnic images must be explored and examined prior to providing HIV prevention activities.
 1. Recommendations included providing participants with messages of empowerment and linguistically and culturally appropriate messages.
- Identification of the diversity of the different populations and the sub-cultures within each during research (which often fails to provide samples according to education, socioeconomic status, participation in the labor force, and urban or rural residency).
 1. Recommendations include involving more people from the racial/ethnic communities in the development of policies which affect their communities. Collaboration with the various CBOs, ASOs, etc., in developing appropriate prevention efforts and being specific in the development of different mechanisms to educate the diverse communities, i.e., based on research findings.

Workshop B: Gay Men and Lesbians

Facilitators: Bil Gordon, AIDS Foundation, San Diego, California; Sabrina Sojourner, National Organization for Women (NOW), Washington, D.C. *Speakers:* Ed Winant, Wolfs, San Diego, California; Chuck Frutchey, San

Francisco AIDS Foundation, San Francisco, California; Karen Marshall, Lesbian and Gay Men's Community Center, San Diego, California; Gavin Morrow-Hall, National Task Force on AIDS of Black and White Men Together, San Francisco, California; Hank Ramirez, Josue House, San Diego, California.

- People from the target population must be involved in all decisionmaking processes regarding program development, implementation, and evaluation.
- Diversity within any community should be celebrated and worked with in a positive way.
- HIV/STD prevention programs must acknowledge and incorporate into planning that all people want to be loved and respected for who they are.
- Although we acknowledge that women are treated as an invisible group, we must also acknowledge that lesbians are an invisible group within that group.

Workshop C: Special Populations: Hearing Impaired, Visually Impaired, Developmentally Disabled, Mentally Ill

Facilitator: Susan Spencer, Intercommunity Action, Philadelphia, Pennsylvania. *Speakers:* C.B. Buchholz, GLAD AIDS Education for the Deaf, Hollywood, California; Judy Matsuoka, Northern Illinois University, Department of E.P.C.S.E., Dekalb, Illinois; Marc Lerro, Association for Retarded Citizens of the United States, Arlington, Texas.

- Adults who are visually impaired when compared with sighted adults have been found to possess lower levels of knowledge, poorer attitudes, and presumably few behaviors related to HIV prevention.
- The problems of all adults with visual disabilities in accessing HIV prevention information are compounded by problems of transportation (e.g., to education sites, drug stores), literacy, and the presence of multiple disabilities.
- To reach the visually impaired, programs must be developed that will address the issues described above.
- The AIDS epidemic strongly impacts the field of mental retardation in two ways:
 1. First, many mentally retarded adults are victims of sexual abuse and sexual exploitation.
 2. Second, babies born with HIV infections are living longer than ever before, but as they grow, 90 percent have neurological impairment. HIV infection is one cause of mental retardation.
- Material for reaching the mentally retarded should be clear and presented by trained individuals who are sensitive to the needs of the mentally retarded.

- Safer sex training should not be forced on someone who is unwilling to participate.
- Because of the nature of the information, sex education should be offered in small groups or on a one-to-one basis.

CBO-3: Substance Abuse and HIV

Workshop A: Substance Use and Sex

Facilitators: Randy Moser and David Johnson, DST/D/HIVP, NCPS, CDC. *Speakers:* Mateen Baaith, Over the Hill, Inc., Houston, Texas; Rod Adams, Man Alive Research, Inc., Baltimore, Maryland; David Smith, Victory House, Boston, Massachusetts; Marty Krepcho Dallas County Health Department, Dallas, Texas.

Workshop B: Addiction and Relapse

Facilitators: Randy Moser and David Johnson, DST/D/HIVP, NCPS, CDC. *Speakers:* Pat Hawkins, M.D., Whitman-Walker Clinic, Washington, D.C.; Marty Krepcho, Dallas County Health Department, Dallas, Texas.

Workshop C: Accessing Treatment Services

Facilitators: Randy Moser and David Johnson, DST/D/HIVP, NCPS, CDC. *Speakers:* Pat Hawkins, M.D., Whitman-Walker Clinic, Washington, D.C.; Elliot I. Bovel, Ph.D., Family and Medical Counseling Service, Washington, D.C.; Nancy Rosenshine, NOVA Research Company, Bethesda, Maryland.

Workshop D: Effective Skills Building for HIV Prevention Programs Targeting Substance Using/Abusing Populations

Facilitators: Randy Moser and David Johnson, DST/D/HIVP, NCPS, CDC. *Speakers:* Pat Hawkins, M.D., Whitman-Walker Clinic, Washington, D.C.; Elliot I. Bovel, Ph.D., Family and Medical Counseling Service, Washington, D.C.

In all four of the workshops, the participants identified major issues concerning the need for more available substance/alcohol abuse treatment services.

- Additional resources for building effective outreach to substance/alcohol abuse treatment services must be identified.
- To provide more effective programs, build stronger alliances to develop better treatment services, support systems, case management, and referral systems.
- Effective substance/alcohol abuse treatment programs should incorporate the many needs of the clients to better provide access for psychological, medical, mental health services, and to build better support for the clients and staff.

CBO-4: Youth and HIV

Workshop A: Sexuality and Youth At-Risk for HIV

Facilitator: Wendy Arnold, Peer Education Programs of L.A., Los Angeles, California. *Speakers:* Choire Sicha, Youth Advocates, Inc., San Francisco, California; Omar Barnett, HEER-US, New Orleans, Louisiana; Myiesha Stewart, Youth Advocates, Inc., San Francisco, California; George Becker, Massachusetts Committee for Children and Youth, Boston, Massachusetts.

Workshop B: Public Policy as it Affects Youth At-Risk for HIV

Moderator: Lisa Gurland, RN, Psy.D., Massachusetts Department of Public Health, AIDS Program, Boston, Massachusetts. *Speakers:* Eunice Diaz, National AIDS Commission, Cerritos, California; Michelle Magee, Youth Advocates, Inc., San Francisco, California; Rosemarie Henson, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Workshop C: Runaway, Throwaway, and Homeless Youth/Youth Engaged in Exchanging Sex for Drugs and/or Money/Incarcerated Youth/Gangs

Facilitator: Gregory Gazaway, Massachusetts Committee for Children and Youth, Boston, Massachusetts. *Speakers:* George Becker, Massachusetts Committee for Children and Youth, Boston, Massachusetts; Myeisha Stewart, Youth Advocates, Inc., San Francisco, California; Eric Morgan, HEER-US, New Orleans, Louisiana; Omar Bennett, HEER-US, New Orleans, Louisiana; Choire Sicha, Youth Advocates, Inc., San Francisco, California.

Workshop D: Outreach/Education/Support Systems for Youth At Risk: Examples of Culturally Focused Programs that "Work"

Facilitator: Alicia Horton, HEER-US, New Orleans, Louisiana. *Speakers:* Randy Wells, HEER-US, New Orleans, Louisiana; Ed Decker, New Conservatory Theater, San Francisco, California; Wendy Arnold, Peer Education Program of Los Angeles, Los Angeles, California; Rev. Terrence Leathers, Sasha Bruce Youthworks, Washington, D.C.; Ben Leonard, Human Services, Inc., Denver, Colorado.

The participants in the four workshops identified several issues and proposed recommendations which include the following:

- Programs targeting youth at risk should be developed, implemented, and evaluated with the full involvement of youth from the populations to be served.

- Effective HIV prevention programs for youth must incorporate the priorities that youth have for themselves. If you don't look at "what is important" to the youth and help them to address the top priorities in their lives (a need for love and affection, for food, for shelter, for acceptance, and for self esteem) you will never be effective in promoting safer sexual and needle-sharing behavior.
- Peer education programs for youth (youth **from** the target population talking **to** the target population) are the **most effective** ways to reach youth.
- Programs focusing on runaway and homeless youth need to acknowledge that there are **valid** and **logical** reasons why youth run away. Some reasons include: domestic violence, substance using/abusing parents and families, rejection by parents and families because of the sexual lifestyle of youth, and environments that do not provide love, affection, and respect for youth.
- It is impossible to look at providing HIV/STD prevention services to youth without looking at the myriad of health-related issues affecting youth.
- It is important to **pay** youth for the HIV prevention work that they do. As with adults, we must validate the work that youth provide through peer education programs with monetary reimbursement.

CBO-5: Outreach and Educational Strategies

Workshop A: Safety Issues and Outreach Workers

Facilitator: Dave Forney, DSTD/HIVP, NCPS, CDC.
Speakers: Issac Searcy, Washington Free Clinic, Washington D.C.; Vernessa Murphy, HERO, Baltimore, Maryland; Lorenzo Hinojosa, Los Angeles STD Program, Downey, California; Harvey Feldman, YES, San Francisco, California.

- Programs should develop written guidelines and procedures to use in protecting outreach workers from personal injury in the field.
- Outreach workers will need different types of equipment and clothing to protect them from harm.
- Police, local merchants, and other community members should be aware of the presence of outreach workers. When possible, they should be involved in protecting outreach workers and helping them during emergencies.
- CBOs can develop field safety committees to discuss potential risks and precautions to avoid injury.

Workshop B: Creating Innovative Educational Strategies for HIV Prevention Programs

Facilitator: Peter Laqueur, Woodhull Hospital, Brooklyn, New York. *Speakers:* Rita Lepicier, KCET, Los Angeles, California; Alex Compagnet, SALUD, Washington, D.C.; Michael Ney, Office for Substance Abuse Prevention, Rockville, Maryland.

- CBOs should attempt to inform and involve media representatives in planning and executing HIV prevention programs.
- Successful models of health communications campaigns should be examined when developing HIV prevention activities.
- Educational programs should be directly linked to the delivery of health care services. CBOs can collaborate with health care providers to assure a continuum of services.
- CBOs should review their program plans to identify which components could be strengthened by including businesses and civic groups as advisors and partners in HIV prevention programs.

CBO-6: Program Development and Management

Workshop A: Program Planning and Evaluation Strategies

Speakers: Gayle Hamilton, Ph.D., George Mason University, Arlington, Virginia; Jennifer Friday, Ph.D., DSTD/HIVP, NCPS, CDC.; John Sheridan, Conwal, Inc., Falls Church, Virginia; Amshatar Monroe, Everyday Theater, Inc., Washington, D.C.

Workshop B: Standards for Staff and Volunteer Training and Development

Facilitator: H. Alexander Robinson, Inner City AIDS Network, Washington, D.C. *Speakers:* Heather Andersen, Northwest AIDS Education and Training Center, University of Washington, Seattle, Washington; Paul C. Purnell, ES Inc., Washington, D.C.; Shauna Dunn, Comprehensive AIDS Program of West Palm Beach, West Palm Beach, Florida.

- Staff and volunteer training and development are **crucial** to the implementation of HIV/STD prevention programs. Agencies should have minimal standards for all staff and volunteers.
- Resources must be identified to provide training and development from the inception of programs.
- Executive staff and boards of directors must support personnel development activities by allowing staff money, time, and resources on a continuing basis to implement training and development activities.
- Agencies must develop evaluation plans that are **realistic** and **responsive** to the program. **Realistic** in terms of what kind of evaluation data can actually be collected and in terms of resources available to implement evaluation activities. **Responsive** in terms of developing an evaluation plan that can continually assist providers in developing and implementing even more effective HIV/STD prevention programs.
- Evaluation plans must be developed in collaboration with front-line program staff and individuals representing the target communities.

CBO Workshop About Condoms and Other Medical Devices

Speakers: Tom Arrowsmith-Lowe, M.D., Deputy Director, OHA, Washington, D.C.; David Johnson, Marise Rodriguez, Renee Brown-Bryant, CBO Project Officers, and Kay Stone, M.D., DSTD/HIVP, NCPS, CDC.

Spermicides and Condoms

- The most effective barrier method to reduce the risk of passing HIV and other sexually transmitted diseases is a latex condom. Both lubricated (wet) and non-lubricated (dry) varieties are effective. Lubricated condoms may also reduce the risk of breakage and help minimize abrasion of the vagina.
- Clinical studies have shown that spermicides used in the vagina decrease the risk of cervical gonorrhea and chlamydia infections. Lab studies have shown that spermicides can destroy HIV when it is outside of cells, but these studies are incomplete. There have been no studies that demonstrate spermicides' effectiveness against HIV during sexual intercourse in humans. Spermicides' effectiveness against other STDs may be influenced by the amount used, where it is put, and how much of the vagina it covers. Spermicides are not a replacement for condoms, but they could be considered an additional aid for reducing STD and HIV risk.
- To be most helpful, spermicide should thoroughly cover the inside of the vagina. Spermicide applied directly inside the vagina is the only way to achieve adequate coverage. The amount of spermicide that is on a spermicidally pre-lubricated condom is probably too little to stop sexually transmitted diseases. Use of spermicides in the rectum has not been shown to be safe or effective in preventing the transmission of STDs and HIV.

Sample Questions and Answers

- ***What is a spermicide?***
A spermicide is a contraceptive — a birth control method that works by killing sperm. It also has an effect against some types of sexually transmitted bacteria and viruses.
- ***How is it used?***
Spermicides are available in creams, gels, foams, tablets, sponges, and suppositories which a woman puts into her vagina before she has sex. Some lubricated condoms also contain a spermicide. The amount of spermicide that is on a pre-lubricated condom is probably too low to have much effect against sexually transmitted diseases.
- ***What kind (brand) should I use?***
Latex condoms are the recommended method of protection against sexually transmitted infections, including HIV. If you choose to use a spermicide in addition to a

latex condom, the best kind to use is a form where the spermicide can completely cover the inside of the vagina, such as foams and creams. It does not matter what brand you use as long as it is used according to the package directions.

- ***Can I use a spermicide without a condom?***
No! We are more certain about the protection offered by latex condoms. Spermicides' effectiveness against sexually transmitted infections depends on the vagina and cervix being thoroughly covered with spermicide. It is not always possible to guarantee complete coverage, so putting spermicide in the vagina serves only as a back-up to reduce, but not eliminate, the risk of infection in case the condom leaks or breaks.
- ***Can I use a condom without a spermicide?***
Yes. Latex condoms, by themselves, provide an effective barrier to reduce the risk of passing sexually transmitted infections. Spermicides used with a condom may serve as a back-up to reduce the risk of infection in the event the condom leaks or breaks.
- ***Where do I put the spermicide? Inside or outside the condom? How much?***
If you decide to use a spermicide, put the spermicide **in the vagina** not on the condom. Spermicide should cover the inside of the vagina thoroughly. Use as much as the package directs.
- ***Are pre-lubricated condoms with nonoxynol-9 okay to use?***
Latex condoms lubricated with nonoxynol-9 are as good as any other lubricated latex condom. Lubrication may reduce the risk of condom breakage.
- ***What is nonoxynol-9?***
Either nonoxynol-9 or octoxynol is the active ingredient in most spermicides. If you are using a spermicide as added protection against sexually transmitted diseases and HIV, the amount of spermicide that is on a condom is probably too little to help. It is better to put spermicidal foam or cream directly into the vagina.
- ***Should a condom be used for oral sex?***
A latex condom should be used in mouth-to-penis contact. There are a variety of sexually transmitted diseases that can be passed through this type of contact, including HIV.
- ***Should you use a spermicide when engaging in oral sex?***
A latex condom should be used in mouth-to-penis contact. Spermicidal lubrication on the condom is not likely to increase the protection provided by the condom. Do not use a spermicidally lubricated condom for oral sex, and **never** use a separate application of spermicide in the mouth.

National Minority Organizations Workshop Tracks

NMO-1: Organizational and Leadership Development

Speakers: Webster Guillory, National Organization of Black County Officials, Inc., Santa Ana, California; Harold Rasmussen, California Department of Health Services, Sacramento, California; John Zamora, Texas Department of Health, Austin, Texas. *Co-Facilitators:* Sandra Thompson, Blacks Educating Blacks About Sexual Health Issues (BEBASHI), Philadelphia, Pennsylvania; Miguel Gomez, National Council of La Raza, Washington, D.C. *Recorder:* Lynn Griffin, Inter Tribal Council of Arizona, Inc., Phoenix, Arizona. *Coordinator:* Miguel Gomez, National Council of La Raza, Washington, D.C.

The workshop focused on management skills and gave six important points about developing good rapport with staff. Other topics included strategic planning versus long-term planning, ten key points to good management such as managing with foresight, project objectives, establishing guidelines for results, and building staff. Evaluation was discussed as the key to success, particularly during times when money is limited. As indicated, evaluation also provides ongoing feedback throughout the project. Three points were discussed as important in evaluation. They are: 1) keep it simple; 2) look to the future, adding information for other concerns; and 3) utilize outside assistance with evaluation.

NMO-2: The Role of National Minority Organizations in Collaborating with Communities Working Together in HIV Prevention

Speakers: Rashidah Hassan, BEBASHI, Philadelphia, Pennsylvania; Salvador Balcorta, El Paso City-County Health Department, El Paso, Texas; Christie M. Reed, HIV Division, Texas Department of Health, Austin, Texas; Carlos Ugarte, Coalition of Hispanic Health and Human Service Organizations (COSSMHO), Washington, D.C. *Facilitator:* Charlene Doria-Ortiz, Center for Health Policy Development, San Antonio, Texas. *Recorder:* Charlene Day, National Association for Equal Opportunity in Higher Education, Washington, D.C. *Coordinator:* Paul Kawata, National Minority AIDS Council, Washington, D.C.

Steps for effective coalition building include:

- Look for coalition members from long-standing community organizations.
- Beware of "front" organizations.
- Get it in writing. Do not depend on verbal agreements or handshakes for initiating coalitions.

- Call local and national officials and ask for support.
- Be willing to openly and honestly share information.
- Recognize that everyone has a place in alleviating the problem.
- Divide up the "turf" by deciding on organizational strong suits. Discuss borderline issues whenever they arise.
- Go directly to the source whenever a question about a coalition member arises.
- Plan for the completion of the project. Work with populations so that when the project is gone, the message remains.

NMO-3: Public Policy and Advocacy on HIV Prevention Issues

Speakers: Eunice Diaz, National Commission on AIDS, Cerritos, California; George Bellinger, Jr., Minority Task Force on AIDS, New York, New York; Al Cunningham, National Association of Black and White Men Together, San Francisco, California; Anita Taylor, National Minority AIDS Council, Washington, D.C. *Facilitator/Recorder:* Maurice Franklin, Southern Christian Leadership Conference, Atlanta, Georgia. *Coordinator:* Anita Taylor, National Minority AIDS Council, Washington, D.C.

- The role of the National Commission on AIDS: how it operates and how it serves the American public.
- How to access lawmakers: differences between lobbying and advocacy and the regulations that govern non-profit organizations.
- How to educate members of Congress about local HIV/AIDS issues: effective legal means of making representatives aware of constituents' concerns.
- Coalition building toward public policy: the importance of working with special interest groups toward mutual goals and objectives.
- Look for commonalities when networking with other health-related groups. Form allies.
- Discussion about how the legislative process works: explanation about formation and passage of bill, and appropriation, authorization, and allocation of funds.

NMO-4: Coordination of HIV and STD Prevention Services

Speakers: Virginia Caine, M.D., Indiana University School of Medicine, Indianapolis, Indiana; Linda Samost, Family Planning Council of Philadelphia, Philadelphia,

Pennsylvania; James Novotny, Maryland Department of Health and Mental Hygiene, Baltimore, Maryland; Kenneth F. Schulz, and Jack Kirby, DSTD/HIVP, NCPS, CDC. *Facilitator*: Lupe Samaniego, Logan Heights Family Health Center, Inc., San Diego, California. *Recorder*: Jacqueline Steadmon, Western Region AIDS Education Project, National Medical Association Comprehensive Health Center, San Diego, California. *Coordinator*: Sandra Thompson, BEBASHI, Philadelphia, Pennsylvania.

- Many people who test HIV positive are also infected with other STDs.
- Coordination of STD and HIV prevention services will decrease the overlapping of services and the waste of valuable resources.
- Recommendations:
 1. Involve staff in the planning process.
 2. Provide staff training.
 3. Define scope, barriers, and limits of the project and alliance.
 4. Be flexible.
 5. Maintain a feedback mechanism among groups involved in such coordination.

WORKSHOP NMO-2: Evaluating National Minority and Community Organizations

Speakers: Ron Rowell, National Native American AIDS Prevention Center, Oakland, California; Mara Paternoster, United States Conference of Mayors, Washington, D.C.; Reggie Williams, National Association of Black and White Men Together, San Francisco, California; Gary West, NCPS, CDC; Charlene Doria-Ortiz, Center for Health Policy Development, San Antonio, California. *Facilitator*: Mary Guinan, M.D., Ph.D., Office of Deputy Director (HIV), CDC. *Recorder*: Mary Ann Borman, Ph.D., United Migrant

Opportunity Services, Inc., Milwaukee, Wisconsin. *Coordinator*: Ron Rowell, National Native American AIDS Prevention Center, Oakland, California.

CDC definition of evaluation: Accountability and performance monitoring of services, not agencies. Three major types of evaluation activities:

- Formative—conduct pilot studies, review data/findings, modify program design/service delivery.
- Process—who/what/where/when/how much? (All grantees should conduct process evaluation.)
- Outcome—documents what works/impacts on behavior.

Use of evaluation data/findings to plan, direct, or improve prevention activities:

- Planning new programs or efforts.
- Replication of new programs.
- Justification for funding and continued support.
- CDC stressed its commitment to assist CBOs in evaluation.
- CBOs have skills to be share, i.e., data collection, evaluation tools.
- Technical assistance and resources about the evaluation process are available from:
 1. United States Conference of Mayors.
 2. Other CBOs and NMOs.
 3. NMO representatives will provide input to CDC about current available NMO/CBO resources.
- A development phase will be needed to modify existing tools to meet NMO/CBO criteria.
- All evaluation components must be language and culturally appropriate.
- The group recommended a limitation on the length of the evaluation tool to achieve equity.
- A draft of the evaluation tool and process will be shared with the NMOs prior to submission to CDC.

STD/HIV Workshop Tracks

STD-1: Outreach and Intervention for Hard to Reach Populations.

Workshop A. Women and Children: Congenital Syphilis and HIV

Moderator: Stuart M. Berman, M.D., DSTD/HIVP, NCPS, CDC. *Coordinator:* Beth Dillon, DSTD/HIVP, NCPS, CDC. *Presenters:* Steve Rubin, New York City STD Program, New York, New York; Wendy Heirendt, TB Control Program, Department of Health, San Juan, Puerto Rico; Patricia Case, Cal-PEP, Oakland, California; Cathleen Walsh, DSTD/HIVP, NCPS, CDC; Jeruse Simmons, USCF PHREDA Project, San Francisco, California.

The goal of this workshop was to present participants with historical perspective, identification of the problems, creation of solutions, and the implementation and preliminary evaluation data for efforts to reduce infant mortality in North Carolina.

The problems:

- Growing concern about the high infant mortality rate.
- Support from the Southern Governors' Association Task Force reinforcing the importance of improving access to prenatal health care.
- Passage of SOBRA legislation in 1986 providing options to expand Medicaid coverage for pregnant women.

The cooperative effort of state agencies to design program services:

- Linkage between Medicaid, rural health centers, and state maternal and child health divisions.
- Eliminating unnecessary barriers such as paperwork and asset tests and providing continuous coverage during pregnancy.
- Initiating "Baby Love" program with the focus group choosing the name.

Some critical aspects:

- Maternity care coordinators. Case management services.
- Attention to personal needs of clients.
- Implementing hotline, continuing media attention, and the infusion of resources from the private sector.

Evaluation:

- Women who received maternal and child care (MCC) services had 17 percent fewer low birthweight babies, 67 percent fewer very low birthweight babies, and a neonatal mortality rate reduced by 39 percent. These results were obtained even though many of the Medicaid women receiving MCC services were at somewhat higher risk for

several factors affecting birth outcome (age, race, marital status, education).

- Savings of \$2.44 occurred for every \$1 spent on MCC services because of decreased expenditures for newborn care.
- During 1988, for all prenatal clients receiving health department services, the infant mortality rate was 14.7 for clients who did not receive maternity care coordination and 9.6 for those who did.

Workshop B. Innovative Intervention: Outreach Strategies for Substance Users

Moderator: T. Stephen Jones, M.D., Office of the Deputy Director (HIV), NCPS, CDC. *Coordinator:* Jill Leslie, DSTD/HIVP, NCPS, CDC. *Presenters:* Sheila Dooley, Philadelphia Department of Health, Division of Disease Control, Philadelphia, Pennsylvania; Tari Owens, Austin Care Project, Austin, Texas; Robert Booth, Ph.D., Project Safe, Denver, Colorado; Mark L. Williams, Ph.D., Affiliated Systems, Houston, Texas.

Four presentations were made during the workshop. The following information was presented and discussed:

- Alternative intervention strategies used by the Philadelphia Department of Health.
 1. Augmenting the traditional partner notification interview and cluster investigation techniques to identify locations (characterized by crack-use-related activities) where persons at high risk for syphilis may be found, and establishing a Screening Activity Team that offers serologic screening for syphilis to persons at these locations.
- The experience of community-based outreach to drug injecting homeless/runaway youth in Houston, Texas, was characterized by their basic demographic, drug using, and sexual behaviors.
- The efficacy of intervention to reduce HIV risk behaviors conducted with injection drug users by Project Safe's indigenous outreach staff.
- The successful delivery of HIV/STD services to hard-to-reach addicted populations through effective collaboration between state and local health department and state addiction agencies.

Workshop C. Special Efforts to Reach Racial/Ethnic Minority Populations

Moderator: Jacob Gayle, Ph.D., Office of the Deputy Director (HIV), CDC. *Coordinator:* Imani Thompson, Office of

the Deputy Director (HIV), NCPS, CDC. *Presenters:* D. Michael Poulson, Columbia HIV Center, New York City; Laura Beaulieu, National Native American Women's AIDS Prevention Center, Minneapolis, Minnesota; Alpha Thomas, Dallas Urban League, Dallas, Texas; Milagros Davila, San Diego, California.

Panels identified and discussed:

- An overview of issues and strategies by STD/HIV programs to coordinate and enhance intervention and outreach to racial/ethnic populations.
- Issues and strategies for outreach and intervention to racial/ethnic populations through community-based initiatives.
- Issues and strategies to effectively reach racial/ethnic populations through the Maternal and Child Health systems.
- Specific intervention issues and approaches for Native Americans (this will be an Indian Health Service planning session).

Workshop D. Realistic Approaches to Providing STD/HIV Prevention Services to the Criminal Justice System

Moderator: Joseph Carter, Director, DPHS, Region II, New York, New York. *Coordinator:* Randy Louchart, DSTD/HIVP, NCPS, CDC. *Presenters:* Henry Masters, III, M.D., Medical Director, Arkansas Department of Health, Little Rock, Arkansas; Charles Alexander, M.D., Medical Director, Texas Department of Corrections, Huntsville, Texas; Philippa Lawson, Genesis House, Chicago, Illinois; Bill Crawford, Louisiana AIDS Prevention Project, New Orleans, Louisiana; Mary Ann Galvin, Social Justice for Women, Boston, Massachusetts.

Problems/Issues:

- Access to the correctional system population is too restrictive for those who can provide STD/HIV prevention services.
- No entity (i.e., health department) has taken the lead role of assuring that STD/HIV prevention services are provided in the correctional system.
- Literacy levels of people in the correctional system are much lower than the average level in the population outside the correctional system.
- Providers of STD/HIV prevention services to people in the correctional system are considered part of "the system" and are not trusted.
- Talking about condoms and cleaning "works" is considered by some as promoting illegal activities.

Proposed solutions:

- STD/HIV prevention services should ride the "coat tails" of those services that have gained access to the correctional system (i.e., T.B., A.A. programs).
- State and local health departments need to work closely with state and local correctional systems and CBOs to develop universal strategic plans addressing STD/HIV prevention service delivery to the correctional system population.
- In the correctional system, peers need to be trained and used to address STD/HIV prevention with the rest of the population (Peer Education).
- Literacy-specific material needs to be developed to provide STD/HIV education to inmates and others within the correctional system.
- CBOs need to be used to provide HIV/STD prevention services and to refer ex-offenders for other services such as treatment for chemical dependency, social services, and health care upon discharge.
- Support needs to be obtained from CDC, National Institute on Drug Abuse (NIDA), National Institute of Justice, and the legislature to promote better STD/HIV prevention and health care for people within the criminal justice system.

STD-2: Prevention Opportunities Through Supervisory Involvement (Training and Education)

Workshop A. Improving Disease Intervention Specialist (DIS) and Non-DIS Intervention Activities

Moderator: Louise Galaska, Chicago STD Program, Chicago, Illinois. *Coordinators:* Steve Fitzgerald, and Shaunette Crawford, DSTD/HIVP, NCPS, CDC. *Presenters:* Homer Simpson, Florida STD Control Program, Crystal River, Florida; Alexander Phillips, Philadelphia STD Control Program, Philadelphia, Pennsylvania; Harold Rasmussen, California Department of Health Services, Sacramento, California; Kim Seechuck, Maryland STD Control Program, Baltimore, Maryland; Megan Marx, Colorado Department of Health, Denver Colorado; Joann Schulte, D.O., and Steve Fitzgerald, DSTD/HIVP, NCPS, CDC.

Panels identified and discussed:

- Issues and strategies of STD programs to enhance interviewing, counseling, and investigative intervention activities through clustering techniques to efficiently identify:
 1. At-risk pregnant women.
 2. At-risk suspects and associates to STD/HIV (crack/drug houses).

3. Sex for drugs.
4. Gangs.
- Issues and strategies that will make syphilis interviews more productive:
 1. Emphasizing the "critical period" during the interview.
- Issues and strategies for field screening of persons at increased risk:
 1. Pregnant women.
 2. Suspects and associates to STD/HIV (crack/drug houses).
 3. Sex for drugs.
 4. Gangs.
- Specific intervention and outreach issues and approaches by community-based non-DIS prevention workers (counseling, testing, referral, and partner notification; health education and risk reduction).

Workshop B. The Role of the Supervisor in STD/HIV Prevention and Intervention Activities

Moderator: Phillip Talboy, Florida STD Control Program, Lauderdale, Florida. *Coordinator:* Nick Farrell, DSTD/HIVP, NCPS, CDC. *Presenters:* Vaughn Jodar, California STD Control Program, Placerville, California; Mike Donnelly, DSTD/HIVP, NCPS, CDC.

- Involved supervision equals a reduction in missed intervention opportunities.
- Auditing interviews and field activity, including "common sense" information, setting priorities, feedback, etc.
- Timely and appropriate case management and case review.
- Better utilization of Disease Intervention Specialists.

STD-3: Providing Alternative Clinical and Referral Services with Limited Resources

Workshop A. Alternative STD/HIV Clinical and/or Referral Services When Resources are Level, Nonexistent, or Limited

Moderator: Nick Curry, M.D., Fort Worth-Tarrant County Health Department, Fort Worth, Texas. *Coordinator:* Carrie Johnson, DSTD/HIVP, NCPS, CDC. *Presenters:* Peggy Smith, M.D., Baylor College of Medicine—Teen Clinic, Houston, Texas; Marty Goldberg, Philadelphia Department of Health, Philadelphia, Pennsylvania; Gloria Lockett, CalPEP, Oakland, California; Donnie Smith, Arkansas Department of Health, Little Rock, Arkansas; Patricia Woods, Seattle, Washington.

Panels will identify and discuss:

- Issues and strategies by state and local STD/HIV programs to provide alternatives to traditional clinic services when resources are limited:
 1. Private sources.
 2. Hospital-based clinics.
 3. Community Health Center.
 4. CBOs.
- Issues and strategies for utilizing community-based and/or private health care providers to provide clinical services.
- Issues and strategies for effective referral to drug treatment centers.

WORKSHOP

Use of HIV Seroprevalence Data in Targeting and Evaluating Prevention Programs

Moderator: Ronald O. Valdiserri, M.D., M.P.H., Deputy Director (HIV), NCPS, CDC. *Leaders:* Timothy J. Dondero, M.D., CID (HIV), CDC; Gail Bolan, M.D., STD Program, San Francisco, California; Gary Livingston, HIV/AIDS Unit, Seattle, Washington; Mark Dal Corso, M.D., M.P.H., Louisiana HIV/AIDS, New Orleans, Louisiana.

Small Group Facilitators: Debbie Deppe, Ronald Sanders, Don Ruberti, Dena Wells, Steven Sloane, Jeff Efird, Dave Collie, Ted Connell, Kay E. Lawton, DHA, CID, CDC; Gary Livingston, HIV/AIDS Unit, Seattle, Washington; Orlando Blancato, Jack Stubbs, Cynthia Adams, Bill Pack, Bill Scott, Tim Quinn, Gene Williams, Janelle Dixon, Chris Tullier, and Tamera Kicera, DSTD/HIVP, NCPS, CDC.

Moderator for Wrap-up and Summary of Group Discussions: Willis R. Forrester, Field Services, DHA, CID, CDC.

- Presentations about surveys on childbearing women, drug treatment, and STD data all showed creative and productive uses of seroprevalence data.
- Six small groups discussed individual applications of data in their areas, each proposing three strategies for use of the data. For example:
 1. Collaborating with CBOs to know where to target resources.
 2. Using the media to educate/inform the public.
 3. Using the data to educate health care providers.
- Discussion was lively and indicated interest in using the seroprevalence data to take action.

WORKSHOP

STD Surveillance

Presenters: Joel Greenspan, M.D., Allyn Nakashima, M.D., Linda Webster, Ph.D., Mary Lyn Gaffield, John Moran, M.D., Ruth Ann Dunn, M.D., and Polly Marchbanks, Ph.D., DSTD/HIVP, NCPS, CDC.

This workshop presented current issues in STD surveillance systems.

- STD surveillance at the local level is the cornerstone of national STD surveillance.
- Emphasis was given to standardizing methodologies, using standard case definitions, and allowing local areas to analyze their own data. Surveillance programs are moving toward local control of surveillance data.

The Future of Electronically Transmitted STD Surveillance Data

Reasons for Collecting STD Data

- How much disease is in your community?
- How can we best characterize and understand who the infected persons are?
- What control strategies are most likely to work in these circumstances?
- How can limited STD resources best be applied toward

these STD problems?

- Are we doing a good job in controlling STD and how do we know it?

What information is needed to address these issues in a timely way?

- Basic demographic and diagnostic information for each case of STD:
 1. State, County, City of Residence.
 2. Age (Date of Birth).
 3. Gender.
 4. Race.
 5. Ethnicity.
 6. Diagnosis.
 7. Date of Disease Onset, Diagnosis, Laboratory Result, First Report to Public Health System.
- Information about how each STD case was identified:
 1. Method of Case Detection.
 2. Information Source.

This information about each patient, arranged in a single computer record for each diagnosis, constitutes "line-listed" data for each STD case.

Advantages of Line-listed Data

- If this information is available and easily accessible for each STD case, this should imply the data are available to state/local STD programs to analyze.
 1. Determine amount of STD being reported in your area.
 2. Routinely examine amount of STD in specific age/race/gender groups to characterize infected persons.
 3. Target control efforts to highest morbidity areas and/or groups.
 4. Evaluate impact of control strategies on morbidity.
- Line-listed data sent regularly to CDC eliminates need for cumbersome aggregate reporting on monthly, quarterly, and annual basis.
- Timeliness of surveillance at national level is dramatically increased, particularly with respect to age/race/gender STD trends.
 1. Becomes much easier to send updates, corrections, and deletions for data.

What is the source for these data?

- Morbidity cards, congenital syphilis forms, and/or interview records.
- Where are data currently stored?
 1. Paper/card files.
 2. Stand-alone personal computers in STD programs.
 3. PCs connected to LANs (Local Area Networks) in STD programs.
 4. State-operated Mini- or Mainframe computers.

What do we mean by electronically transmitted data?

- Data that is in "machine-readable" form, has been arranged in a standard format and is sent to CDC via some telecommunications network/software.
- National Electronic Telecommunications Surveillance System (NETSS).
 1. States electronically transmit to CDC each week line-listed individual case reports of certain notifiable diseases.
 2. Data transmitted from a single point in each reporting area (*50 States, Washington, D.C., New York City, and 5 U.S. territories—Puerto Rico, Virgin Islands, American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands*).

Steps in moving to Electronic (NETSS) Reporting

- **Management and Control of STD data.**
 1. STD program must have access to data.
 2. Issues/Options:
 - a. Install and maintain software to manage data within STD program.

- (1) Data entry responsibilities within STD program.
 - (2) Data editing responsibilities within STD program.
 - (3) Data update responsibilities within STD program.
 - (4) Amount of staff time and type of staff required for data entry, editing, updating.
- b. Ongoing relationship, good communication with mainframe programming staff.
 - c. STD staff's perceived accuracy of data, satisfaction with "system."
3. Ability to abstract data required for NETSS record, arrange data in standard NETSS format.
- **Transmission of STD Data to CDC.**
 1. Bridge/Link to NETSS staff in state/local area.
 2. Technical Issues.
 - a. How data transferred to NETSS staff (physically).
 - b. Format of data.
 - c. How corrections/updates made to data already transferred.
 - **Evaluation of Electronically Transmitted STD Data.**
 1. Demonstrate ability to sustain ongoing, weekly reporting of line-listed data via NETSS.
 2. Compare data reported via NETSS with data sent on standard aggregate reporting forms (998, 688, 2638).
 3. Account for discrepancies between NETSS and aggregate data.
 4. Determine accuracy of NETSS data.
 5. Eliminate aggregate reporting requirements.
 - The two newest systems being revised and developed are for congenital syphilis and chlamydia.
 - The two main goals of chlamydia surveillance are to provide quantitative estimates of disease occurrence and to monitor secular trends.
 - The analysis of surveillance data should be the basis for decision-making in chlamydia control programs.
 - While mandatory reporting laws are necessary for chlamydia surveillance and control, they will not necessarily ensure the useful flow of information from providers and laboratories to public health departments.
 - To ensure this useful flow of information, states are encouraged to develop active chlamydia surveillance systems that will probably combine sentinel surveillance with period polling of local laboratories.
 - Areas will no longer be required to report "military" cases of STD separately on any reporting forms. Areas should include these cases with "public" cases or exclude them. Since military cases represent a very small percentage of

total cases, this policy is unlikely to affect rates significantly. Some areas with large numbers of military facilities may want to continue to track military cases for local reasons, and this policy allows flexibility at the local level.

- The "old CDC form 126" for reporting individual cases of congenital syphilis has been revised and distributed. All cases of congenital syphilis reported after January 1, 1991, should be reported using the "revised 126 form."
- Project areas should stop sending information for the following diseases to CDC on form 73.688: herpes genitalis, trichomoniasis, genital warts, pediculosis, scabies, genital molluscum contagiosum, nonspecific vaginitis

(female). Data sent on these diseases will be disregarded. Data collection for the other diseases on CDC form 73.688 should remain unchanged for the present.

- As of January 1, 1991, information on antibiotic resistant gonorrhea to measure trends for the nation will be collected only through the Gonococcal Isolate Surveillance Project (GISP). Data on penicillin-producing *Neisseria gonorrhoeae* (PPNG) and antibiotic resistant GC collected on CDC forms 73.688 and 73.998 are no longer required.
- CDC form 2127 is no longer required. Program activity data will be monitored through alternative systems as per the Program Operations Branch.

Concurrent Continental Breakfast Sessions

HIV/AIDS Health Beliefs Among Racial/Ethnic Communities

Summary not available.

Use of HIV Surveillance Data in Program Planning

Summary not available.

Migrant Workers and STD/HIV Infection

Speaker: Ed Zuroweste, M.D., Keystone Migrant Health Clinic, Chambersburg, Pennsylvania. *Facilitator:* Marvin Bailey, DSTD/HIVP, NCPS, CDC.

- A myriad of health problems confront migrant workers in the United States. They live in crowded, often unsanitary conditions, work under hazardous conditions, and are constantly exposed to pesticides and herbicides. Their health problems are exacerbated by inadequate health care. Often they lack basic transportation to get to available health care. More commonly they experience financial and language barriers to receiving health care. Given the conditions under which they live and work and their lack of health care, it is easily demonstrated that communicable diseases like STD/HIV have penetrated into many components of the migrant worker population in the United States.

Behavioral Research Update

Summary not available.

Nursing Issues

Speaker: Polly Ryan, R.N., M.S.N., University of Wisconsin-Milwaukee, School of Nursing, Milwaukee, Wisconsin.

- The "Nursing Minimum Data Set" (NMDS) is the first attempt to standardize the collection of essential nursing data. Collected on an ongoing basis, a standardized nursing data base will enable nurses to compare data across populations, settings, geographic areas, and time. Ms. Ryan has been involved in the development of the NMDS with Dr. Harriet Werley since its inception. After presentation of the NMDS, discussion was related to its applicability to public health, STD, and HIV nursing activities.

Talk to the Directors

Leaders: Jack Spencer, DSTD/HIVP, NCPS, CDC; Windell Bradford, NCPS, CDC; Illeana Herrell, Health Resources

and Services Administration, Rockville, Maryland; Gary West, NCPS (HIV), CDC.

- An informal atmosphere was provided for conference participants to ask questions and voice concerns to CDC leaders.

HIV Counseling in STD Clinics: The Need for Tailored HIV Education Approaches

Summary not available.

The Afrocentric Perspective: A New Approach to HIV Prevention

Summary not available.

Immigration and Border Issues

Moderator: Charlene Doria-Ortiz, Center for Health Policy Development, Inc., San Antonio, Texas. *Panel members:* Salvador Balcorta, El Paso City/County Health District, El Paso, Texas; Rosalind Gold, National Association of Latino Elected and Appointed Officials, Los Angeles, California; Sana Loue, J.D., Legal Aid Society of San Diego, San Diego, California.

- This breakfast focused on a discussion of the health care issues surrounding Hispanic populations on the U.S.-Mexico border. Topics included recent developments in Hispanic poverty, income, and employment, racial stereotypes, Mexico-U.S. perspective about the AIDS problem, and the U.S.-Mexico border hospitals' struggle to survive.

Resource Allocation in STD/HIV Prevention Programs

Moderator: Jill Leslie, DSTD/HIVP, NCPS, CDC. *Speaker:* Jean Finn, Colorado Department of Health, Denver, Colorado.

- Ms. Finn's presentation focused on the need for detailed program planning to obtain maximum objectives with allocated resources. Suggestions included: 1) Identifying target populations by establishing a hierarchy of need for the program area; 2) clarifying the value of programs by asking the question, "What is important?" 3) evaluating the effectiveness of programs; 4) determining the most cost effective methods to achieve maximum results; 5) refining staff objectives to reflect these priorities; and 6) analyzing staff time to determine the best utilization of time.

American Indian/Alaska Native Community AIDS Network

Summary not available.

Report on International STD/HIV Activities

Moderator: Kenneth F. Schulz, DSTD/HIVP, NCPS, CDC.

Speakers: John S. Moran, M.D., Samuel R. Perry, and Stephen A. Fitzgerald, DSTD/HIVP, NCPS, CDC; Robert N. Evans, IHPO, CDC. Richard Wimberley, Virginia Department of Health, Richmond, Virginia.

- During this session, the purpose and findings of the Jamaica STD consultancy was discussed. It focused on the feasibility of integrating STD diagnostic, treatment, and partner referral services into existing primary health clinic services. The contrast between STD programs in the United States with a first overseas assignment was also presented.

Practical Tips on Safety on the Street

Speakers: Evelyn Blankenship, North Carolina Department of Health, Raleigh, North Carolina; Lorenzo Hinojosa, Los Angeles STD Control Program, Los Angeles, California; Christopher S. Parker, STD Control Program, Dallas, Texas; Margaret A. Malone, STD Control Program, Chicago, Illinois.

- The drug problem, especially "crack cocaine," has changed life on the streets across America. As a result of this change, many of the STD field staff have expressed concern for safety while performing patient investigations and follow-up in certain neighborhoods. Evelyn, Lorenzo, Chris, and Margaret shared with the attendees various "do's" and "don'ts" that they had learned while working the streets as a DIS. All four speakers agreed that the number one thing to keep in mind was to always be aware of one's surroundings and try not to get into a position where there is no way out. If a DIS gets a feeling that the time and situation may not be safe, leave and go back at another time or go with someone. All agreed that individual programs should provide new employees with basic guidelines on field safety during orientation and especially guidelines that may be particular to that area, especially areas that have gangs. Several of the speakers indicated that their programs have developed "safety committees" that meet regularly to discuss street safety and develop recommendations that are shared with the field staff. All agreed that the best teacher is time and experience and while that experience is being gained, the experienced staff should be assisting less experienced staff as much as possible.

Sex, Drugs, and AIDS are Not a Laughing Matter – Or are They?

Moderator: Frankie Barnes, DSTD/HIVP, NCPS, CDC.

Speaker: Stephen R. Sroka, Ph.D., Cleveland State University, Lakewood, Ohio.

- Dr. Sroka demonstrated materials and methods to use in teaching life social skills for the prevention of HIV infections. His presentation stressed ways to teach young people decision-making skills about sex, drugs, and AIDS, and messages to enhance communication skills. He emphasized the use of humor as a method to put people at ease and break down barriers of denial and fear. He cautioned that information must be culturally sensitive and consistent with community need and values.

Asian – Pacific Islanders Issues

Moderator: Nicolette Philips, Association of Asian/Pacific Community Health Organizations (AAPCHO), Oakland, California. *Coordinators:* Dorothy Wong, Asian AIDS Project, San Francisco, California and Kathy Miller, Center for Southeast Asian Refugee Resettlement, San Francisco, California. *Panelists:* Willy Wilkinson, Asian AIDS Project, San Francisco, California; Merina Sapolu, Kokua Kalihi Valley Community Health Center, Honolulu, Hawaii; Namphet Panichpant-M, Immigrant and Refugee Health Program, Orange County Department of Public Health, Santa Ana, California; Martin Hiraga, Indochinese Community Center, Washington, D.C.; Teresa R. Ferrer, Filipinos for Affirmative Action/Filipino Task Force on AIDS, Oakland, California.

- During this session, the moderator described various Asian-Pacific Islander communities in the United States and how the AIDS epidemic has impacted them. The panelist gave an overview of the work being done in their respective communities. They discussed outreach, education, and cultural barriers which challenge outreach workers and health educators working with this specific target population.

Hispanic Issues

Moderators: Chris Sandoval, San Francisco Department of Health, San Francisco, California; Miguelina Maldonado, Hispanic AIDS Forum, New York, New York. *Presenters:* Elizabeth Valdez, M.D., Latino Health Council, Maricopa County Department of Health Services, Phoenix, Arizona; Raul Magana, Ph.D., Buenacare, AltMed Health Services Corporation, Los Angeles, California.

- Presenters were asked to address the issue of Latino(a) sexuality and HIV/AIDS prevention. Dr. Magana spoke on the minimal research that has been done in this area and the need for researchers to conduct research on Latino sexual attitudes, belief, and behaviors and how these findings could help us to design HIV/AIDS prevention interventions targeted at Latinos. Dr. Valdez addressed the issue of sexual heterogeneity among Latino subgroups and how the design of HIV/AIDS prevention intervention must take

this into consideration. Dr. Valdez also addressed Latino myths around human sexuality, in particular Latino perceptions and views on homosexuality and lesbianism.

- Mr. Sandoval introduced Dr. Valdez and briefly spoke on the issue of being Latino and gay from a personal perspective and Ms. Maldonado introduced Dr. Magana and briefly addressed the issue of Latino sexuality as it relates to HIV/AIDS prevention from a female perspective.

Exhibits for 1991 National STD/HIV Prevention Conference

The YAPP: A Creative Approach to Modifying Teen Behavior

N.J. Goodwin
Brooklyn, New York

The Women's Project

R.M. Bailey
Little Rock, Arkansas

American Social Health Association

C. Ebel
Research Triangle Park, North Carolina

AIDS and the African-American Church: An AIDS Education and Training Guide for African-American Church Religious Leaders and Ministers

V. Hartwell
Jackson, Mississippi

Planned Parenthood of Maryland's Teen Empowerment Program: An Active Approach to HIV Education

T. Post, K.A.T. Mullaney, D. Curry
Baltimore, Maryland

American Indian Health Care Association

J.M. Myrick
St. Paul, Minnesota

Display of HIV-Related Tuberculosis Educational Materials

W. Walton
Atlanta, Georgia

Tuberculin Skin Testing

M.F. Schein
Atlanta, Georgia

Sex, Drugs, and AIDS are Not a Laughing Matter—Or are They?

S.R. Sroka
Lakewood, Ohio

New Hampshire HIV/AIDS Program's Hotline Promotion Campaign

J.J. Welch
Concord, New Hampshire

AAPCHQ

N. Philips, T. Nguyen
Oakland, California

COSSMHO

C.A. Ugarte
Washington, D.C.

Youth Advocate's Teen HIV Program

M. Darmstadter
San Francisco, California

AIDS Education Project for High-Risk Youth

B.A. Walker
Los Angeles, California

HIV Seroprevalence Results Used in HIV Outreach Education to STD Clients

K.M. Keating, G. Williams, F. Myers, B. Ward
Wilmington, Delaware

National AIDS Minority Information and Education Program

P. Valentine, W.L. Greaves
Washington, D.C.

Influencing AIDS Knowledge and Attitudes in African American Congregations

E.G. Lowery, M.O. Franklin, Washington, D.C.
S.B. Thomas, College Park, Maryland

NAPWA

P.R. Sathrum
Washington, D.C.

National Minority AIDS Council

C. Velez
Washington, D.C.

Results of an Adolescent HIV Services Needs Assessment for Chicago

S. Neuhauser
Chicago, Illinois

Taking it to the Streets: A Model of Effective Street Based Outreach Intervention for Intravenous Drug Users, Their Sexual Partners, Crack Users, The Homeless, and Addicted Prostitutes at Risk for HIV

Y. Serrano, J.M. Cruz
New York, New York

Pilsen-Little Village Community Mental Health Center

A. Vasquez, N. Luna
Chicago, Illinois

Q-Sorts

R.L. Guadarrama
Los Angeles, California

The Forgotten People: Latinas with AIDS

R. Lepicier
Los Angeles, California

Technical Assistance Program Model for Community Based Organizations

S. Thompson, R.L. Hassan
Philadelphia, Pennsylvania

AIDS Risk Reduction Education in Crack Cocaine Neighborhoods

C.A. Falana
West Palm Beach, Florida

Asian AIDS Project

D. Wong
San Francisco, California

National Urban League Posters

T.T. Cowans
New York, New York

Impact of AIDS on Hispanics in the Southwest

I. Escobar
San Antonio, Texas

Western Region AIDS Education Project

P.R. Olivia
San Diego, California

Demonstrating Safer Sex Practices in STD Clinics: A Modest Approach Riding the Bus to Better Health: Combatting Congenital Syphilis in Los Angeles County and

Reaching High-Risk STD Clients at the Community Pharmacy

E. Sullivan, G.A. Richwald, A.R. Henningburg, N. Williams, H. Rederer, J. Melrod, K. Higgins, M. Ramos
Downey, California

When You Love Someone Who Has AIDS and An Interview with Robert

M. Maye, W. Reid, Washington, D.C.
D. Giusti-Bradford, San Diego, California

An HIV/AIDS Prevention Education Program for Incarcerated and Paroled Youth

A. Trufat
Los Angeles, California

The Efficacy of HIV Prevention Education in Substance Abuse Treatment Programs

D. Smith
Boston, Massachusetts

Field Guide to Sexually Transmitted Disease: An Educational Resource for HIV Counselors and Outreach Workers

S. Shaw, G. Joachim
Hartford, Connecticut

The Georgia DIS Training Center Safety Committee: Addressing the Issues

W.A. Boyd
Decatur, Georgia

Seattle STD Prevention/Training Center—Identifying the Need for Off-Site Training: An On-the-Road Approach to Training Delivery

E.A. Wilch
Seattle, Washington

Poster Presentations for 1991 National STD/HIV Prevention Conference

Expanding Syphilis Screening in Epidemic Counties in New York

D.P. Murphy, L. Hoback, J. Grabau
Albany, New York

Use of Dual Therapy for the Treatment of Gonorrhea and its Effect on the Incidence of *Chlamydia trachomatis* Urogenital Infection in an STD Clinic Population

J.W. Martin, D. Much
Reading, Pennsylvania

Chancroid: Detection in STD Clinics, 1990, United States

J.M. Schulte
Atlanta, Georgia

HIV/AIDS Health Beliefs Among Ethnic Communities

L.M. Samaniego
San Diego, California

Using STD/HIV Risk Assessment Counseling to Promote Prevention Behaviors in STD Clinic Clients

C. Rabins, E. Renier, C. Gibson
Springfield, Illinois

Partner Notification for HIV Infection in Colorado: Results Across Patient Groups and Benefit-Cost Considerations

N.E. Spencer, R.E. Hoffman, C.A. Raevsky, F.C. Wolf, T.M. Vernon
Denver, Colorado

HIV Counseling and Testing as an Adjunct to STD Field Intervention

N.E. Spencer, G.E. Ware, J.L. Belak, R.O. Charter
Denver, Colorado

Syphilis and HIV Antibody Testing at Two Gay Bars

J.A. Smith, R.O. Charter, S. Przekwas
Denver, Colorado

California's Early Intervention Program

D.P. Francis
Berkeley, California

Illiteracy: A Potential Barrier to HIV Prevention Education Among Inmates Entering a State Prison

H.L. Masters, III
Little Rock, Arkansas

Targeting HIV Prevention in Prisons: Crime Category Type Among Inmates Entering a State Prison as a Significant Risk Factor for HIV

H.L. Masters, III, Little Rock, Arkansas
J. Byus, B. King, Pine Bluff, Arkansas

Alternative Casefinding Methods in a Crack-Related Syphilis Epidemic, Philadelphia, Pennsylvania

J.P. Lutz, S.P. Dooley
Collingswood, New Jersey

The Extent of Counseling and Testing Services in STD Clinics in 15 United States Cities with High Syphilis AIDS Incidence

C. Campbell, K. Cahill, M. Moore
Atlanta, Georgia

HIV Counseling and Testing Services for Women in Public Clinics, United States, 1989-1990

K. Cahill, C. Campbell, M. Moore
Atlanta, Georgia

High Prevalence of Syphilis Detected Through a Jail Screening Program, New York

T. Heimberger, H.G. Chang, G. Birkhead, G. DiFerdino, A. Greenberg, R. Gunn, D. Morse
Albany, New York

Evaluation of Michigan's AIDS Prevention Media Campaign

J. Ruff, R.S. Pope, L.M. Randall, Lansing, Michigan
J. Rossi, Southfield, Michigan

High-Risk Sexual Activities Among Female Clients of In-Treatment Drug Programs in Area with Low Prevalence of HIV-1/STD

L. Araba-Owoyele, M. Hughes, J. Singleton, S. Jain
Sacramento, California

Providing STD Screening and Referral Services for In-Treatment IVDU Population: A Pilot Program

L. Araba-Owoyele, M. Hughes, J. Singleton, S. Jain
Sacramento, California

Evaluation of Voluntary Partner Notification Strategies in Confidential Test Sites, Out-of-Treatment Drug Users, and Early Intervention Program

V.P. Sneller, Sacramento, California

L. Anderson, Berkeley, California

R. Bundy, R. Keilch, Long Beach, California

M.M. Ginsberg, San Diego, California

HIV Partner Notification in Michigan's Prisons

L.M. Randall, R. Cotton, A. Woodruff, R.S. Pope, C. Hutchinson

Lansing, Michigan

HIV Knowledge and Attitudes and the Use of Universal Precautions Among Public Health Employees in Michigan

L.M. Randall, M.J. Bertler, R.S. Pope, Lansing, Michigan

J.W. Bryce, Atlanta, Georgia,

D.W. Lawrenchuck, Westland, Michigan

A Method of Determining Geographical Areas in Relative Need of HIV Prevention/Education Efforts

E. Townsend, C. Reed, C. Bell

Austin, Texas

Missouri's "Level II Intervention" for Individuals Infected with HIV

T. Baumgartner, W. Huber, K. Gipson

Jefferson City, Missouri

HIV Syphilis Testing in a Mobile Unit

M. Henrickson

Hartford, Connecticut

Partner Notification Activities at an HIV Early Intervention Program

M.M. Ginsberg, V. Sneller, M. Flores, S. Hart, P. Murray

San Diego, California

False Name Survey

T. Hoxworth, C.A. Raevsky, F.C. Wolf

Denver, Colorado

Assessing the Relative Effects of HIV Counseling and Testing on Subsequent Risk Behavior

T. Hoxworth

Denver, Colorado

Congenital Syphilis in Upstate New York in 1989-1990: Observations Before/After a Mandatory Syphilis Delivery Test Regulation

S. Hipp, D. Murphy, E. Tobey

Albany, New York

Screening for *Chlamydia trachomatis* in a Primarily Rural Family Planning Population Using the DNA Probe

B. Sottile, Houghton, Michigan

E.H. England, R. McDuffie, R. Martin, Lansing, Michigan

Sexual and Substance Abuse Behaviors Among Clients Attending a Detroit STD Clinic

M.K. Brooks, L.M. Randall, M.A. Miller, R.S. Pope

Lansing, Michigan

"Targeted" HIV Pre-Test Counseling in Cleveland's STD Clinics

M. Neal

Cleveland, Ohio

The Use of HIV Risk Assessments in Iowa STD Clinics

C. Jacobson, J. Katz

Des Moines, Iowa

Evaluating Gonorrhea Interview Periods to Determine Casefinding Efficiency

R.L. Jordan, M.M. Mattson, G.E. Ware, N.E. Spencer

Denver, Colorado

A Program to Interrupt an Increasing Trend Toward Riskier STD and HIV-Related Behaviors in an STD Clinic

S.B. McCombs, M.L. DeCiantis, B.A. DeBuono

Providence, Rhode Island

A Regional Program for Chlamydia Control That Works

S. DeLisle, D. Fine, J. Lossick, L. Kloppenstein, M. Aubin

Seattle, Washington

Seropositivity and Risk Factor Analysis Among HIV Counseling and Testing Clients

S.K. Hussain, D. Hirano, K. Fleming, B. England,

S.J. Englander

Phoenix, Arizona

Impact of a 1989 Testing Policy Change in Arizona: Preliminary Analysis

D. Hirano, S.J. Englander, K. Fleming, B. England,

K. Komatsu, M. Moore

Phoenix, Arizona

AIDS Prevention and Education Among Incarcerated Youth: A Case Study

C.E. Rowe
Burbank, California

**Facilitating Communication Between Sex Partners:
A Survey of STD/HIV Trainers in Georgia**

J. Greenberg, S.O. Aral, J. Hall
Atlanta, Georgia

Factors That Predict Testing for HIV Infection

J.E. Anderson, A.M. Hardy, K. Cahill, S.O. Aral
Atlanta, Georgia

**Integration of Hepatitis B Screening and Immunization
into the STD Clinic**

S.G. Pavelich, J.A. Williams
Allentown, Pennsylvania

PLENARY SESSION SPEAKERS AND MODERATORS

John E. Arradondo, M.D.

Director, Department of Health and Human Services, City of
Houston
Houston, Texas

Ronald Bayer, Ph.D.

Associate Professor, Division of Sociomedical Sciences
Columbia University School of Public Health
New York, New York

Windell Bradford

Deputy Director
National Center for Prevention Services
Centers for Disease Control
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Willard Cates, Jr., M.D., M.P.H.

Director, Division of Training
Epidemiology Program Office
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Chief, Behavioral and Prevention Research Branch
Division of STD/HIV Prevention, NCPS
Centers for Disease Control
Atlanta, Georgia

Jane L. Delgado, Ph.D.

Executive Director
Coalition of Hispanic Health and Human Services Organization
Washington, D.C.

Don C. DesJarlais, Ph.D.

Director of Research
Chemical Dependency Institute
Beth Israel Medical Center
New York, New York

John N. Dyer, M.D.

Regional Health Administrator
Region VI, Public Health Service
Dallas, Texas

M. Joycelyn Elders, M.D.

Director, Arkansas Department of Health
Little Rock, Arkansas

E. Frank Ellis, M.D.

Regional Health Administrator
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Deputy Director (HIV)
Office of the Director, CDC
Atlanta, Georgia

Donald G. Ramras, M.D.

Director
San Diego Health Department
San Diego, California

William L. Roper, M.D., M.P.H.

Director, Centers for Disease Control and Administrator, Agency for
Toxic Substances and Disease Registry
Atlanta, Georgia

George W. Rutherford, M.D.

State Epidemiologist
Berkeley, California

Mervyn F. Silverman, M.D., M.P.H.

President, American Foundation for AIDS Research
Director, The Robert Wood Johnson Foundation
Los Angeles, California

Ronald O. Valdiserri, M.D., M.P.H.

Deputy Director (HIV), NCPS
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Atlanta, Georgia

Sheridan L. Weinstein, M.D.

Regional Health Administrator
Region IX, Public Health Service
San Francisco, California

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- **Ileana Herrell, Ph.D.**
Associate Administrator for Minority Health HRSA,
Rockville, Maryland
- **Alan R. Hinman, M.D., M.P.H.**
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- **Mark Schrader**
Chief, Program Operations Branch
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- **Jack N. Spencer**
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- **Ronald O. Valdiserri, M.D., M.P.H.**
Deputy Director (HIV)
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- **Gary West**
Assistant Deputy Director (HIV)
NCPS, CDC

Conference Coordinator

- **Pegi Brooks, Ph.D.**
Staff Training Coordinator
DSTD/HIVP, NCPS, CDC

Housing Coordinator

- **Cynthia Yerges**
Writer-Editor, Information Services
NCPS, CDC

CDC Registration Coordinator

- **Glenndolyn Hallman**
Public Health Analyst, DSTD, NCPS, CDC

Workshops Coordinator

- **Marvin Bailey**
HIV Health Education Specialist
DSTD/HIVP, NCPS, CDC

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- Michael Donnelly

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- Paul O. Poppe
- George P. Schmid, M.D.
- Katherine M. Stone, M.D.
- Kathleen Toomey, M.D.

GROUP MEETINGS

SUNDAY

Comprehensive AIDS Resource Emergency Act

DSTD/HIVP, NCPS, CDC:

- Jack Kirby
- Paul O. Poppe
- Mark V. Schrader

Community-Based Organizations

DSTD/HIVP, NCPS, CDC:

- Tim Broadbent
- George-Ann Stokes

National Minority Organizations

Co-Chairpersons

DSTD/HIVP, NCPS, CDC:

- Walter K. Chow
- Lauretta D. Pinckney

Office of Minority Health

• Georgia Buggs
Office of Minority Health
Washington, D.C.

Public Health Advisors

- Steven J. Barid
Field Services Office, NCPS, CDC
- Mark V. Schrader
DSTD/HIVP, NCPS, CDC

STD Prevention Training Center

Coordinators

DSTD/HIVP, NCPS, CDC:

- Kim Geissman
- Chester L. Pogostin

THURSDAY AFTERNOON

Coordinators for CBOs, NMOs, OMH, and STD PT Centers, same as Sunday.

Indian Health Service

- Jack Kirby
DSTD/HIVP, NCPS, CDC
- Ron Rowell
National Native American AIDS Prevention
Center, Oakland, California

POSTERS AND EXHIBITS

Co-Chairpersons

- David Byrum
D.I.S. Training Center, Decatur, Georgia
- Randy D. Louchart
DSTD/HIVP, NCPS, CDC

Selection Committee

DSTD/HIVP, NCPS, CDC:

- Janelle Dixon
- David Johnson
- William Kassler, M.D.
- Polly A. Marchbanks, Ph.D.
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