

FEDERAL CENTRE
FOR HEALTH EDUCATION



WHO-COLLABORATING CENTRE
FOR HEALTH EDUCATION

REPORT

AIDS INFORMATION AND EDUCATION
IN THE U.S.A.

BY

ERWIN J. HAEBERLE

(Commissioned and financed by the Federal
Centre for Health Education, Cologne)

April 1987

14 000 P

AIDS PREVENTION IN THE U.S.A.

**Report to the
"Bundeszentrale für gesundheitliche Aufklärung"
Köln-Merheim**

April 30, 1987

**Erwin J. Haeberle
San Francisco CA**

TABLE OF CONTENTS

I. INTRODUCTION	3
II. SOURCES	4
1. Personal Interviews	4
2. Printed Material	8
III. EPIDEMIOLOGY	10
IV. U.S. NATIONAL AIDS PREVENTION POLICIES	18
1. The CDC Recommendations	18
2. The Surgeon General's Report	18
3. The Report of the National Academy of Sciences	18
4. Reorganization within the CDC	30
5. CDC Practical Prevention Efforts	31
6. The Federal Information/Education Plan	34
7. Federal Policy on HIV-Antibody Testing	79
8. The Need for Stronger National Leadership	83
V. AIDS PREVENTION AT THE LOCAL LEVEL -- Two Cities Compared	87
VI. AIDS PREVENTION IN NEW YORK	89
1. The State of New York	89
2. The New York City Department of Health	89
3. The Gay Men's Health Crisis	93
VII. AIDS PREVENTION IN SAN FRANCISCO	96
1. The State of California	96
2. The San Francisco Department of Public Health	102
3. The San Francisco AIDS Foundation	110
4. The Shanti Project and Hospice of San Francisco	115

VIII. AIDS PREVENTION AND THE PRIVATE SECTOR	116
1. The American Foundation for AIDS Research	116
2. The Robert Wood Johnson Foundation	118
IX. DOES AIDS PREVENTION WORK? -- PROGRAM EVALUATION	128
1. General Observations	128
2. Two Special Populations: Women and IV Drug Users	131
3. Measures of Effectiveness	169
X. SUMMARY AND RECOMMENDATIONS	175
XI. SUPPORTING MATERIAL (under separate cover)	

I. INTRODUCTION

This report was prepared for the Bundeszentrale für gesundheitliche Aufklärung in the months of March and April, 1987.

During this time, the author personally interviewed a number of American leaders in the fight against AIDS in the San Francisco Bay Area, New York City and at the Centers for Disease Control (CDC) in Atlanta, Georgia. In these locations he also collected various relevant original materials. In addition, he subscribed to several journals, magazines, and newsletters. The report as a whole is based on information from all of these sources.

At the present time, the author is further trying to arrange for subscriptions to several computer information services which may provide additional information in the future.

The author wishes to express his sincere appreciation to all of his American interview partners and to the various institutions and organizations he visited. Without exception they were extremely helpful and considerate, in spite of their work overloads and busy schedules. Many of them had to be approached on very short notice, but they all recognized the importance of international cooperation. Indeed, in the United States there is a great interest in sharing information and in establishing organizational links between countries. This report should, therefore, also be seen as a first step in a continuing process of transatlantic exchange and as a basis for intensified future communication.

Erwin J. Haeberle, Ph.D., Ed.D.
1100 Gough Street, Apt 7-C
San Francisco CA 94109
Tel. (415) 885-6859

II. SOURCES

1. PERSONAL INTERVIEWS

The following persons in Atlanta, New York and in the San Francisco Bay Area were interviewed for this report:

1. CENTERS FOR DISEASE CONTROL, Atlanta GA 30333

A. Office at 1600 Clifton Road

James W. Curran, M.D., M.P.H.
Director, AIDS Program
(404) 329-3311

William W. Darrow, Ph.D.
Research Sociologist, AIDS Program
(404) 329-3162

Walter Dowdle, M.D.
Director, AIDS Office
(404) 329-3311

D. Peter Drotman, M.D., M.P.H.
Medical Epidemiologist, AIDS Program
(404) 329-2891

Lawrence D. Zyla
Surveillance and Evaluation Branch
(404) 329-3651

B. Office at 1644-C Tullie Circle (Center for Preventive Services)

Willard Cates, Jr., M.D., M.P.H.
Director, Division of Sexually Transmitted Diseases
(404) 329-2552

Russ Havlack
Chief, TEC Section, Division of Sexually Transmitted Diseases

Jack Jones
Public Health Advisor, Division of Health Education
(404) 329-3824

Kevin O'Reilly, Ph.D.
Research Anthropologist, Division of Sexually Transmitted Diseases
(404) 329-2580

Kenneth F. Schulz, M.B.A
Assoc. Director, Center for Prevention Services
(404) 329-1260

Susan Lloyd Schulz
Clinical Services Consultant, TEC Section, Division of Sexually Transmitted Diseases
(404) 320-2778

2. NEW YORK CITY

Don C. Des Jarlais, Ph.D.
Asst. Deputy Director, Research and Evaluation
State of NY, Div. of Substance Abuse Services
55 West 125th Street, 10th Floor
New York NY 10027
(212) 870-8472

James Holmes
Associate, AIDS Prevention, Dept. of Education
Gay Men's Health Crisis
132 West 24th Street
New York NY 10011
(212) 807-7517

Salvatore Licata, Ph.D.
Department of Health, City of New York
Bureau of Public Health Education, AIDS Education Unit
125 Worth Street
New York NY 10013
(212) 566-8290

Mel Rosen
AIDS Institute, State of New York
10 East 40th Street
New York NY 10017
(212) 340-3388

Tim Sweeney
Deputy Executive Director for Policy and Program Management
Gay Men's Health Crisis
254 West 18th Street
New York NY 10011
(212) 807-6664

Joyce Wallace, M.D.
266 West 12th Street
New York NY 10014
(212) 929-2530

3. SAN FRANCISCO BAY AREA

Jim Bunn
KPIX Channel 5
855 Battery Street
San Francisco CA 94111
(415) 765-8600

Larry Bush
Aide to Assemblyman Art Agnos
350 McAllister Street, Room 1064
San Francisco CA 94102
(415) 557-2253

Larry L. Bye
Communication Technologies
260 California Street, Suite 803
San Francisco CA 94111
(415) 391-2770

James Chin, M.D.
California State Department of Health Services
2151 Berkeley Way
Berkeley CA
(415) 540-2566

[Dr. Chin has now permanently moved to the WHO headquarters in Geneva]

James P. Dilley, M.D.
Director, UCSF AIDS Health Project
1855 Folsom Street
San Francisco CA 94103
(415) 476-6430

John D. Dupree, Ph.D.
East Bay AIDS Project
P.O. Box 908
Berkeley CA 94701
(415) 548-8283

Dean Echenberg, M.D., Ph.D.
Disease Control, City and County of San Francisco, Department of Health
110 Grove Street
San Francisco CA 94102
(415) 558-4046

Don Francis, M.D.
California Department of Health Services
215 Berkeley Way, Room 715
Berkeley CA
(415) 540-2566

Michael Helquist
Editor, FOCUS Newsletter
522 Noe Street
San Francisco CA 94114
(415) 626-9924

Michael Housh
Aide to Assemblyman Art Agnos
350 McAllister Street, Room 1064
San Francisco CA 94102
(415) 557-2253

Mark Madsen
Director, Department of Continuing Medical Education
California Medical Association
44 Gough Street
San Francisco CA 94103
(415) 863-5522

Glen Margo, Ph.D.
Department of Public Health, City and County of San Francisco
110 Grove Street
San Francisco CA 94102
(415) 558-4648

Jackson Peyton
Education Director, San Francisco AIDS Foundation
333 Valencia Street, 4th Floor
San Francisco CA 94103
(415) 864-4376

Marsha Quackenbush
UCSF AIDS Health Project
1855 Folsom Street
San Francisco CA 94103
(415) 476-6430

George Rutherford, M.D.
Department of Public Health, City and County of San Francisco
1111 Market Street
San Francisco CA 94103
(415) 621-5979

Mervyn F. Silverman, M.D.
Director, American Foundation for AIDS Research
Director, AIDS Program, Robert Wood Johnson Foundation
119 Frederick Street
San Francisco CA 94117
(415) 558-9116

2. PRINTED MATERIAL

For this report a great deal of printed material was collected, consisting mainly of brochures, pamphlets, leaflets, posters, published and unpublished scientific papers, workbooks and reports. This material remains for further reference in the possession of the author in San Francisco. However, some publications are informative and important enough to be directly included in or attached to this report. They are:

EPIDEMIOLOGY

1. CDC Weekly Surveillance Report -- United States, April 13, 1987
2. New York City Department of Health, AIDS Surveillance Update, March 25, 1987
3. City and County of San Francisco, Department of Public Health, AIDS Monthly Surveillance Report, March 31, 1987

PLANS AND GUIDELINES

1. U.S. Department of Health and Human Services (Public Health Service), AIDS-- Information/Education Plan to Prevent and Control AIDS in the United States March 1987.
2. San Francisco Department of Public Health, AIDS in San Francisco: Status Report and Plan for Fiscal Year 1987-1988 March 1987.

POLICY RECOMMENDATIONS

1. ASTHO Foundation, Guide to Public Health Practice: HTLV-III Screening in the Community.
2. New York City Department of Health, HIV Counseling and Testing Policy March 1987.
3. C. Everett Koop (U.S. Department of Health and Human Services), Surgeon General's Report on Acquired Immune Deficiency Syndrome October 1986.
4. Centers for Disease Control, AIDS-- Recommendations and Guidelines, November 1982 - November 1986.

DIRECTORIES

1. GMHC, Client Services Directory.
2. New York City Department of Health, AIDS--A Resource Guide for New York City.

TRAINING MANUALS

1. GMHC, Volunteer Training Manual.
2. San Francisco AIDS Foundation, AIDS Hotline Training Manual.

SCHOOL MATERIALS

1. Marsha Quackenbush and Pamela Sargent, Teaching AIDS--A Resource Guide on Acquired Immune Deficiency Syndrome 1986.
2. William L. Yarber, AIDS: What Young Adults Should Know (Volume I. Instructor's Guide, Volume II. Student Guide) 1987.

SAFE SEX

1. GMHC, Chance of a Lifetime--the safer sex education video movie with facilitator's guide.
2. The Institute for Advanced Study of Human Sexuality, The Complete Guide to Safe Sex, Specific Press 1987.

CATALOGUE

1. San Francisco AIDS Foundation, AIDS Educator--A Publications Catalog Spring 1987.
2. San Francisco AIDS Foundation, AIDS in the Workplace, announcement and order form.

III. EPIDEMIOLOGY

Although the epidemiology of AIDS in the United States is not the focus of this report, it may be useful to include here some basic data. The attached surveillance reports of the CDC and the cities of New York and San Francisco contain all necessary details. The following pages simply reprint some total figures illustrating the growing threat to American public health.

- As the figures show, by mid-April 1987 the total number of AIDS cases in the United States was over 33,000. The respective figure for New York City was over 9,000, for San Francisco over 3,000. Moreover, as compared to the same date one year ago, the numbers had nearly doubled.
- It is extremely difficult to make predictions about the future spread of the epidemic, and even the most responsible prognosis cannot be more than guesswork. Nevertheless, several educated guesses have been made of which the most reliable is probably the one published in October, 1986, by the Institute of Medicine of the American Academy of Sciences under the title Confronting AIDS -- Directions for Public Health, Health Care and Research. According to this report, the total number of AIDS cases in the United States will reach over 270,000 by 1991 with more than 50,000 deaths per year. However, it is not this projection alone which now prompts American authorities to make extraordinary efforts to fight the disease.
- As the figures also show, the HI virus has begun to spread outside the groups originally considered at high risk. While the spread of AIDS in the general population may be much slower than in these original groups, it is considered to be a serious danger.
- For example, it is a source of great concern that by now in New York City 22% of the female AIDS cases have resulted from infection through heterosexual contact. Moreover, there is a growing number of children born with AIDS.
- It is also quite clear that the disease is spreading very quickly outside of the large urban centers into virtually every state of the Union.

The following pages provide the latest total figures for (1.) the United States as a whole, (2.) New York City and (3.) San Francisco. In addition, a report on AIDS in San Francisco and its surrounding counties illustrates the increasing spread of the virus to the suburbs.

Finally, a newspaper report on a prognostic survey hints at the possible dimensions of the AIDS epidemic in the U.S. by the turn of the century. Of course, the predictions reported here are by no means certain and must be read with great caution. Nevertheless, by their publication alone they provide a context for many political decisions that are made today.

AIDS WEEKLY SURVEILLANCE REPORT¹ - UNITED STATES
 AIDS PROGRAM, CENTER FOR INFECTIOUS DISEASES
 CENTERS FOR DISEASE CONTROL

APRIL 13, 1987

UNITED STATES CASES REPORTED TO CDC

TRANSMISSION CATEGORIES ²	MALES		FEMALES		TOTAL	
	Since Jan 1	Cumulative	Since Jan 1	Cumulative	Since Jan 1	Cumulative
	Number (%)	Number (%)	Number (%)	Number (%)	Number (%)	Number (%)
ADULTS/ADOLESCENTS						
Homosexual/Bisexual Male	3299 (72)	22032 (71)			3299 (67)	22032 (66)
Intravenous (IV) Drug Abuser	537 (12)	4442 (14)	156 (46)	1162 (51)	693 (14)	5604 (17)
Homosexual Male and IV Drug Abuser	320 (7)	2569 (8)			320 (7)	2569 (8)
Hemophilia/Coagulation Disorder	48 (1)	285 (1)	1 (0)	8 (0)	49 (1)	293 (1)
Heterosexual Cases ³	83 (2)	642 (2)	99 (29)	658 (29)	182 (4)	1300 (4)
Transfusion, Blood/Components	88 (2)	424 (1)	44 (13)	231 (10)	132 (3)	655 (2)
Undetermined ⁴	178 (4)	829 (3)	40 (12)	236 (10)	218 (4)	1065 (3)
SUBTOTAL [% of all cases]	4553 [93]	31223 [93]	340 [7]	2295 [7]	4893 [100]	33518 [100]
CHILDREN⁵						
Hemophilia/Coagulation Disorder	1 (3)	22 (8)		2 (1)	1 (1)	24 (5)
Parent with/at risk of AIDS ⁶	30 (79)	194 (74)	28 (85)	186 (86)	58 (82)	380 (79)
Transfusion, Blood/Components	4 (11)	37 (14)	1 (3)	19 (9)	5 (7)	56 (12)
Undetermined ⁴	3 (8)	10 (4)	4 (12)	9 (4)	7 (10)	19 (4)
SUBTOTAL [% of all cases]	38 [54]	263 [55]	33 [46]	216 [45]	71 [100]	479 [100]
TOTAL [% of all cases]	4591 [92]	31486 [93]	373 [8]	2511 [7]	4964 [100]	33997 [100]

N.Y.C. DEPARTMENT OF HEALTH - PEDIATRIC AIDS SURVEILLANCE, MARCH 1987

CHILDREN WITH AIDS

	<u>PCP</u>	<u>PCP + OI</u>	<u>OI</u>	<u>TOTAL</u>	<u>Known Deaths</u>	<u>(%)</u>
Male	48	10	34	92	68	(74)
Female	46	10	35	91	67	(74)
TOTAL	94	20	69	183	135	(74)

New cases this month: 5

Total New York City cases:
CDC total pediatric cases:

183
480

**DISTRIBUTION OF ADULT AIDS CASES
BY RISK**

	<u>MALES</u>		<u>FEMALES</u>		<u>TOTAL</u>	
	<u>Cases</u>	<u>(%)</u>	<u>Cases</u>	<u>(%)</u>	<u>Cases</u>	<u>(%)</u>
Male Homosexual/bisexual	5427	(63)	0	(0)	5427	(57)
Male Homosexual/bisexual and IV user	459	(5.4)	0	(0)	459	(5.0)
IV user	2265	(26)	597	(61)	2862	(30)
Heterosexual contact of Person at risk	5	(0.1)	222	(22)	227	(2.3)
Persons from countries in which most AIDS cases have no known risks	168	(2.0)	41	(4.2)	209	(2.0)
Transfusion Associated	42	(0.5)	39	(3.9)	81	(0.8)
Hemophiliac/Factor Def'y	17	(0.2)	2	(0.1)	19	(0.2)
Interviewed-no risk factor	46	(0.5)	24	(2.3)	70	(0.7)
Died before interview, refused interview or lost to follow-up	53	(0.6)	24	(2.5)	77	(0.8)
Under investigation	69	(1.0)	26	(3.6)	95	(1.2)
TOTAL (row %)	8551	(90)	975	(10)	9526	(100)



March 30, 1987

Acquired Immunodeficiency Syndrome (AIDS) Monthly Surveillance Report
 Summary of Cases Meeting the CDC Surveillance Definition in San Francisco
 Cases Reported through - 03/31/87

AIDS Cases by Transmission Category and Sex, San Francisco, 1981 - 1987(1)

Transmission Category(2)	SEX				Total	
	Male		Female		N	%
	N	%	N	%		
Adult/Adolescent						
Homosexual or bisexual male	2608	85.4	0	0.0	2608	84.8
Intravenous (IV) drug User	26	0.9	9	37.5	35	1.1
Homosexual/bisexual IV drug User	382	12.5	0	0.0	382	12.4
Hemophiliac/coagulation disorder	3	0.1	0	0.0	3	0.1
Transfusion recipient	15	0.5	7	29.2	22	0.7
Heterosexual contact(3)	8	0.3	8	33.3	16	0.5
None of the above/Other(4)	11	0.4	0	0.0	11	0.4
Subtotal: Adult/Adolescent	3053		24		3077	
Children (0-12 years)						
Transfusion recipient	3	60.0	1	25.0	4	44.4
Child of high risk/AIDS parent(5)	2	40.0	3	75.0	5	55.6
Subtotal: Children	5		4		9	
Total	3058		28		3086	

AIDS REPORTED CASES

(from 7/81 to) 3/31/87

Total San Francisco Cases: 3,086

Total San Francisco Deaths: 1,844

Total S.F. cases month to date: 123

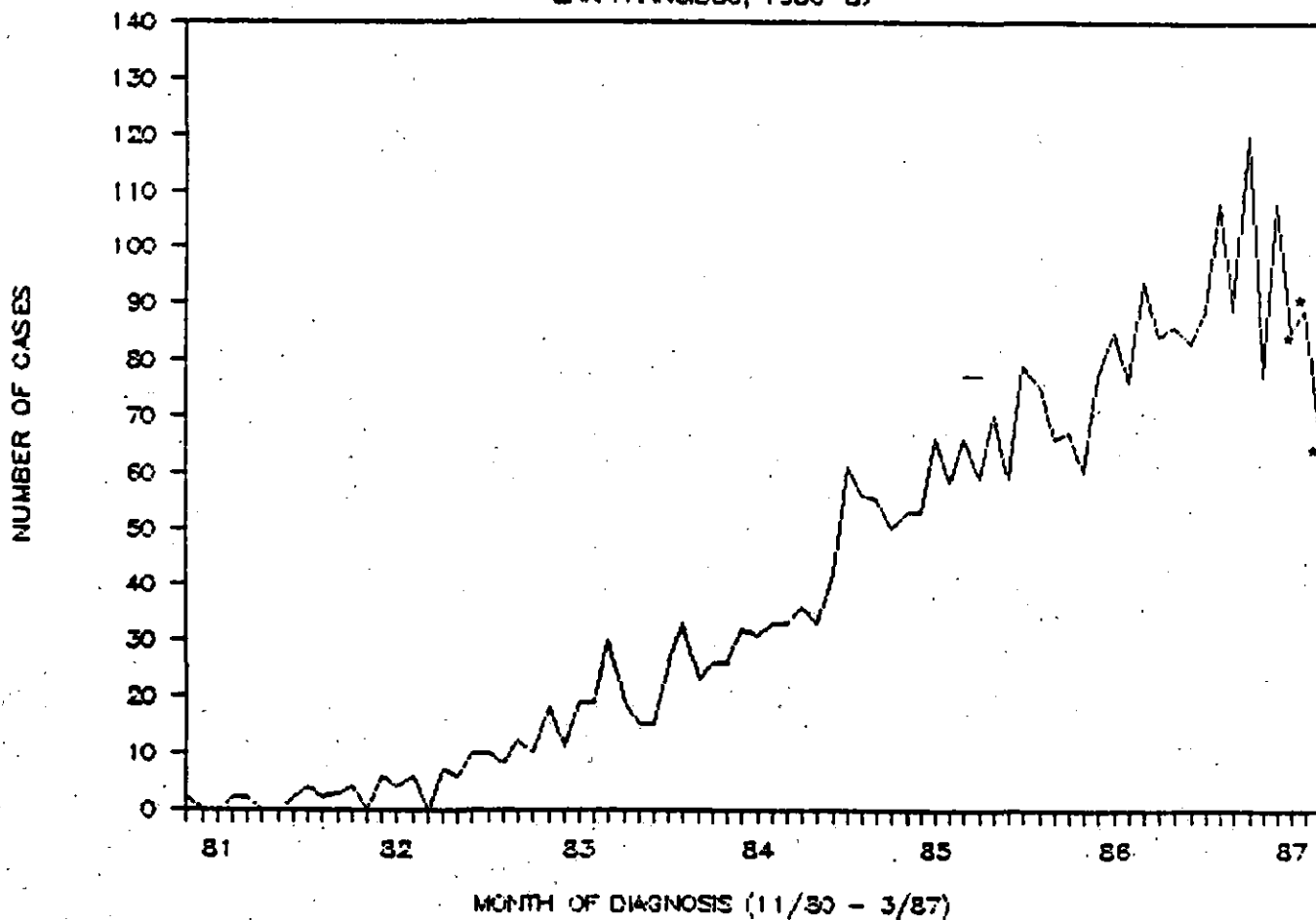
Total S.F. deaths month to date: 73

Total California cases: 7,490 cases; 4,086 deaths
(as of 2/28/87)

Total U.S. cases: 33,482 cases; 19,394 deaths
(as of 3/30/87)

AIDS CASES BY MONTH OF DIAGNOSIS

SAN FRANCISCO, 1980-87



* Reporting for recent months is incomplete

AIDS Office

AIDS Hitting Hard in Bay Suburban Areas

Chron. July 7, 1986
By Randy Shilts

The number of reported AIDS cases in six Bay Area suburban counties is growing at much greater rates than in San Francisco, state and county health records show.

Despite warnings by state and federal officials that higher levels of new AIDS cases in the region will continue to appear outside San Francisco, few Bay Area counties have any plans to provide services for their already burgeoning AIDS case loads.

San Francisco health officials warn that the city's pioneering AIDS patient services may soon be "stretched to the limit" by patients streaming in from counties that offer no comparable programs.

"Epidemics don't respect county borders," said Dr. David Werdegar, San Francisco's public health director. "We're being stretched to

Page 4 Col. 1

San Francisco Chronicle, July 7, 1986

4 *****

Bay Area Suburbs Unprepared for Big AIDS Increase

From Page 1

the limit. We need to start looking at this problem regionally, not merely as San Francisco's problem. The other counties have to start doing something to carry their share of services."

While cases of acquired immune deficiency syndrome have doubled in San Francisco in the last year, incidence of the disease has increased in suburban counties by 270 percent, according to figures from the California Department of Health Services.

Last year, one out of six AIDS patients in the Bay Area lived in Alameda, Contra Costa, Marin, San Mateo, Santa Clara or Sonoma counties. Today, nearly one in four AIDS patients lives in one of these six counties, accounting for more than 650 of the Bay Area's 2800 AIDS cases.

"The gay men in San Francisco clearly got infected with this virus several years earlier than other counties," said Dr. Bob Anderson, chief of prevention services for the state health department's Office of AIDS.

"Now, you're seeing a higher proportion of new cases coming out of the these counties around San Francisco, because they were infected with the virus later," said Anderson.

"We project that this trend will continue as AIDS becomes a problem that, ultimately, every county will have to deal with."

So far, only Alameda County has developed comprehensive services for AIDS patients, offering the only in-patient ward and out-patient AIDS clinic to be found outside San Francisco anywhere in the United States.

The lack of services in other counties has prompted many patients either to move to San Francisco or simply to give a city address to local agencies so they can take advantage of the city's nationally recognized network of hospice, in-patient and out-patient hospital services.

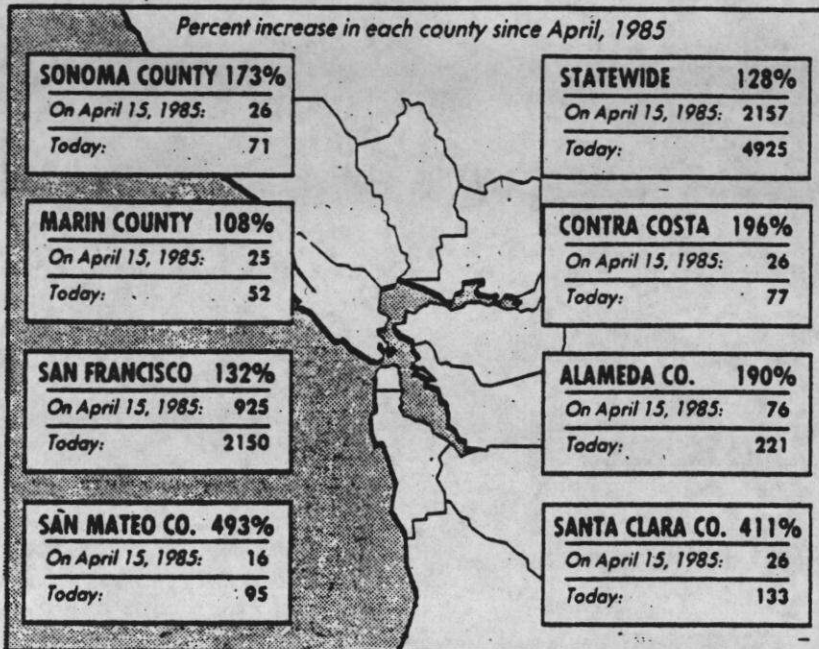
The falsification of addresses has made it extremely difficult for some public health officials to monitor AIDS trends.

In Marin County, "it's almost impossible for us to keep track of the numbers," said Mary Jo Burger, the public health nurse who is the only county staff member assigned to the epidemic. "We get our numbers from what the state tells us."

San Mateo County has somewhere between 65 and 95 AIDS patients, according to county AIDS coordinator Rick Crane, but it is impossible to give an authoritative, specific number because of patient migration for services.

"In Alameda County, we always have 40 or 50 more patients than show up on health department figures because people lie about where they live so they can get into San Francisco General Hospital," said John David Dupree of the AIDS Project of the East Bay.

AIDS IN THE SUBURBS



Sources: California Department of Health Services, county health departments.

A San Francisco health department study last year found that 15 percent of the people using the city's patient services were out-of-county residents.

Health director Werdegarr thinks this figure is "very conservative" and that the patient flow may overcome the city's limited resources.

"You can run out of convalescent care beds, hospice space and personnel to take care of these people," Werdegarr said. "These are the kinds of resources I worry about."

The new call by state officials for more regional planning in the Bay Area comes as state projections have forecast between 10,000 and 15,000 AIDS cases in Northern California within the next four years.

"Regionalization of AIDS services has gotten very hot in the last few months," said Carol Spain of the Health Officers' Association of California, a Sacramento-based group that is studying Bay Area co-

ordination of the epidemic.

"It's hitting people over the head that they have to start talking with each other," she said. "More than anything, the numbers in each county are convincing them this will be a growing regional issue."

Werdegarr called a meeting of all Bay Area county health directors last month to discuss an attempt to get other counties to begin consideration of services they will need for the expected AIDS case loads in future years.

"We agreed we needed to start talking to each other — it's not just a San Francisco or Oakland problem," said Dr. Carl Smith, Alameda County health officer. "There's a lot of work we need to do."

It is unclear whether other counties will be able to come up with the money needed to provide their own services for AIDS patients.

The \$10.8 million San Francisco spends on its patient services, contract agencies and education programs represents 98 percent of the combined county funds being put into AIDS by all the Bay Area counties.

Virtually all the money spent on AIDS outside San Francisco comes from state grants. Contra Costa County's AIDS program, for example, consists of just one health educator. Marin County has no special budget for AIDS. Sonoma and Santa Clara County each employ only two AIDS staff members, paid from state funds.

Most counties have supported the organization of volunteer groups that provide counseling and practical support for AIDS victims, although few have provided any funds for such community-based efforts.

"The county has let us know that they love what we're doing, but they don't want us to ask for any money," said Steve Parker, coordinator of the Sonoma County AIDS Project.

Several county health officers said their low AIDS case loads do not justify the creation of expensive wards and clinics. Some areas, like Contra Costa County, have channeled AIDS patients into existing hospice and home-health care programs.

"People have chosen to go to San Francisco because that has been the center of excellence for AIDS care and we can't stop them from doing that," said Dr. Wendall Brunner, Contra Costa County public health director.

"We've been trying to disseminate that excellence and expertise all over the Bay Area so people can stay closer to home," he said. "At one point, if I had AIDS, I would have gone to San Francisco too. Now, I think you can get adequate care at our county facility."

U.S. Experts' AIDS Forecast: 1 Million Cases by Year 2000

By Harold M. Schmeck Jr.

New York Times

New York

Chron. March 5
87

Barring some dramatic advance in AIDS treatment or prevention, more than 1 million Americans will have developed the disease by the year 2000, according to a group of experts surveyed by Louis Harris & Associates.

The survey, based on interviews with 227 scientists, covered all major areas of medicine and biomedical research. It was commissioned by Bristol-Myers Co. in an effort to establish medical priorities

and predict promising areas of research as the next century dawns. Acquired immune deficiency syndrome was one of the health issues considered by the panel of experts.

The scientists, including six Nobel Prize-winners, were chosen from among leaders in research fields including cancer, heart disease, disorders of the brain and central nervous system, infectious diseases, biotechnology and the use of medical implants and transplanted organs.

Some questions were asked of all the scientists involved. Of the other questions, only those in appropriate specialties were queried.

The median estimate among specialists in biotechnology, cancer and infectious diseases was that there would be a cumulative total of slightly more than 1 million U.S. victims of AIDS by the turn of the century. An estimated 31,000 Americans have currently been diagnosed as having the disease, which is invariably fatal.

Among the same group of specialists, who made up more than a quarter of the total panel, 46 percent predicted that a safe and effective vaccine against AIDS would become generally available at some time from 1990 to 1999. Only 28 percent of this subgroup expected "an effective cure for AIDS" to be available before the end of the century.

When the entire panel was questioned, 19 percent said there was "a reasonable chance" that AIDS would be eliminated by the year 2000. Seventeen percent said there is a reasonable chance of eliminating measles within the same time frame.

The scientists said diseases related to aging would be the principal health problem facing Western nations at the turn of the century. Foremost among these they listed heart disease and cancer. Infectious diseases and malnutrition were predicted as the main problems of the developing world.

The specialists in heart disease who were questioned foresaw the probable elimination of most of the 70,000 coronary bypass operations that Americans presently undergo each year. They would be replaced by the use of clot-dissolving drugs and operations in which clogged arteries would be reopened by inserting a catheter into the heart through a blood vessel. Most of the heart specialists predicted that heart transplants would be preferred over the use of artificial heart devices.

A majority of the experts in research on the brain said that use of traditional psychoanalytic therapy would be substantially curtailed compared with today. Half of the specialists in the field said psychoanalysis would be "somewhat unimportant," while 36 percent said it would be "not important at all."

IV. U.S. NATIONAL AIDS PREVENTION POLICIES

THE CDC RECOMMENDATIONS

Generally speaking, the AIDS prevention policies and strategies are still in a state of evolution. In the early stages of the epidemic it was mainly cities like San Francisco, Los Angeles and New York which developed local programs aimed at preventing its further spread. The states were much slower to respond, as was the federal government. However, the Centers for Disease Control (CDC), a federal agency, soon developed recommendations and guidelines on how to deal with the medical issues raised by AIDS. A compilation of these guidelines dating from November, 1982 to November, 1986, is attached to this report.

THE SURGEON GENERAL'S REPORT

The United States Federal Government also charged its highest public health officer, the U.S. Surgeon General, Dr. C. Everett Koop, with preparing an official report. It appeared in October, 1986, under the title Surgeon General's Report on Acquired Immune Deficiency Syndrome. A copy of this report is also attached.

Through his very concise and highly informative report, the Surgeon General managed to set the tone for the national discussion of AIDS. His recommendations were rational, farsighted and uncompromising as well as humane. He very quickly gained the respect of nearly everyone working in the field of AIDS prevention in all parts of the country. Very important was his refusal to recommend compulsory blood testing, quarantine or the identification of AIDS virus carriers. Instead, he rejected these and similar mandatory measures most emphatically as unworkable and possibly counter-productive. On the other hand, the Surgeon General demanded education concerning AIDS in all schools starting at the lowest grade possible. Specifically, he wrote:

"There is now no doubt that we need sex education in schools and that it must include information on heterosexual and homosexual relationships. The threat of AIDS should be sufficient to permit a sex education curriculum with heavy emphasis on prevention of AIDS and other sexually transmitted diseases."

The Surgeon General's Report was also quite straightforward and explicit about protection during sexual contact with potentially infected partners. He recommended either abstinence or the use of a condom and the avoidance of mouth contact with the penis, vagina or rectum.

Since its publication, the Surgeon General's Report has gained increasing acceptance and importance for state and local health authorities as they are trying to develop their own medical and educational responses. Dr. Koop continues to make personal appearances in various parts of the country explaining and promoting his recommendations. He has been especially effective because of his unassailable, conservative credentials. The fact that his position virtually coincides with that of 'liberal' health authorities now makes their common case all the more convincing.

THE REPORT OF THE NATIONAL ACADEMY OF SCIENCES

Another very important publication in this context was the report by the National Institute of Medicine of the National Academy of Sciences titled: Confronting AIDS--Directions for Public Health, Health Care and Research which also appeared in October, 1986.

The National Academy of Sciences was created in the 19th Century for the purpose of advising

the U.S. Congress on scientific matters. By addressing the question of AIDS, the Academy therefore simply fulfilled its historical mandate. This rather voluminous report came to virtually the same conclusions as had the Surgeon General.

Since the Academy Report is easily available in book form even in the Federal Republic of Germany, it is not attached here. However, it seems appropriate to provide two extensive quotations. The first specifically addresses the issue of AIDS prevention. It is also rather critical of the federal, state and local efforts to date:

Opportunities for Altering the Course of the Epidemic

1. Education can sometimes be a soft substitute for hard action. In contrast, public education about HIV infection is, and will continue to be, a critical public health measure, even if a vaccine or drug becomes available.

Education in this instance is not only the transfer of knowledge but has the added dimension of inducing, persuading, and otherwise motivating people to avoid the transmission of HIV. Hence, education to prevent HIV infection can be strongly expected to bear results. In addition, by accompanying it with behavioral research directed at improving the knowledge of how to induce more effectively the desired behavior changes, its effect can be heightened. (p. 96-97)

2. The present level of AIDS-related education is woefully inadequate.

It must be vastly expanded and diversified, targeted not only at the general public but at specific subgroups such as those in which significant transmission can be anticipated, those in a position to influence public opinion, and those who interact with infected individuals.

3. Admonitions that one must avoid "intimate bodily contact" and the "exchange of bodily fluids" while simultaneously averring the safety of "casual contact" convey at best only a vague message.

For instance, they may be understood as implying that one must avoid all sexual activities, a program that few will be willing to follow. People also need reassurance that certain sexual practices involve little or no risk of infection. (p. 97)

4. Prudishness about the use and promotion of condoms has inhibited their use.

They need to be widely available in establishments that have the potential to foster sexual liaisons, such as bathhouses and singles bars. They should also be readily accessible in less sexually oriented establishments, both to maximize their availability and to minimize the stigma associated with their use. Sexually active use (both homosexual and heterosexual, male and female), being less likely to have been infected with HIV, have the most protection to gain from condoms. Increased condom use has been demonstrated following explicit, focused educational programs in the past. More needs to be done. The increased availability of condoms probably will raise concerns about encouraging sexual activity by young people who are not sufficiently mature. Such concerns, while understandable, are overshadowed by the dire consequences of HIV infection.

5. An integral aspect of an educational campaign must also be the wide dissemination about behaviors that do not transmit the virus.

The public must be assured that ordinary standards of personal hygiene that currently prevail are more than adequate for preventing transmission of AIDS even between persons living within a single household; transmissions will not occur as long as one avoids the relatively short list of dangerous sexual and drug practices that have been identified. Unreasonable alarm about so-called casual contact with individuals perceived as possibly infected with HIV has produced many needless instances of discrimination and distress in the workplace and elsewhere.

6. Public education programs must aim at reducing this ignorance both in the general population and in the groups that will be particular targets of public education -- those at highest risk of contracting or transmitting the infection.

In this regard, the committee is concerned about the Centers for Disease Control directive that empanels local review boards to determine whether materials developed for AIDS education are too explicit and in violation of local community standards -- this is the so-called "dirty words" issue. The result of such a process could be to cut off frank, explicit information from areas where it is needed the most -- in regions outside those urban centers that have large concentrations of homosexual men and IV drug users where awareness of the specifics of HIV transmission is already high.

(p. 99)

7. For those already diagnosed with an HIV-related condition, information should be available regarding the kinds of treatment and volunteer services available.

AIDS sufferers have been desperate for information about the testing of new drugs. Equitable access to drugs being tested in clinical trials will depend in part on HIV-infected individuals being aware of such endeavors. (p. 100)

8. Research is needed to identify the educational techniques that will be most effective in convincing users of the danger of needle sharing.

9. Also needed are ways to impress women users that infection can be transmitted by them to their fetuses with disastrous results. (p. 100)

10. Another goal of educational activities should be to replace the atmosphere of hysteria and irrational fear that is found in some quarters with rational information that will engender a level-headed attitude about the disease and one's own risk of becoming infected with the virus.

Since many diverse groups must be educated, an early activity in this campaign must be the training of trainers. A network of individuals who are firmly grounded in the facts of the disease and who are adept at transmitting those facts in diverse settings should be established. (p. 100)

11. The most obvious targets for a campaign of education about AIDS are the presently identified high-risk groups: homosexual men, IV drug users, prostitutes, and sexual partners of those in high-risk groups.

Some efforts have already been made in this direction, but in general the only efforts with any claim to success have been those conducted by homosexuals through voluntary activist organizations. (p. 101)

12. It is important to communicate broadly the message that specific sexual practices involving infected persons are dangerous, not that homosexual men are at risk.

13. Heterosexuals, particularly those who have multiple partners, must be made aware of the risk to them.

14. Health care professionals must acquire and constantly update their store of information to be helpful to their clients (not only those suffering from clinical consequences of the infection but also the "worried well," both infected and uninfected) and to others with whom they are in a position to communicate.

15. Public officials, opinion makers, and the press represent other groups to which extensive education about AIDS must be targeted.

Their influence on matters of public policy is of prime importance, and misinformation among these groups can counteract the beneficial effects of many other educational efforts. (p. 101)

16. The youth of the nation, emerging into the sphere of sexual activity and becoming potential customers in the illicit drug trade, must be alerted to the existence of the disease and to its mode of transmission. (p. 101)

17. Blacks and Hispanics...require specially focused programs developed by health departments in areas having large black and Hispanic populations (p. 102)

18. The public at large deserves to receive considerable attention.

19. The lack of available treatment programs and facilities for IV drug users represents a serious problem.

Drug treatment programs are greatly overtaxed at present, and a program that inspired widespread efforts at rehabilitation about IV drug users (to avoid AIOS) could swamp already strained facilities. Thus, efforts to achieve access to IV drug users must be coupled with realistic planning of ways to cope with success. (p. 103)

20. Health professionals -- doctors, nurses, health educators, public health officials -- are all important links in the educational process.

They must be taught through professional associations, academic curricula, and continuing education so that they, in turn, can teach their patients and associates. (p. 103)

21. Among members of high-risk groups, counseling by peers is likely to be the most effective source of information, and such counseling should be available for those at risk.

Government at all levels, not only local officials in certain high-incidence areas, must be willing to support and fund efforts to educate members of high-risk communities. (p. 103)

22. Many governmental efforts will necessarily address the general public rather than special target groups and will probably be limited to activities such as the distribution of pamphlets, placement of advertisements, and organization of telephone "hotlines."

However, if nothing else is done, these general educational efforts will be grossly inadequate. (p. 103).

23. Government must prepare to fund targeted education through grants and contracts to private organizations that can communicate with special groups, in language appropriate to those groups, about relevant aspects of the disease.

These include homosexual organizations (among which appropriate educational work has already begun in some areas), schools and colleges, women's groups, youth groups, prisons, prostitutes' groups, and any type of organization with access to the IV drug user population. (p. 103).

24. Although there is need for much greater involvement of foundations and private sector organizations with expertise in health promotion, such participation would not relieve the government of a fundamental responsibility in funding and implementing educational programs.

25. The most fundamental obligation for AIDS education rests with the federal government, which alone is situated to develop and coordinate a massive campaign to implement the educational goals outlined above. (p. 104)

26. In addition to measures of disease and incidence and knowledge about disease transmission as reflected in polling data, it will be crucially important to obtain reliable indicators of changes in the incidence of behaviors that involve risk of infection.

27. The launching of a massive and decentralized education program will have many unique elements, and it may involve a slow leading process with considerable trial and error.

Rigorous evaluations of these education programs will be important if we are to learn from experience and thereby improve the programs.
(p. 105)

28. The evaluation of AIDS education programs should be conducted by a group independent of those responsible for developing and implementing the programs, and the evaluators should provide for strong centralized oversight and quality control of their work.

Past experience with large-scale, decentralized social research and evaluation programs indicates that research may be of poor quality without such oversight.
(p. 105)

29. Understanding of this group [IV drug users] is critical, however, not only because they are the second largest group to have developed AIDS in the United States, but because they are the primary source for heterosexual transmission to their sexual partners and fetuses.

Moreover, the large differences in seropositivity prevalence rates among IV drug users in different parts of the country mean that there is a tremendous opportunity to halt the further spread of infection by changing behavior among IV drug users. (p. 105)

30. Prevention programs targeted at reducing initiation into IV drug use may have to operate outside of school settings and focus on resisting social pressures to begin injecting drugs (similar to the cigarette-smoking prevention programs that focus on teaching skills to resist initiation into cigarette smoking).

Such programs are undoubtedly more expensive than are the in-school programs, but they are no less critical. (p. 108)

31. The availability of treatment was significantly less than the demand for treatment even before the AIDS epidemic.

Expanding the treatment system could significantly reduce IV drug use and the transmission of HIV. At a purely economical level, treating AIDS costs anywhere from \$50,000 to \$150,000 per case, whereas providing drug abuse treatment costs as little as \$3,000 per patient per year in certain nonresidential programs (p. 109)

32. Although questions of priority are important, limitations on resources are not an acceptable excuse for not using drug abuse treatment to halt further spread of infection. (p. 109)

33. It is time to begin experimenting with public policies to encourage the use of sterile needles and syringes by removing legal and administrative barriers to their possession and use.

34. For at least the next several years, the most effective measure for significantly reducing the spread of HIV infection is education of the public with respect to modes of transmission of the virus.

The present effort is woefully inadequate. It must be vastly expanded and diversified, aimed particularly at population subgroups such as those in which significant transmission has already occurred or can be anticipated, those in a position to influence public opinion, and those who interact with infected individuals.

35. The major aim of AIDS education is modification of certain behavior with respect to sexual and drug use practices, such as unprotected anal and vaginal intercourse with those who are infected or at risk of being infected and sharing of injection equipment.

In order to achieve this aim, educators and educational materials must be free to use clear and direct, possibly colloquial, language that will be understood by those being addressed. The committee recognizes that the reluctance of governmental authorities to address issues of sexual behavior reflects a society reticence regarding open discussion of these matters. However, it believes that governmental officials charged with protection of the public health have a clear responsibility to provide leadership and guidance when the consequences of certain types of behavior have serious health consequences.

36. Discussion of alternative sexual behavior that provides at least a large measure of protection against transmission of the virus must be conveyed to those targeted for AIDS education.

The proper use of condoms, in particular, should be stressed, and condoms must be widely and readily available to the public. It can no longer be assumed that unprotected heterosexual intercourse is safe. It probably is safe only in such situations as a long-term exclusive relationship in which both partners have not engaged in risk-taking behavior or where both partners test negative for HIV infection after six months of refraining from risk-taking behavior.

37. Special efforts must be made to educate the population of intravenous drug users and their sexual partners about HIV transmission both by sharing of injection equipment and by sexual intercourse.

This population is one of the least cohesive subgroups in the nation, and innovative methods for reaching it educationally must be developed.

38. The total educational effort is the combined responsibility of all levels of government, and the private and philanthropic sectors must also participate significantly in this activity.

Government agencies that are reluctant to use direct and colloquial language in the detailed content of education programs must be able to accomplish their educational goals by contractual arrangements with private organizations not subject to the same inhibitions.

39. Special attention must be paid to AIDS education for young people in schools and colleges, many of whom are entering periods of experimentation with sex and drugs.

Frank discussion of behaviors that do and do not transmit HIV has become an urgent necessity for this target population.

40. One of the most difficult high-risk groups to deal with in the current AIDS epidemic is IV drug users.

More research, methadone and other treatment programs, detoxification programs, and testing and counseling services related to drug treatment programs are needed. If there are legal barriers to the implementation of such programs, these barriers should be dismantled.

41. Efforts to reduce sharing of injection equipment should include experimenting with removing legal barriers to the sale and possession of sterile, disposable needles and syringes.

Institute of Medicine, National Academy of Sciences

42. AIDS education should be pursued with a sense of urgency and a level of funding that is appropriate for a life-or-death situation.

Greatly expanded educational programs to effect behavioral change are necessary for high-risk groups and the public at large. These efforts should be supported not only by the government, but also by experts in advertising and the media. The total budget for AIDS education and public health measures from governmental and private sources combined should approximate \$1 billion annually by 1990.

43. The decision of whether to be tested for antibody to HIV should remain a matter for individual discretion, given the array of potential risks and benefits that the test poses for those tested.

Testing should be encouraged in light of its potential public health benefits. Mandatory screening of at-risk individuals is not an ethically acceptable means for attempting to reduce the transmission of infection. In addition, such a mandatory program would not be feasible in an open society.

44. Testing programs should be coupled with strong guarantees of confidentiality.

Such assurances should perhaps be backed by punitive sanctions for unauthorized disclosure of antibody test results. The committee does not recommend compulsory reporting of seropositive test results.

45. The committee does not favor the establishment or the use of compulsory measures for isolation or quarantine of AIDS patients or seropositive persons in the general population.

There may be need, however, to use compulsory measures, with full due process protection, in the occasional case of a recalcitrant individual who refuses repeatedly to desist from dangerous conduct in the spread of the infection.

46. Special precautions against the spread of AIDS and the AIDS virus may be necessary in closed populations, such as in prisons, jails, mental institutions, and residences for the retarded.

Such measures should be applied with caution and only as clearly necessary and should not be used or cited as models for compulsory programs among the general population.

47. As a general policy, children with AIDS should be admitted to regular primary and secondary classes.

The CDC guidelines are recommended for further reference in this area.

Institute of Medicine, National Academy of Sciences

48. The committee believes that discrimination against persons who have AIDS or who are infected by HIV is not justified, and it encourages and supports laws prohibiting discrimination in employment and housing as formal expressions of public policy.

The committee also supports a federal policy to include AIDS as a handicapping condition under the federal law prohibiting improper discrimination against the handicapped.

49. Any form, direct or indirect, of discrimination against vulnerable high-risk groups for AIDS should be discouraged and prohibited by state legislation and, where appropriate, by federal regulation and statute.

In a positive manner, participation by representatives of high-risk groups in policymaking bodies should be encouraged where appropriate and practicable, and the help of organizations representing high-risk groups should be enlisted for public service programs such as health education, personal counseling, and hospital and home treatment services.

The second quote from the Academy Report summarizes its major recommendations. They have now become the measuring stick by which all American AIDS prevention efforts are judged. Moreover, they seem, in principle, to be applicable in most other countries. Indeed, they could, and perhaps should, be followed immediately in the Federal Republic of Germany:

"MAJOR RECOMMENDATIONS

- 1. Undertake a massive media, educational, and public health campaign to curb the spread of HIV infection.**
- 2. Begin substantial, long-term, and comprehensive programs of research in the biomedical and social sciences intended to prevent HIV infection and to treat the diseases caused by it.**

Within a few years these two major areas of action should each be supported with expenditures of \$1 billion a year in newly available funds not taken from other health or research budgets. The federal government should bear the responsibility for the \$1 billion in research funding and is also the only possible majority funding source for expenditures of the magnitude seen necessary for education and public health.

Furthermore, to promote and integrate public and private sector efforts against HIV infection, a National Commission on AIDS should be created. Such a commission would advise on needed actions and report to the American people.

Curbing the spread of HIV infection will entail many actions, including the following:

- **Expand the availability of serologic testing, particularly among persons in high-risk groups. Encourage testing by keeping it voluntary and ensuring confidentiality.**
- **Expand treatment and prevention programs against IV drug use. Experiment with making clean needles and syringes more freely available to reduce sharing of contaminated equipment.**

The care of HIV patients can be greatly improved by applying the results of health services research. In the meantime, the following actions should be taken:

- **Begin planning and training now for an increasing case load of patients with HIV infection. Emphasize care in the community, keeping hospitalization at a minimum.**
- **Find the best ways to collect demographic, health, and cost data on patients to identify cost-effective approaches to care.**
- **Devise methods of financing care that will provide appropriate and adequate funding.**

The recommended research efforts should include the following actions:

- **Enhance the knowledge needed for vaccine and drug development through basic research in virology, immunology, and viral protein structure.**
- **Improve understanding of the natural history and pathogenesis of AIDS, and trace the spread of HIV infection by means of epidemiologic and clinical research.**
- **Study sexual behavior and IV drug use to find ways to reduce the risk of infection.**
- **Encourage participation of academic scientists in research against AIDS, in part by increasing the funding for investigator-initiated research proposals.**
- **Solicit participation of industry in collaboration with federal and academic research programs.**

- Expand experimental animal resources, working especially to conserve chimpanzee stocks, and develop new animal models of HIV infection.

Because AIDS and HIV infection are major and mounting health problems worldwide:

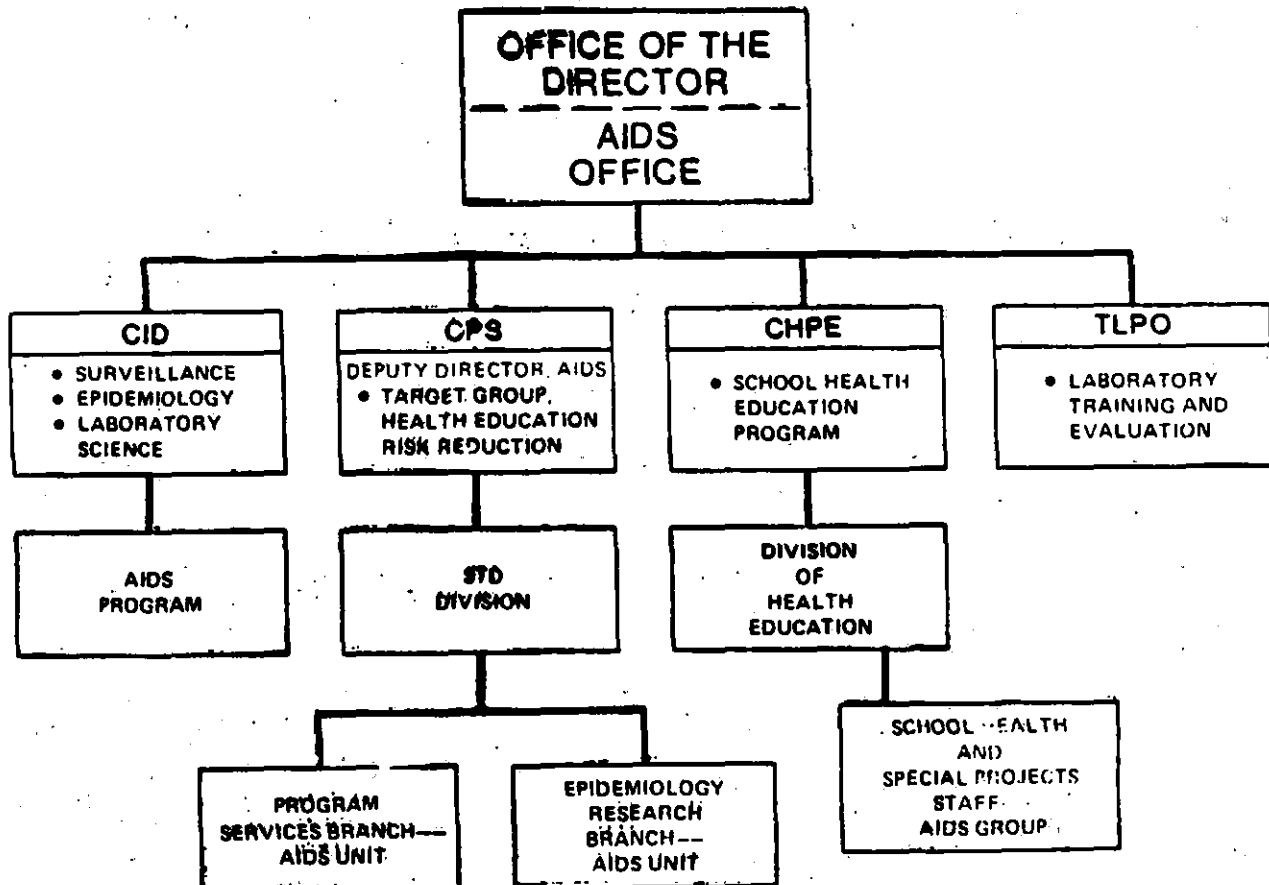
- The United States should be a full participant in international efforts against the epidemic.
- United States involvement should include both support of World Health Organization programs and bilateral efforts."

REORGANIZATION WITHIN THE CDC

The Centers for Disease Control in Atlanta, Georgia, which had been involved early on in various aspects of the fight against AIDS, eventually found themselves somewhat hampered in their efforts by their organizational structure. Since many different departments had to deal with this increasingly complex issue, there was a certain amount of duplication and overlap. In the meantime, in order to insure greater efficiency, a special AIDS office has been created, headed by Dr. Walter Dowdle, which now cuts across and coordinates the various CDC programs dealing with AIDS.

The following is an organizational flow chart illustrating the new structure which has been superimposed on the existing departments:

CDC AIDS ORGANIZATION



CDC -- PRACTICAL PREVENTION EFFORTS

1. "TRAINING THE TRAINERS"

Realizing that the new epidemic of AIDS would require training or retraining a large number of health personnel all over the country, the Centers for Disease Control, through its Department of Sexually Transmitted Diseases, decided to embark on a program of "training the trainers".

The details of this program are summarized in the following pages. They also provide a summary of the courses taught in the fiscal year 1986. The summary, in turn, spells out a detailed spectrum of courses, of which "Training the Trainers" is only one segment. However, in a general sense, this term is appropriate for the entire training effort, which relies on the principle of "snowballing". In other words, all graduates of these CDC training courses are expected to train others who then will train others and so on.

The entire program has model character. It not only ensures certain standards nationwide, but also allows the CDC to maintain a leadership role in this field.

TRAINING IN DISEASE INTERVENTION, SUPERVISION, AND MANAGEMENT

- o DSTD provided training in the above areas through four ongoing courses and five courses developed around specific needs and events.
- o Instructors for introductory disease intervention courses were located in Atlanta, Chicago, and Long Beach. Courses were also conducted in Indianapolis, Winston-Salem, Miami, Fresno, Tampa, Norwalk, Baltimore, Rapid City, DesMoines, Boston, and West Germany.
- o Other courses usually were taught by instructors drawn from CDC, although one course (Introduction to Microcomputers for STD Control) was conducted through a private firm and another (Train the Trainer) utilized three former instructors now in field assignments.
- o "Introduction to STD Intervention" was given to newly-hired Disease Intervention Specialists (D.I.S.) who had undergone a minimum of 3 weeks orientation at their worksites using detailed orientation materials developed and supplied by DSTD. For this purpose, DSTD provided 262 STD Employee Development Guides and 100 STD Employee Development Supervisor's Guides. Extensive revisions were made to the ISTD curriculum during the year, principally to add material on interviewing/counseling about HTLV-III/LAV antibody testing, and more sophisticated case analysis and management exercises.
- o "Fundamentals of STD Intervention" was given for people with some public health background and less than fulltime involvement with STD interviewing/counseling activities.
- o "Principles of Supervision in STD Control" emphasized the involvement of first line supervisors in direct observation, modeling, and feedback for outreach workers.
- o Materials were developed to improve budgeting and other skills in the week-long management problem for the "STD Clinic Administrator/Manager Seminar."
- o STD program managers and other representatives from 58 STD project areas attended "Introduction to Microcomputers for STD Control" in Atlanta. Participants gained hands-on experience on IBM AT equipment which was subsequently shipped to their respective program areas.
- o Four instructors were oriented with newly-developed materials for presenting a "Train the Trainers" course to enable other instructors to teach the course, "Counseling and Sex Partner Referral for HTLV-III/LAV Infection." Participants were prepared to teach the course in almost every State. By the end of FY 1986, DSTD had received evaluation reports from 15 states indicating that 736 people had been trained in 62 sessions by instructors who attended the original "Train the Trainers" courses.
- o Two AIDS courses were developed in response to needs identified in the Nine Cities AIDS Health Education Study, a survey of public health departments, and reviews of AIDS health education workplans submitted to CDC. The courses were a joint project with the Center for Health Promotion and

Education and the Training and Laboratory Program Office. "Working Together Towards AIDS Prevention/Education" was a one day session stressing collaboration and was attended by people from a number of groups including State and local governments, drug abuse programs, blood banks, and community organizations. Following these sessions was the three day course, "Planning AIDS-Related Health Education/Risk Reduction Programs." The latter was attended by senior AIDS program managers and dealt with program planning, implementation, and evaluation in connection with the cooperative agreements for AIDS Health Education/Risk Reduction Programs.

- o "The Role of the Disease Intervention Specialist in STD Control" was presented to STD clinicians and clinic management staffs of the Houston City Health Department as part of their orientation to expanded duties in the management of the local STD control program.
- o The Training and Laboratory Program Office is working with DSTD to produce a homestudy course for experienced Disease Intervention Specialists which will be modeled after the popular "Principles of Epidemiology" course. The first two of a proposed seven modules are under review. The course will rely heavily on STD examples to teach skills in epidemiologic description, investigation, and report writing.

SUMMARY OF COURSES FY 1986

COURSE	SESSIONS	CITIES	STUDENTS	STUDENT DAYS
Introduction to STD Intervention	19	9	192	1,920
Fundamentals of STD Intervention	5	4	73	365
Principles of Supervision in STD Control	3	2	35	175
STD Clinic Administrators/Managers Seminar	3	2	33	165
Introduction to Microcomputers for STD Control	9	1	135	675
Train the Trainers	7	7	72	360
Working Together Towards AIDS Prevention/Education	6	6	300	300
Planning AIDS-Related Health Education/Risk Reduction	5	5	75	225
Role of the D.I.S. in STD Control	<u>1</u>	<u>1</u>	<u>22</u>	<u>44</u>
Total	58	*	937	4,229

* 19 different cities hosted training during FY 1986

- o Until FY 1986, the number of people trained has been influenced by the declining number of new hires for the STD program field staff. In FY 1986, the number of people trained increased by 250%, which reflects a commitment to providing training for more experienced personnel. This trend is likely to continue for the immediate future as new courses are developed and provided for experienced D.I.S. and program managers.

2. FUNDING OF LOCAL PROGRAMS

The CDC also acts as a clearinghouse for federal funding of local prevention programs. In order to fulfill this obligation it has developed detailed guidelines and has trained a staff in supervising the programs funded. Again, the goal is a certain minimum uniformity of standards and the preservation of federal leadership. This does not mean, however, that the guidelines are used as a straitjacket hampering innovation or new initiatives. Indeed, in the application, they are quite liberal, leaving a great deal of room for local diversity.

In order to illustrate the principles of this program as well as its rapid development, the following pages document the announcements and guidelines for the fiscal years 1985 and 1987. Both of these texts are detailed enough to be self-explanatory.

Following this, the actual implementation of such programs, their potential scope, as well as local differences, are illustrated by a few brief summaries. They were provided by Dr. Kevin O'Reilly of the CDC, and they describe programs in several American cities: Albany NY, New York City, Dallas, Denver, Seattle, Chicago, and Long Beach CA.

Billing Code 4160-18

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control

COOPERATIVE AGREEMENTS FOR:

I. COMMUNITY-BASED DEMONSTRATION PROJECT FOR ACQUIRED IMMUNODEFICIENCY
SYNDROME (AIDS) PREVENTION AND RISK REDUCTION

AND

II. INNOVATIVE PROJECTS FOR AIDS RISK REDUCTION;
AVAILABILITY OF FUNDS FOR FISCAL YEAR 1985

INTRODUCTION

The Centers for Disease Control (CDC) announces the availability of funds for Fiscal Year 1985 for competitive applications for cooperative agreements in the following two areas: I. Community-Based Demonstration Project for Acquired Immunodeficiency Syndrome (AIDS) Prevention and Risk Reduction and II. Innovative Projects for AIDS Risk Reduction. These projects are authorized by section 301(a) of the Public Health Service Act (42 U.S.C. 241(a)), as amended. The Catalog of Federal Domestic Assistance Number is 13.118.

BACKGROUND

The acquired immunodeficiency syndrome continues to grow as a major public health problem in the United States. Through June 1985, more than 11,000 cases have been reported and more than 5,400 persons have died from AIDS. The virus (Human T-Lymphotropic Virus-Type III (HTLV-III)) that causes AIDS is transmitted sexually, through contaminated needles, through blood and blood components, and perinatally. A serologic test for HTLV-III antibody has been

developed, and its use on donated blood and plasma will decrease the risk of AIDS for transfusion recipients and hemophiliacs. However, these two groups account for only 2 percent of reported AIDS cases. In the absence of an AIDS vaccine or therapy, the basis for AIDS prevention in other groups is a thorough understanding of the risk factors for HTLV-III infection and efforts to change the behaviors which contribute to those factors. Significant gaps still exist in the understanding of risk factors for HTLV-III infection, and the behaviors which contribute to those factors are complex and difficult to change.

I. INFORMATION SPECIFIC TO COMMUNITY-BASED DEMONSTRATION PROJECT FOR AIDS PREVENTION AND RISK REDUCTION

A. Purpose - The purpose of this comprehensive community-based demonstration project for AIDS prevention and risk-reduction is to design, implement, and evaluate an intensive program in a well-defined geographic/political subdivision to:

1. Determine the prevalence of HTLV-III infection in high-risk groups;
2. Determine the prevalence of HTLV-III infection in the general population;
3. Determine the current level of knowledge of HTLV-III infections and attitudes concerning AIDS among groups at risk;
4. Assess current risk-associated behavior among such high-risk populations as homosexuals and intravenous drug users;
5. Promote and carry out multifaceted educational programs intended to persuade individuals to take action to remain uninfected, and prevent transmission to others, if infected;

6. Promote and carry out programs to counsel seropositive and seronegative individuals;
7. Document steps taken to implement multifaceted education and counseling programs;
8. Evaluate programmatic efforts to prevent the spread of HTLV-III infection and change risk-associated behavior;
9. Provide learning opportunities for other State and local personnel that are planning, implementing, or evaluating AIDS health education/risk reduction programs.

B. Cooperative Activities

1. Recipient Activities

- a. Design and conduct seroprevalence studies to determine the prevalence of HTLV-III infection in groups at risk and in the general population.
- b. Design and conduct studies to determine current knowledge of HTLV-III infection and attitudes concerning AIDS among groups at risk as well as baseline data on risk-associated behaviors of individuals within these groups.
- c. Develop and distribute written and audiovisual materials with accurate information on AIDS, risk factors, prevention guidelines, and community resources available.
- d. Develop, promote, and conduct programs, presentations, group discussions, and other activities designed to promote awareness of AIDS risk situations and support for prevention measures.
- e. Promote and carry out programs to counsel seropositive and seronegative individuals.

4

f. Repeat studies to document whether and to what extent changes in the understanding of AIDS risk factors and risk-associated behaviors have occurred.

g. Repeat seroprevalence study to monitor changes in the prevalence of HTLV-III infection in groups at risk.

h. Monitor trends in other illnesses which are sensitive indicators of behavior change in populations at risk (e.g. reportable sexually transmitted infections, hepatitis B, and non-A, non-B).

i. Evaluate and revise programmatic efforts in reaction to changes in behavior and infection with HTLV-III.

j. Provide information and insight for use in the development of curricula and other learning opportunities to train personnel from other State and local programs.

2. Centers for Disease Control Activities

a. Collaborate in the design of the initial and followup seroprevalence studies for HTLV-III infection in groups at risk and in the general population.

b. Collaborate in the design of the initial and followup studies of individuals at risk, and provide consultation regarding data-collection instruments and procedures.

c. Participate in the analysis of information gathered from studies.

d. Provide up-to-date scientific information regarding the natural history of AIDS, sensitivity and specificity of serologic tests, and national program for the prevention of AIDS and the transmission of HTLV-III infections.

e. Provide on-site technical involvement in planning, operating, and evaluating prevention activities.

f. Develop course curricula, training materials, job aids, and other learning opportunities to train personnel from other State and local programs.

C. Eligible Applicants - Eligible applicants are the official public health agencies of State and local governments, including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Trust Territory of the Pacific Islands, the Northern Mariana Islands, and American Samoa, which have reported at least 75 cases of AIDS, meeting the CDC surveillance case definition:

1. Presence of reliably diagnosed disease at least moderately indicative of underlying cellular immune deficiency (e.g., Kaposi's sarcoma in patients who are less than 60 years of age or patients with Pneumocystis carinii pneumonia or other opportunistic infections); and
2. Absence of known causes of underlying immune deficiency and of any other reduced resistance reported to be associated with the disease.

D. Availability of Funds - Approximately \$400,000 to \$500,000 will be available in Fiscal Year 1985 to fund one cooperative agreement. It is expected that the initial cooperative agreement award will begin on or about September 30, 1985, and will be funded for 12 months in a 1- to 4-year project period. Continuation awards within the project period will be made on the basis of satisfactory progress in meeting project objectives and on the availability of funds. Funding estimates outlined above may vary and are subject to change.

E. Review and Evaluation Criteria - Applications will be reviewed and evaluated according to the following criteria:

1. The applicant's understanding of AIDS prevention activities and the purpose of the cooperative agreement.
2. The ability of the applicant to identify experienced, qualified personnel and a satisfactory description of how they will supervise, coordinate, and operate the program.
3. The establishment of objectives which are consistent with the stated purpose of the cooperative agreement, and which are specific, measurable and time phased.
4. Evidence of the ability of the applicant to generate community cooperation and support for AIDS prevention activities and maintain close collaboration and working relationships with community-based organizations serving the interests of groups at risk for AIDS.
5. The quality and scope of the applicant's current activities in AIDS information and education.
6. The quality of the applicant's proposed plan to determine current prevalence and knowledge of HTLV-III infection in groups at risk as well as how the applicant will assess current risk-associated behavior of individuals within these groups.
7. The quality of the applicant's proposed plan to promote behaviors designed to persuade individuals to remain uninfected, and prevent transmission to others if infected.
8. The soundness and potential operational impact of the overall approach.

- 9. An evaluation plan which specifies the method and instruments of measurement to be used.
- 10. The willingness to participate in technology transfer to personnel from other States and local communities.
- 11. The capability or plan of the applicant to maintain maximum confidentiality of all records related to clinical laboratory results on individuals and/or studies with personal identifiers.
- 12. The extent to which the budget is reasonable and consistent with the intended use of the cooperative funds.

II. INFORMATION SPECIFIC TO INNOVATIVE PROJECTS FOR AIDS RISK REDUCTION

A. Purpose - The purpose of the innovative projects for AIDS risk-reduction is to stimulate the development of unique and innovative approaches for the prevention of HTLV-III transmission, and to evaluate the effectiveness of these approaches. The approaches to be developed should be directed toward persons infected with HTLV-III, or at risk of acquiring such infection. These persons include homosexual and bisexual men, heterosexual persons with at least one infected sex partner, women of child-bearing age with evidence of infection, users of intravenous drugs, or others potentially at risk.

Applicants may focus on components of innovative risk-reduction approaches, such as targeted education for individuals and groups at high risk of AIDS and other sexually transmitted diseases, techniques to motivate individuals to act according to information they receive, and other creative aspects of risk-reduction behavior.

The social setting for which the proposed innovative risk reduction approaches might be developed could include individuals, small groups, or larger units of analysis.

B. Cooperative Activities**1. Recipient Activities**

- a. Assess levels of knowledge, personal beliefs, and/or recent experiences regarding exposures to persons with AIDS, life-style changes, and HTLV-III infections in the population to be studied.
- b. Select a sample of the population for more intensive study of the proposed risk-reduction approach.
- c. Design and implement an innovative risk-reduction program and report the number of individuals who participate.
- d. Measure knowledge, attitudes, behavioral intentions and behaviors before, during, and after participation in the risk reduction program.
- e. Compare knowledge, attitudes, behavioral intentions and/or self-reported behaviors of the individuals who participate and those who do not (a control group).

2. Centers for Disease Control Activities

- a. Collaborate in the design of the study, and provide consultation regarding data-collection instruments and procedures, data analysis of information gathered, and preparation of a final report.
- b. Provide up-to-date scientific information regarding the natural history of HTLV-III, sensitivity and specificity of serologic tests, and other aspects of preventing transmission of HTLV-III infections.

C. Eligible Applicants - Eligible applicants are the official public

health agencies of State and local governments (including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Trust

Territory of the Pacific Islands, the Northern Mariana Islands, and American Samoa) and other public or nonprofit private community organizations, educational institutions or other organizations that can demonstrate the capability to work in close cooperation with State or local health departments on the prevention and control of AIDS.

D. Availability of Funds - Approximately \$600,000 to \$700,000 will be available in Fiscal Year 1985 to fund two to three cooperative agreements ranging from approximately \$200,000 to \$300,000. It is expected that the initial cooperative agreements will begin on or about September 30, 1985, and will be funded for 12 months in a 1- to 3-year project period. Continuation awards within the project period will be made on the basis of satisfactory progress in meeting project objectives and on the availability of funds. Funding estimates outlined above may vary and are subject to change.

E. Review and Evaluation Criteria - Applications will be reviewed and evaluated according to the following criteria:

1. Evidence of the applicant's understanding of the objectives of HTLV-III prevention activities, and the rationale for innovative risk-reduction proposals.
2. Successful outcomes from the applicant's involvement in previous projects designed to prevent HTLV-III infections, other infections transmitted sexually, or other lifestyle related health problems.
3. Evidence of the ability of the applicant to generate community cooperation and support for AIDS prevention research activities and maintain close collaboration and working relationships with community-based organizations serving the interests of groups at risk for AIDS.

4. The extent to which technical expertise in the following areas is available: HTLV-III antibody testing, research design, and data analysis.
5. Evidence that a qualified and experienced research team will be available to test hypotheses.
6. The selection of an appropriate study population and an adequate description of the characteristics of the population to be investigated.
7. A clear statement of objectives consistent with the stated purpose of the cooperative agreement and which are specific, measurable, and time phased.
8. Demonstration that the proposed approach will achieve objectives.
9. Demonstration that proposed project has potential for interrupting transmission of HTLV-III.
10. The adequacy of the evaluation plan to detect effects of the proposed project to reduce transmission of HTLV-III and document the impact of the program..
11. The extent to which the budget is reasonable and consistent with the intended use of the cooperative funds.

INFORMATION APPLICABLE TO COOPERATIVE AGREEMENT PROGRAMS IN I. AND II. ABOVE

Reporting Requirements - Progress reports are required on a quarterly basis and are due 30 days after the end of each quarter. Financial status reports are required no later than 90 days after the end of each budget period. Final financial status and progress reports are required 90 days after the end of a project period.

Guidelines for Application Narrative - Applications must include a narrative which details the following:

- . The background and need for project support, including information that relates to factors by which the applications will be evaluated.
- . The objectives of the proposed project which are consistent with the purpose of the cooperative agreement and which are measurable and time phased.
- . The methods which will be used to accomplish the objectives.
- . The methods which will be used to evaluate the success of the project.
- . Any other information that will support the request for assistance.
- . Fiscal information, including narrative justification, pursuant to utilization of awarded funds in a manner consistent with the purpose and objectives of the project.

Submission of Applications - The original and two copies of the application must be submitted to Leo A. Sanders, Chief, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control, 255 East Paces Ferry Road, N.E., Room 321, Atlanta, Georgia, 30305, on or before 30 p.m. (e.d.t.) August 30, 1985.

Deadline: Applications shall be considered as meeting the deadline if they are either:

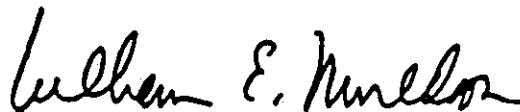
1. Received on or before the deadline date, or
2. Sent on or before the deadline date and received in time for submission to the independent review group. (Applicants must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or U.S. Postal Service. Private metered postmarks shall not be acceptable as proof of timely mailing.)

Late Applications: Applications which do not meet the criteria in A. 1. and 2. above are considered late applications. Late applications will not be considered in the current competition and will be returned to the applicant.

C. Review Requirements: Applications are not subject to the review requirements of the National Health Planning and Resources Development Act of 1974, as amended, and are not subject to Intergovernmental review pursuant to Executive Order 12372.

D. Where to Obtain Additional Information: Information on application procedures, copies of application forms, and other material may be obtained from Nancy Bridger, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control, 255 East Paces Ferry Road, N.E., Room 321, Atlanta, Georgia 30305, or by calling (404) 262-6575 or FTS 236-6575. Technical assistance may be obtained from Willard Cates, M.D., M.P.H., Division of Sexually Transmitted Diseases, Center for Prevention Services, Centers for Disease Control, Atlanta, Georgia 30333, telephone (404) 329-2552 or FTS 236-2552.

Dated: JUL 15 1975



William E. Muldoon
Director, Office of Program Support
Centers for Disease Control

FEDERAL FUNDING OF AIDS PREVENTION PROGRAMS

Centers for Disease Control

Program Announcement and Availability of Funds for Fiscal Year 1987 for Cooperative Agreements; Acquired Immunodeficiency Syndrome (AIDS) Prevention Projects

Introduction

The Centers for Disease Control (CDC) announces the availability of funds for Fiscal Year 1987 for cooperative agreements for Acquired Immunodeficiency Syndrome (AIDS) Prevention Projects. These awards will consolidate existing State-Based AIDS Projects for Community Health Education and Risk Reduction (HE/RR) and Projects for Augmentation and Evaluation of HE/RR Programs in Communities with High Incidence of AIDS with existing AIDS Projects for Human Immunodeficiency Virus (HIV) Counseling and Testing Sites (CTS).

Authority

These projects are authorized under section 301(a) of the Public Health Service Act (42 U.S.C. 241(a)), as amended, section 311(b) of the Public Health Service Act (42 U.S.C. 243(b)), as amended, and section 318 of the Public Health Service Act (42 U.S.C. 247c), as amended. The Catalog of Federal Domestic Assistance Number is 13.118.

Eligible Applicants.

Eligible applicants are the official public health agencies of States, including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, the Republic of Palau, the Northern Mariana Islands, and American Samoa, and local governments which have reported at least 2,000 cases of AIDS.

Program Background

The acquired immunodeficiency syndrome (AIDS) continues to grow as a major public health problem in the United States. Through December 1986, more than 29,000 cases have been reported and more than 18,300 persons have died from AIDS as defined by the CDC surveillance case definition for national reporting:

1. Presence of reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency; and

2. Absence of all known underlying causes of cellular immunodeficiency (other than HIV infection) and absence of all other causes of reduced resistance reported to be associated with the disease.

HIV, the virus that causes AIDS, is transmitted sexually, through contaminated needles, through blood and blood components, and perinatally. A serologic test for HIV antibody has been developed, and its use for donated blood and plasma has greatly decreased the risk of AIDS for transfusion recipients and hemophiliacs. These two groups account for approximately 3 percent of reported AIDS cases. The test has also permitted the establishment of educational outreach to target important risk reduction messages to individuals at high risk for AIDS, e.g. gay and bisexual men, IV drug abusers, and their sex and needle-sharing partners.

Without a vaccine or therapy, the main bases for AIDS prevention in these and other groups are a thorough understanding of the risk factors for HIV infection, and efforts to change the behaviors which contribute to those factors.

Purpose

The purpose of these awards is to assist State and local health departments in reducing the spread of AIDS and HIV infection by (1) establishing and/or maintaining AIDS health education/risk reduction programs for the general public and high-risk groups; (2) maintaining counseling and testing services that

confidentially and effectively target individuals at high risk for AIDS through AIDS prevention education on sexual activity, parenteral drug use, and donation of blood, semen, or body organs; and (3) evaluating the effectiveness of these programs and services in reducing transmission of HIV.

Cooperative Activities

1. Recipient Activities—AIDS HE/RR Component (All activities below apply to new applications; only activities g-m below apply to continuation applications)

a. Assess current levels of resources for AIDS prevention and areas of need for support in the community among organizations serving high-risk groups and the general population;

b. Determine the baseline prevalence of HIV infection in groups at risk and in the general population;

c. Determine baseline levels of disease-related knowledge, attitudes, and behaviors among persons at risk of infection;

d. Determine baseline levels of disease-related knowledge in the general population, including fears and beliefs about methods of transmission, and perceptions about people at risk or with the disease;

e. Develop specific, numerically measurable HE/RR objectives that specify the expected change that program efforts will produce from the baseline levels of HIV seroprevalence, for the long term, and, for the budget period, from the baseline levels of knowledge, attitude, and behavior regarding AIDS among risk groups, health care providers, and the general populations;

f. Develop a comprehensive program plan to achieve these objectives which includes building a core capacity involving existing AIDS service groups plus other community groups/organizations and service delivery programs (e.g., drug abuse treatment facilities, family planning clinics, maternal and infant care projects, Comprehensive Hemophilia Treatment Centers, etc.) that come into contact with people at high risk for AIDS;

g. Based on the comprehensive program plan guided by specific and measurable HE/RR objectives and through financial support, such as of existing AIDS service groups, as may be indicated and appropriate, use the core capacity to:

(1) Assist the community in organizing itself as needed to reinforce and support the lifestyle changes that individuals are trying to make and maintain;

(2) Deliver HE/RR services to prevent the transmission of HIV that are specifically targeted to groups and individuals known to have risk factors for AIDS, specifically:

(a) Gay and bisexual men;

(b) IV drug abusers;

(c) Prostitutes;

(d) Heterosexuals with multiple sex partners; and

(e) The sex and needle-sharing partners of all individuals above;

(3) Deliver AIDS education to medical and dental health providers to promote safe, yet accessible, quality care for AIDS and HIV patients and to mental health professionals who could provide psycho-social support and negotiating skills to assist AIDS and HIV patients in adjusting and effecting risk-reducing behavior changes;

(4) Deliver information and HE/RR services specifically to black and Hispanic populations and involve representatives of these populations in the overall effort to ensure a maximum level of awareness that they have been disproportionately affected by AIDS, particularly perinatal AIDS, and need to consider measures that will prevent the further spread of HIV; and

(5) Deliver health education messages to the general population to:

(a) Communicate clear messages about what AIDS is, how it is transmitted, how it is not transmitted, and how it can be prevented; and

(b) Alleviate unwarranted fears by clarifying dominant misunderstandings about AIDS and about persons with AIDS or at risk for HIV infection;

h. Participate with the State Education Agency (SEA)/Local Education Agency (LEA) in its efforts to carry out a CDC cooperative agreement with the SEA/LEA to promote a program of high quality AIDS education in the schools that includes sexually transmitted disease (STD) and substance abuse-related issues by:

(1) Coordinating an assembly of experts (e.g., from the health department AIDS, STD, and health education programs and the State/local substance abuse control agency) to provide technical assistance to the SEA/LEA during the project's planning and development phases;

(2) Collaborating on the development or selection of curriculum and materials with a behavioral focus (as opposed to one which stresses biomedical facts and statistics); and

(3) Providing logistical and technical support to the SEA/LEA (e.g., by arranging to have AIDS, STD, and substance abuse technical experts available for teacher workshops) to

facilitate a successful implementation of the program:

i. For applicants from areas which do not successfully compete for CDC cooperative agreements with the SFA/LEA for AIDS education in the schools, collaborate with, administratively support, and technically assist State/local school agencies and systems in their implementation of a program of high quality AIDS (at minimum in conjunction with STD and substance abuse) education using curricula and materials with a behavioral focus;

j. Coordinate cooperative agreement activities with other CDC-supported AIDS programs such as Surveillance, Community Demonstration projects, Innovative Risk Reduction projects, and initiatives funded through the United States Conference of Mayors (where such programs are in place) and with any other federally funded or private service efforts associated with the AIDS problem;

k. Through the direct observation of performance by individuals and organizations, evaluate the quality with which all programmatic activities are carried out to prevent the spread of HIV and to change risk-associated behaviors, including those carried out by AIDS service groups or others supported by, or working in collaboration with, the program;

l. Working closely with existing AIDS service groups and/or others collaborating with the program, evaluate the impact of programmatic efforts through periodic reassessments of seroprevalence and, at least annually, reassessments of the prevalence of AIDS-related knowledge, attitudes, and behaviors among risk groups and the general population particularly related to the subjects of HE/RR objectives; and

m. In concert with existing AIDS service groups and/or others collaborating with the program, appropriately adjust the target levels of specific, numerically measurable objectives and amend the focus and direction of program plans for achieving them based on evaluation findings.

Recipient Activities—AIDS CTS Component

a. Operate counseling and testing sites for HIV antibody testing at places and times that are reasonably convenient for the majority of people in risk groups for AIDS and publicize the service in ways which best ensure that persons at risk could be able to determine where and when services are available and how to obtain scheduling an appointment, or acquiring information about the program;

b. Provide sensitive and effective pretest and posttest counseling,

encourage seropositive patients to refer their sex or needle-sharing partners and offer them guidance in making referrals when feasible; and provide assistance by notifying their partners and counseling them regarding evaluation and/or testing, if they prefer;

c. Assure the confidentiality of all patient records and records of test results in accordance with the confidentiality requirements of section 318(e)(5) of the Public Health Service Act, as specified below, or through a system of anonymous testing and record keeping that minimizes the maintenance or use of name-identified documents;

d. Maintain the laboratory capability to perform HIV antibody testing by using the latest approved technology and by ensuring that a secondary testing procedure, i.e., Western blot or other appropriate tests, is established and is used routinely to process all specimens repeatedly reactive by the ELISA procedure;

e. Ensure the CTS personnel who perform posttest counseling are promptly provided with all antibody test result information judged necessary for them to explain results and deliver risk reduction messages to patients whose tests indicate antibody to HIV;

f. Evaluate the population tested, test results, and counseling and partner referral efforts in a manner which preserves confidentiality or maintains anonymity; and

g. Ensure coordination between this program and any current CDC cooperative agreements for AIDS;

3. Centers for Disease Control Activities

a. Provide consultation and technical assistance in planning, operating and evaluating prevention activities;

b. Provide training in HE/RR program planning and management, the organization of community resources, and antibody test counseling, sex partner referral, and laboratory procedures related to the ELISA and Western blot or other appropriate testing procedures;

c. Provide up-to-date scientific information regarding the risk/protective factors for AIDS and HIV infection, and sensitivity and specificity of serologic tests, and the national program strategy for the prevention of AIDS and the transmission of HIV infection that may have impact on the nature and scope of the operation of AIDS prevention programs;

d. Develop, refine, and disseminate AIDS prevention program guidelines and describe any methods developed to carry out program operations or monitor progress that appear workable and effective;

e. Participate in the analysis of information and data gathered from program activities and facilitate the transfer of information and technology to other States and communities;

f. Assist in the evaluation of the overall effectiveness of program operations; and

g. In cooperation with the Project Director of the cooperative agreement area, maintain ultimate responsibility for the supervision and evaluation of any CDC personnel assigned in response to an applicant request for detail through direct assistance.

Availability of Funds

A total of approximately \$24,500,000 will be available in Fiscal Year 1987 for these awards.

1. New Application

Of this amount, approximately \$100,000 will be available to fund up to 7 new AIDS Prevention Project cooperative agreements ranging from \$5,000 to \$50,000 with an average award of \$15,000. It is expected that new cooperative agreements will begin on or about April 30, 1987, and will be funded for 12 months in a 1 to 5-year project period.

2. Other Applications

In addition, approximately \$24,400,000 will be available to fund up to 55 AIDS Prevention Projects ranging from \$125,000 to \$1,800,000 with an average award of \$444,000. Of this amount, approximately \$12,000,000 will be available for competing applications for the CTS component of this project and approximately \$12,400,000 will be available for non-competing continuation applications for the HE/RR component of this project. HE/RR continuation awards will be made on the basis of satisfactory progress in meeting HE/RR project objectives and on the availability of funds. Funding estimates outlined above may vary and are subject to change.

Use of Funds

Funds may be used to support personnel, their training and travel, and to purchase supplies and services directly related to planning, organizing, and conducting the AIDS project described in this announcement.

Requests for direct assistance (i.e., "in lieu of cash") for personnel, supplies, and other forms of direct assistance will be considered.

Funds may be expended for written materials, pictorials, audiovisuals, questionnaires or survey instruments, and educational group sessions related

to AIDS risk reduction education efforts if approved in accordance with guidance provided below under the heading *Content of Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions*. Funds from the project may not be spent for research activities, for surveys, or for questionnaires except as may be needed to collect patient demographics to meet the basic evaluation requirements of this announcement.

Funds shall not be used for purchasing computers, office equipment and furniture, and renting or leasing office space unless specifically approved. Funds may not be used to support construction or renovation costs.

Confidentiality

In accordance with section 316(e)(5) of the Public Health Service Act (42 U.S.C. 247c(e)(5)), all information obtained in connection with the examination, care, or treatment provided to any individual under any program which is being carried out with a cooperative agreement made under this announcement shall not, without such individual's consent, be disclosed except as may be necessary to provide services to the individual or as may be required by a law of a State or political subdivision of a State. Information derived from any such program may be disclosed (A) in summary, statistical, or other form, or (B) for clinical or research purposes, but only if the identity of the individuals diagnosed or provided care or treatment under such program is not disclosed.

Reporting Requirements

Progress reports which include results data pertinent to numerically measurable objectives and activities related to their achievement may be required on a quarterly basis 30 days after the end of each quarter (with the fourth quarter report including a summary of the year's activities) subject to clearance by the Office of Management and Budget. Annual financial status reports are required no later than 90 days after the end of each budget period. Final financial status and performance reports are required 90 days after the end of a project period.

Recipient Financial Participation

This program has no statutory cost sharing formula. No specific matching funds are required; however, the application should include data on the applicant's contribution to the overall program costs.

Guidance—Content of Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions

The current lack of therapeutic or vaccine methods to control the spread of HIV infection and AIDS requires the promotion of sexual and lifestyle behaviors for individuals which will reduce their risk of acquiring and spreading the virus. Behavioral science research suggests that expecting people to permanently alter any set of behaviors affecting their health is unrealistic unless the educational message provides acceptable alternatives to the behaviors creating the risk. Consequently, AIDS risk reduction efforts have focused on the promotion of responsible sex practices for individuals such as gay and bisexual men, for whom sexual activity is an important factor of risk in acquiring or spreading HIV.

The adoption of "safer sex" practices is a practical concept of AIDS risk reduction and is being suggested as a strategy intended to minimize the spread of HIV infection among sexually active individuals, including gay and bisexual men. The promotion of a "safer sex" risk reduction strategy may involve supporting the communication of suggestions using candid terms, some of which may be offensive to society at large. The Centers for Disease Control (CDC) is answerable for the use of Federal funds and broad support is vital to its public health mission. CDC also has an obligation to take actions designed to control the spread of HIV. This guidance is meant to promote such actions, and to require local review panels to consider the bounds of explicitness believed needed to communicate an effective message to those for whom it is intended.

1. Basic Principles

a. Language used in written materials (i.e., pamphlets, brochures, fliers), audiovisual materials (i.e., motion pictures and video tapes), and pictorials (i.e., posters and similar educational materials using photographs, slides, drawings, or paintings) to explain "safer sex" practices and/or to contrast them with "unsafe sex" practices concerning AIDS should use terms or descriptors necessary for the target audience to understand the messages.

b. Such terms or descriptors used should be those which a reasonable person would conclude should be understood by a broad cross-section of educated adults in society, or which when used to communicate with a specific group, such as gay men, about

high risk sexual practices, would be judged by a reasonable person to be unoffensive to most educated adults beyond that group.

c. The language of items in questionnaires or survey instruments which will be administered in any fashion to any persons should use terms to communicate the information needed which would be understood by a broad cross-section of educated adults in society but which a reasonable person would not judge to be offensive to such people.

d. Educational group sessions of any size should avoid activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

2. Program Review Panel

a. Prospective cooperative agreement recipients will be required to establish a program review panel whether the applicant plans to conduct the total program activities or plans to have part of them conducted through subvention to nongovernmental organization(s). This panel, guided by the CDC Basic Principles (in the previous section) in conjunction with prevailing community standards, will review and approve all written materials, pictorials, audiovisuals, questionnaires or survey instruments, and proposed educational group session activities to be used under the project plan. This panel is intended to review materials only and should not be empowered either to evaluate the proposal as a whole or to replace any other internal review panel or procedure of the local governmental jurisdiction. Specifically, applicants for cooperative agreements will be required to include in the application the following:

(1) Identification of a panel of no less than five persons representing a reasonable cross-section of the general community which might include members of existing AIDS service groups, but which is not drawn predominantly from the target population or groups to whom the written materials, pictorials, audiovisuals, questionnaires, survey instruments, or educational groups sessions are directed; and

(2) A letter or memorandum from the proposed project director, countersigned by the business office, which includes:

(a) Concurrence with this guidance and assurance that its provisions will be observed;

(b) The identity of proposed members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were

considered in their selection for the panel:

- b. When a cooperative agreement is awarded, the recipient will:
- (1) Convene the Program Review Panel and present for its assessment original copies of written materials, pictorials, and audiovisuals proposed to be used;
 - (2) Provide for assessment by the Program Review Panel draft text, scripts, or detailed descriptions for written materials, pictorials, or audiovisuals proposed to be used;
 - (3) Prior to expenditure of funds allocated to the ultimate program use of these materials, assure that their project plans are documented with a statement(s) signed by the Program Review Panel which itemizes their majority vote of approval or disapproval of all proposed written materials, audiovisual materials and pictorials submitted to them for assessment as part of the proposed project plan.
 - (4) Provide to CDC in progress reports a statement(s) of all members of the Program review panel itemizing their majority vote of approval or disapproval of all proposed written materials, audiovisual materials and pictorials needed during the quarter."

Applications

Special Guidelines for Application Preparation

Within the AIDS Prevention Project, HE/RR and CTS activities represent two distinct components. A single application shall be submitted, but a separate application narrative and budget request is required for each component for which assistance is requested. Applications which do not contain separate narratives and budget requests will not be evaluated and will be returned to the applicant. Award of funds will be on a consolidated basis. If applicable, the use of funds awarded for the CTS component of this program may be restricted until funds awarded in existing HIV Counseling and Testing cooperative agreements are exhausted.

Application Content

Compliance with Program Review Panel Requirement

Applications which include written materials, pictorials, and audiovisuals related to AIDS risk reduction for use with HE/RR activities or with the operation of counseling and testing sites must contain the documentation required in paragraph 2.a under the part of this announcement entitled "Content of Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey

Instruments, and Educational Sessions. Applicants for continuation HE/RR and for competing CTS funding that have previously complied with this requirement need only include an assurance that the role of the Program Review Panel continues to be in accordance with paragraph 2.a.

b. New Applications—AIDS HE/RR Component

A competing application for the HE/RR component of this program for a new project period must also include:

- (1) The background and need for project support, including the total number of AIDS cases reported since June 1981 that meet the CDC surveillance case definition, and information that relates to factors by which the application will be evaluated;
- (2) Process objectives for the developmental phase of the proposed project which are consistent with the purpose of the cooperative agreement, address Recipient Activities a-f, and are measurable and time-phased;
- (3) A plan of operation for the developmental phase with proposed milestones for assembling baseline data to define the problem, establish specific, numerically measurable HE/RR objectives, and develop plans for carrying out Recipient Activities g-m involving program implementation and evaluation;
- (4) A description of how program activities are fully coordinated with other AIDS cooperative agreement activities;
- (5) A budget and accompanying justification which is consistent with the purpose, objectives, and plans for this component of the project and which estimates the amount of resources to be devoted to information/education activities directed at the general public, including school age children; to health education/risk reduction activities directed at high-risk group members; and to training activities; and
- (6) Any other information that will support the request for assistance with this component of the project.

c. Continuation Application—AIDS HE/RR Component

An application for continued funding of the HE/RR component of this program should also contain the following information:

- (1) A progress report on activities of the prior budget period and results thus far in terms of measured changes from the baseline levels of knowledge, attitude, or behavior among AIDS risk groups, health care providers, and the general population;

(2) Short-term HE/RR objectives for the new budget period which are realistic, specific, numerically measurable, and time-phased and establish the expected changes that program efforts will produce relative to either the original baseline levels of knowledge, attitude, or behavior among AIDS risk groups, health care providers, and the general population, or to subsequent levels established through data gathered to measure progress;

(3) A description of the method of operation that will be used to accomplish any new HE/RR objectives or objectives which set target levels 10 percent higher or lower than for the previous year and/or what was actually achieved during that period;

(4) A description of any budget period plans for carrying out Recipient Activities g-m involving program implementation;

(5) A description of how program activities are fully coordinated with other AIDS cooperative agreement activities; and

(6) A budget and accompanying justification consistent with the purpose and HE/RR objectives of the project and which estimates the amount of resources to be devoted to information/education activities directed at the general public, including school age children; to health education/risk reduction activities directed at high-risk group members; and to training activities.

d. New Applications—AIDS CTS Component

A competing application for the CTS component of this program for a new project period must also include the following:

(1) A progress report on HIV antibody counseling and testing activities, including outreach activities directed at the referral of sex and needle-sharing partners for testing and counseling services, and the results achieved to date;

(2) The background and need for project support, including the total number of AIDS cases reported since June 1981 that meet the CDC surveillance case definition, and information that relates to factors by which the applications will be evaluated;

(3) The objectives of the proposed project which are consistent with the purpose of the cooperative agreement and which are realistic, specific, numerically measurable, and time-phased;

(4) The methods and activities which will be undertaken to accomplish the objectives;

(5) The methods which will be used to evaluate the success of the project;

(6) A description of how program activities are coordinated with other AIDS cooperative agreement activities;

(7) A budget and accompanying justification consistent with the purpose and objectives of the project and which estimates the amount of resources to be devoted to information/education activities directed at the general public, including school age children; to health education/risk reduction activities directed at high-risk group members; and to training activities; and

(8) Any other information that will support the request for assistance.

Review and Evaluation Criteria

1. New Applications—AIDS HE/RR Component

A competing application for the AIDS HE/RR component of the program will be reviewed and evaluated according to the following criteria:

a. The justification for funding as set forth in the statement of background and need for support;

b. The applicant's understanding of AIDS prevention activities and the purpose of the cooperative agreement as described in Recipient Activities a-m;

c. The quality of the applicant's developmental plan and process objectives to assess community needs and resources and to define the problem by determining the baseline seroprevalence of HIV infection and the baseline prevalence of AIDS knowledge, attitudes, and behaviors related to AIDS among risk groups, health care providers, and the general population, as described in Recipient Activities a-d;

d. The establishment of HE/RR objectives that meet the criteria set forth in Recipient Activity e;

e. In the applicant's comprehensive program plan in Recipient Activity f, evidence of a commitment to identify and coordinate program activities with existing AIDS service groups, other community groups/organizations, and service delivery programs which are able to assist in reaching the various HE/RR objectives;

f. The quality of the applicant's proposed plan to develop a core capacity to carry out the AIDS HE/RR program, as described in Recipient Activities f and g;

g. The quality of the applicant's proposed plan regarding the implementation of a program of high quality AIDS (at minimum in conjunction with STD and substance abuse) education in the schools, and described in Recipient Activities h and i;

h. The quality of the applicant's proposed plan to coordinate program activities with other federally funded and privately supported efforts to combat AIDS, as described in Recipient Activity j;

i. The quality of an evaluation plan which specifies the method and instruments to be used, as described in Recipient Activities k-m;

j. The extent to which the budget is reasonable and consistent with the intended use of cooperative agreement funds;

k. The assurance that the confidentiality of all information obtained related to clinical laboratory results, medical, or counseling information on individuals and/or studies with personal identifiers will be maintained; and

l. The size, qualifications, and time allocation of proposed staff, a description of how the project will be administered, and availability of equipment and facilities to be used during the project.

2. Continuation Applications—AIDS HE/RR Component

A continuation application for the HE/RR component of the program will be reviewed and evaluated according to the following criteria:

a. The quality of the applicant's report of progress;

b. The extent to which the applicant's progress has been satisfactory in terms of:

(1) The assessment of community needs and resources;

(2) Definition of the problem through a determination of the baseline seroprevalence of HIV infection and baseline prevalence of AIDS knowledge, attitudes, and behaviors related to AIDS among risk groups, health care providers, and the general population;

(3) The establishment of specific, numerically measurable HE/RR objectives;

(4) The development of a comprehensive program plan described with evidence of an effort to work with existing AIDS service groups and to identify other community groups and organizations best able to assist in reaching the various HE/RR objectives and to maintain close collaboration and working relationships with such groups and organizations; and

(5) The development of a core capacity involving AIDS service groups, other community groups/organizations and service delivery programs to carry out the AIDS HE/RR program;

c. Evidence of satisfactory progress toward use of the core capacity, as described in Recipient Activity g;

d. The quality of the applicant's proposed plan regarding implementation of a program of high quality AIDS (at minimum in conjunction with STD and substance abuse) education in the schools, and described in Recipient Activities h and i;

e. The quality of the applicant's proposed plan to coordinate program activities with other federally funded and privately supported efforts to combat AIDS, as described in Recipient Activity j;

f. The extent to which the objectives for the new budget period are realistic, specific, numerically measurable, and time-phased and establish the expected changes that program efforts will produce relative to either the original baseline levels of knowledge, attitude, or behavior among AIDS risk groups, health care providers, and the general population or to subsequent data gathered to measure progress from the baseline levels;

g. The extent to which the plan of operation adequately describes methods that will be used to accomplish any new HE/RR objectives or objectives which set target levels 10 percent higher or lower than for the previous year and/or what was actually achieved during that period or describe any modifications in previous operational plans to reflect technological or methodological changes or adjustments needed to assure that HE/RR objectives are met;

h. The quality of an evaluation plan which specifies the method and instruments of measurement to be used, as described in Recipient Activities k-m;

i. The extent of which the budget is reasonable and consistent with the intended use of cooperative agreement funds;

j. The assurance that the confidentiality of all information obtained related to clinical laboratory results, medical, or counseling information on individuals and/or studies with personal identifiers will be maintained; and

k. The size, qualifications, and time allocation of proposed staff, a description of how the project will be administered, and availability of equipment and facilities to be used during the project.

3. New Application—AIDS CTS Component

A competing application for the AIDS CTS component of the project will be reviewed and evaluated according to the following criteria:

a. The justification for funding as set forth in the statement of background and need for support;

b. The patient response to counseling and testing sites established previously and the quality and extent of services provided;

c. The extent to which the stated objectives are consistent with the purpose of the program, and are realistic, specific, numerically measurable, and time-phased;

d. The capability of the applicant to effectively provide sensitive pre- and post-test counseling;

e. The feasibility of encouraging seropositive patients to refer their sex and/or needle-sharing partners by emphasizing that patients conduct such referrals and by making staff available to assist in notifying partners, if patients prefer, and the extent of commitment to carry out this process;

f. The soundness and potential operational impact of collaborative efforts between the health department and organizations in the community which provide services to members of groups at high risk for AIDS to carry out the counseling and testing site program;

g. The extent to which program activities are coordinated with other current CDC cooperative agreements for AIDS;

h. Whether the plan of operation communicates a sound approach to conducting and overseeing activities designed to meet project objectives;

i. The capability of the applicant to maintain public health facilities for the general public whose services to high-risk group members are appropriate and nonjudgmental and whose services are sought out by a reasonable number of such individuals from the community;

j. The capability of the applicant to carry out education and training activities to support HIV counseling and testing site activities;

k. The assurance that the Western blot or another appropriate secondary testing procedure is used to routinely process all specimens repeatedly reactive on ELISA;

l. The assurance that laboratories report reactive ELISA test results; and

m. The degree to which confidentiality of all records related to counseling, sex partner referral, and clinical laboratory test results will be maintained.

Application and Submission Deadline

The original and two copies of the application must be submitted to Chief, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control, 255 East Paces Ferry Road NE., Room 321, Atlanta, Georgia, 30305, on or before March 18, 1987.

1. **Deadline:** Applications shall be considered as meeting the deadline if they are either:

a. Received on or before the deadline date, or

b. Sent on or before the deadline date and received in time for submission to the independent review group. (Applicants must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or U.S. Postal Service. Private metered postmarks shall not be acceptable as proof of timely mailing.)

2. **Late Applications:** Applications which do not meet the criteria in 1. a. or b. above are considered late applications. Late applications will not be considered in the current competition and will be returned to the applicant.

Other Submission and Review Requirements

Applications are not subject to review as governed by Executive Order 12372, Intergovernmental Review of Federal Programs.

Where to Obtain Additional Information

Information on application procedures, copies of application forms, and other material may be obtained from Nancy Bridger, Grants Management Specialist, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control, 255 East Paces Ferry Road NE., Room 321, Atlanta, Georgia 30305, or by calling (404) 282-8575 or FTS 238-8575.

Technical assistance may be obtained from Willard Cates, M.D., M.P.H., Division of Sexually Transmitted Diseases, Center for Prevention Services, Centers for Disease Control, Atlanta, Georgia, 30333, telephone (404) 329-2552 or FTS 238-2552.

Dated: March 3, 1987.

William E. Muldoon,

Director, Office of Program Support, Centers for Disease Control.

[FR Doc. 87-4792 Filed 3-5-87; 8:45 am]

BILLING CODE 4160-10-M

NEW YORK STATE (ALBANY) COMMUNITY DEMONSTRATION PROJECT

DESCRIPTION

This community demonstration project for reducing the risk of acquiring AIDS focuses on a group of homosexual men in the semi-urban environment of the Capital District of New York. We argue that the low-case density area is the critical site for such a project and that the Capital District is of particular interest because of its proximity to New York City. In Phase I, we will enroll 300 men to participate in an in-depth interview in order to define current demographic, social, behavioral and sexual, and serologic features of the group. In Phase II (to run concurrently, but conceptualized as "the next step" for each individual) we will randomize individuals to study and control groups. The control group will receive the counseling and referral services, on an as-needed basis, that are currently available in this area. The study group will be invited to participate in a further exploration of their personal core networks, with referral of their social and sexual partners for participation in this study. It is anticipated that this will bring an additional 200 individuals into the study. Study group "contacts" will be asked to participate in the interview process, and they along with study group members will be provided with AIDS information and education. In this setting, there will be particular emphasis on the fact that the network of individuals is receiving the same information, with assurance that individuals are aware of their friends' awareness.

The study thus hopes to reach an estimated 10% of the homosexual community in this area. Three major measures are available for evaluation: (1) the level of HTLV-III positivity in the community; (2) the incidence of disease; (3) the knowledge, attitudes and risk-related practices of the group. It is proposed that the study run for a four year period, so that the influence of the risk reduction technique can be seen over a time period sufficient for a community to experience introduction of the virus, transmission and dissemination, and ultimately disease. The design permits evaluation of the extra effect that might be obtainable from a network approach, since it is neither possible nor desirable to restrain information acquisition by the control group. It is anticipated that the approach will furnish considerable information about the general structure of a homosexual community, about the personal core networks that contribute to such structure, about the rate of dissemination of HTLV-III virus in such a community, the degree to which behavioral norms can be modified, and the concomitant control of disease transmission.

NEW YORK STATE (NEW YORK CITY) COMMUNITY DEMONSTRATION PROJECT

DESCRIPTION

The Public Health Service has advocated provision of readily accessible HIV antibody testing to all members of AIDS risk groups as a means of reducing IV drug related, heterosexual and in utero transmission of HIV. The testing would necessarily include appropriate counseling and confidentiality safeguards.

In order to determine whether readily accessible HIV antibody testing would lead to significant IV drug related and heterosexual risk reduction it will be necessary to conduct a longitudinal study of persons at risk for these types of HIV exposure.

One objective of this demonstration project is to evaluate the effectiveness of readily accessible HIV antibody testing for current IV drug users who are not in drug treatment programs.

In order to meet this objective, a readily accessible alternative test site will be established in a high drug use area in Manhattan. Those IV drug users who express a desire for testing would be personally escorted to the alternate test site where they would receive education/counseling about HIV antibody testing (full informed consent would be obtained prior to testing). A blood sample would then be immediately drawn. The study would compare these subjects' HIV related behaviors and knowledge over the six months following their taking the test with those of IV drug users from the same area who decide not to be tested.

A second component to this project is to examine the utility of providing readily accessible HIV antibody testing to non-IV drug users who are at risk for heterosexual exposure to HIV (and therefore also at risk of transmitting the virus to other heterosexual partners or to newborn children). Two groups of subjects will be utilized in this part of the demonstration research: persons who do not inject drugs themselves, but are heterosexual partners of IV drug users; and heterosexuals who are highly sexually active and reside in a geographic area (New York City) in which the number of seropositive individuals creates a relatively high probability for heterosexual contact with HIV seropositive IV drug users and HIV seropositive bisexual men. These subjects will be recruited from couples in which one member is an IV drug user and from individuals attending a sexually transmitted disease clinic and a family planning clinic. This component will be funded by the AIDS Institute from its annual New York State appropriation for research studies.

While the primary purpose for each of the two components of the study will be to assess the utility of antibody testing for reducing AIDS risk behavior, the demonstration research will also provide important data on the potential rate of IV drug related, heterosexual and in utero transmission of HIV in the New York City area.

DALLAS HEALTH DEPARTMENT COMMUNITY DEMONSTRATION PROJECT

DESCRIPTION

Active Outreach

a. High Risk Groups

- i. To identify key opinion leaders in each of the target groups, or subgroups thereof and make contact with all those identified by the end of month 5, as evidenced by in-person meetings to discuss our program and HIV infection.
- ii. For each outreach worker to conduct four inservices or group presentations each month beginning in month 2.

b. Education in Schools

- i. To contact every public and private school system in Dallas County within the first three months regarding the procedure to provide HIV transmission information to students in grades 8-12.
- ii. To establish active discussion as evidenced by meetings with administration in 75% of the systems within the first six months.
- iii. To develop a procedure for HIV education in 80% of those districts within the first eight months.
- iv. To have HIV education provided in all those districts within ten months.

c. Partner Referral

- i. To immediately develop and incorporate in all counseling sessions a request for voluntary partner referral.
- ii. To design and implement during the first two months a partner referral card to be given to all counseling clients.
- iii. To identify during months three and four agencies that do HIV counseling and supply them with partner referral cards as needed.
- iv. To implement a study of the efficacy of partner referral in reinforcing the behavior of persons in sexual acquaintance clusters.

d. Mass Media/Counseling Promotion

- i. To develop a total of eight brochures on AIDS and HIV transmission for different target groups.
- ii. To develop a total of six posters on casual contact, risk behaviors of specific target groups and support for "playing safe".

- iii. To develop, produce, and show on commercial television two public service announcements.
- v. To design three billboards, each to be used in six locations for one month.
- vi. To produce one television program on a public access cable channel on HIV transmission.

Community Collaboration

- a. To participate in weekly AIDS-ARMS Network meetings and assist with evaluation of the case management system.
- b. To enhance the contract with the Oak Lawn Counseling Center to provide a skills attainment program.
- c. To seek assistance from various community agencies in executing plans developed by PRECEDE model below.

Planning

a. PRECEDE Model Building

- i. To complete the identification of behavioral messages for all the defined target groups within month 2.
- ii. To assign priorities to the target groups and to the behavioral messages within each target group during month 3.
- iii. To develop, during months 4-10, the predisposing, enabling and reinforcing factors for the high priority groups and messages by first drawing on our staff's knowledge and then refining the factors through discussions with risk group members and other knowledgeable persons.
- iv. To determine, as the factor lists are completed during months 6-12, the appropriate media and approaches and to complete the work plans.

b. Intergration of Programs

- i. To hold meetings twice a month with STD program managers.
- ii. To train all STD personnel in HIV counseling.
- iii. To incorporate TB skin testing into routine of HIV clinic by December, 1986.

Evaluation

HIV Survey

- a. To determine the prevalence and to estimate the incidence density of HIV infection in Dallas County.

- b. To determine the risk factors for HIV infection in Dallas County and develop a risk index.
- c. To evaluate interventions in terms of incidence reduction and alterations of risk associated behaviors.
- d. To serve as the basis for a vaccine field trial in the future.

Negative Cohort Study (homosexual men)

a. Objectives for Year 2:

- i. To incorporate the joint demonstration project risk behavior questionnaire into our counseling and testing clinic by October, 1986.
- ii. To develop a system of confidential record keeping and a recall system by October, 1986.
- iii. To complete study design by October, 1986.
- iv. To begin recruitment of HIV antibody negative homosexual men through our testing clinics in October, 1986.
- v. To design, test and implement a data entry system by November, 1986 and begin prospective data entry.
- vi. To initiate and maintain close contact with the CDC on study design, operations and analysis throughout the year.

b. Objectives for future:

- i. To estimate the incidence of new HIV infections in homosexual men.
- ii. To determine the risk factors for HIV infections in homosexual men and to participate in the development of a risk index with the other projects.
- iii. To evaluate our interventions in terms of incidence reduction and alterations of risk associated behaviors.
- iv. To serve as the basis for a vaccine field trial.

Risk of transmission model

- a. To complete initial model using 1985 syphilis case-contact pairs and AIDS rates by September, 1986.
- b. To expand model to include Hepatitis B, deaths due to intravenous drug abuse, and rectal gonorrhoea by December, 1986.
- c. To develop the capacity in the STD Division to key punch syphilis data by November 1986.

- d. To use the model to evaluate effectiveness of the intervention by monitoring the index of transmission.
- e. To identify census tracts in Dallas County with high probabilities of current and future HIV transmission in which to concentrate intensive surveillance and risk reduction efforts by October, 1986.
- f. To use the prediction model as a basis for an efficient sampling strategy for a community survey.

Cross Sectional Surveys

- a. To continue to perform behavior and risk factor surveys on persons volunteering for HIV testing and to analyze changes in behavior cross-sectionally for risk groups other than homosexual men.
- b. To count number of partner referral cards distributed and number returned.

DENVER COMMUNITY DEMONSTRATION PROJECT

DESCRIPTION

Development of educational materials and programs

- a. Brochures. Drafts of five updated brochures are currently in process. The topics include information pertaining to the (1) Seropositive Patient, (2) Seronegative Patient, (3) General Public, (4) Safe Sex, (5) HIV Testing. Examples of previous editions published by CAP are seen in Appendix 6.
- b. Posters. Several posters for buses, bathhouses, bars, and other public establishments are currently in process. Topics of posters include: (1) risk reduction and safe sex for populations at risk, (2) education of intravenous drug users and prostitutes, and (3) education of the general public.
- c. The post-test counseling information sheets for the Alternate Test Site were revised based on updated information.
- d. Other educational materials. Additional materials which are currently being planned include information about proper condom usage, and nutrition and exercise information for seropositive, asymptomatic individuals. Several inquiries were made between March 1986 and the present about production of and payment for educational video tapes. Pre and post-test counseling tapes from San Francisco were borrowed and reviewed as was an STD educational tape produced for CDC by the Educational Development Center of Newton, Massachusetts. Preliminary discussions with a local cable network, CAP, CDC, Seattle ACDP and Mildred Solomon from the Educational Development Center took place without final resolution, in part owing to the high cost of high-quality professionally produced tapes. Preliminary discussions about public service announcements have occurred.
- e. AIDS Information Service. In concert with ACDP, DCS is now expanding and improving its current educational services into a formal AIDS Information Service. This will provide phone call information service, epidemiologic updates, speakers bureau, and several different types of educational materials including brochures, journal reprints, and general media information (Appendix 6).
- f. Lectures and In-Services. Drs. Judson and Cohn gave approximately 40 lectures to various groups of health care workers during the first two quarters of 1986. In January, Dr. Judson, Peter Ralin, and other representatives from the gay/lesbian community and ACLU spoke at a forum on bathhouse regulations before about 300 people. Pat Gourley, as both CAP representative and ACDP employee gave 10 AIDS in-services to about 300 people in the first two quarters of 1986; these were directed toward both health care workers and gay men. Peter Ralin gave ten updates to 200 people and one larger in-service to the City

and County of Denver Department of Social Services. CAP had 28 speaking engagements with 840 people in the first quarter of 1986 and 35 engagements with 1200 people in the second quarter. These were mostly directed toward the general population, with about 10% directed toward high-risk populations. CAP runs many internal support groups and seminars, but the one most relevant to ACDP is an "HIV Information" group, held biweekly for individuals, mostly seropositive, who need additional counseling and follow-up. This has been run by Pat Gourley and Peter Ralin, and is attended by about ten men per session.

- g. Phone Services. DCS continues to handle a high volume of phone calls related to AIDS and HIV, 40-50/week at the main desk (not triaged further), 50-75/week at DMHC, and 50-100/week at the Alternate Test Site. CAP handles about 175 calls/week regarding AIDS and HIV information.
- h. General Media. Since August, 1985, Peter Ralin has published a biweekly column, "AIDS Update" in "Out Front", Denver's largest gay newspaper. Drs. Judson and Cohn had several interviews with local newspapers, TV, and radio, although not to the same extent as in 1985.
- i. Public School Curriculum. The incorporation of AIDS and HIV education into the Denver Public School curriculum and networking with other educational agencies will be pursued.

Seroprevalence studies

Continuation of previous seroprevalence studies now specifically incorporated into ACDP are as follows (Appendix 7):

- a. Denver Metro Health Clinic, June 1986 (Table 1).
- b. Vice Squad Referral to DMHC, first and second quarters (Table 2).
- c. DCS Alternate Test Site, first and second quarters, 1986 (Table 3).
- d. Intravenous (I.V.) drug user seroprevalence study, with analysis of data from three I.V. drug treatment centers in Denver (Table 4). This study was done in conjunction with Tom Novotny, EIS Officer assigned to the Colorado Department of Health. It will soon be submitted for publication and the abstract is included in Appendix 7.
- e. Belle Bonfils Blood Bank seroprevalence study, first and second quarters, 1986 (Table 5).
- f. Military recruits. Tim Dondero has agreed to supply Denver ACDP with seroprevalence data for military recruits in the Denver metro area by age, sex and race (Letter, Appendix 7).

Other Sexually Transmitted Diseases

First and second quarter, 1986 statistics for gonorrhoea (Table 1), syphilis (Table 2), and hepatitis (Table 3), by sexual preference and gender are seen in Appendix 8.

AIDS Surveillance

AIDS surveillance data from the first half of 1986 are seen in Appendix 9.

Cohort Study

Extensive discussions planning for the cohort study of gay men have occurred. A summary chart for the study is seen in Appendix 10. A physical exam and laboratory assessment form for seropositive patients is being drafted. Dr. Cohn is drafting an "Open Letter to the Gay Community" to encourage enrollment into the cohort.

Knowledge, Attitude and Belief Surveys

- a. Analysis of a three-year serial study of AIDS awareness and changes in sexual behavior at DMHC was completed in the second quarter of 1986 and was submitted for publication entitled "AIDS Awareness and Changes in Sexual Behavior in a Metropolitan Sexually Transmitted Clinic"; the abstract of the submitted manuscript is seen in Appendix 11.
- b. A survey of knowledge and risk factors in intravenous drug users was also performed as part of the intravenous drug use study referred to in Section E.3. Some of the data from this study is seen in Appendix 7.
- c. Physician survey - In the first quarter of 1986 with the cooperation of the Colorado and Denver Medical Societies, questionnaires were sent out to 3,600 physicians about AIDS awareness and HIV testing. A copy of this questionnaire is seen in Appendix 11 and data are currently being collated and analyzed.

SEATTLE COMMUNITY DEMONSTRATION PROJECT

DESCRIPTION

Longitudinal Gay Cohort Study

In September 1986, we will begin registering clients into a longitudinal gay cohort study previously described in our application of August, 1985 and in accord with the negotiations carried out during the January and June, 1986 site visits made by CDC staff to Seattle.

We will collect standard data on all consenting participants, including demographic data (see Appendix D) reason(s) for participating in the project, detailed information about previous health and symptoms of disease, directed physical examination data, and the standard attitude, belief, and intention survey data negotiated between the CDC staff and demonstration sites. (Our latest recommendations for this instrument are contained in Appendix D).

Recruiting cohorts and protecting data: Because of great concerns over potential misuses of "confidential" (as opposed to "anonymous") testing, heightened by recent Supreme Court and Justice Department decisions, we have negotiated a compromise with a consortium of leaders of the Seattle gay community around our earlier decision to request names and other identifying information from participants. This compromise will consist of allowing persons to participate in the study anonymously if they choose. We will offer both anonymous and confidential participation, carefully describing the pros and cons of each.

The identity of persons who choose confidential participation will be maintained in the fashion previously designed in cooperation with the gay community, using mother's maiden name and date of birth to identify the record. These data will be linked only on a computer disc with the patient identifying data. Additionally, the project has been granted a Certificate of Confidentiality from the National Institute for Drug Abuse (See Appendix E) which further safeguards against unauthorized accessing of client identifiers. We believe that a substantial proportion of participants in the program will be satisfied with these measures and will provide identifying information. Nevertheless, these protections are still viewed with skepticism by many leaders of the gay community whose support is important to the success of the project. Accordingly, we have agreed to offer participants both options. We hope that community review of our protocol for counseling, presently in draft form (Appendix F) will reassure them about the possibility of the Public Health Department applying "strong arm" tactics to push confidential (as opposed to anonymous project involvement and HIV antibody testing).

For those who choose anonymous participation, we will develop a means of assuring that follow-up visits data can be accurately linked to earlier visit data so that changes over time can be assessed. In addition, the community is helping us fashion means to assure high levels of follow-up.

A present suggestion is for the use of a "campy" name ("Marilyn Monroe", "Judy Garland", for example) to be given to participants registering in different months. Then six months later, we would advertise in prominent places for all Marilyn Monroes or Judy Garlands to return for follow-up assessment. Whatever method is chosen, the gay community leadership is committed to actively working to facilitate subjects' attendance for follow-up visits.

This strategy could actually enhance follow-up beyond that anticipated for the "confidential" track, and might have the effect of enhancing recruitment as well.

In trade for the offer of anonymous participation, the gay community leaders believe they will be able to enlist their community groups to enthusiastically endorse our AIDS prevention project. We believe such an endorsement is crucial to wide-scale community participation, at least to the point of data collection (as above) and one-on-one counseling. For reasons not entirely understood, however, the rates of testing in Seattle, both at the AIDS Assessment clinic at Harborview, and at the anonymous testing site at the Seattle Gay Clinic have fallen slightly in recent months. (Please see Appendix G for numbers of persons tested by site -- including the private sector -- since the inception of testing in the spring of 1985). This decline may represent saturation of persons wanting to be tested, rising concern over threats to civil liberties, or apathy towards AIDS or antibody testing.

We will evaluate the relative frequencies of enrollment and follow-up associated with confidential and anonymous testing at the end of the first year following initiation of the actual start of the study. We have insisted that if there is substantially less complete follow-up of persons anonymously tested, we will require the gay community leaders to renegotiate the strategy of offering both options.

Although some persons initially recruited for the gay longitudinal cohort study may not return as directed for the six-month follow-up, these persons' data will still be useful in the cross-sectional studies.

Our initial August, 1985 proposal suggested that we would ask only one in five persons to return for follow-up after one year. As a result of our site visits, we have agreed upon a six-month follow-up period, and that all persons will be asked to return. If the number of persons interested in participating are sufficiently large, we will have to rethink this strategy.

In the third quarter, basic advertising techniques were initiated for the purpose of informing the public about the Project's expanded capabilities. Those included ads in the gay and mainstream press, bulk mailing of moving announcements, descriptive articles on the Project's initial study and others (see Appendix H for examples of documentation). We propose to expand upon these outreach activities through further advertising, articles, radio and television public service announcements, brochure development and media contacts. This renewed effort will begin with the

open house and press introduction on August 22, 1986. In addition, referrals to the Project from private physicians will be encouraged by a series of activities aimed at informing them about the study through the King County Medical Society, the sentinel physicians group, waiting room posters, and training and consultation (see Appendix 1 for plans). The sentinel physicians, many of whom are members of the gay community themselves, have served a majority of persons with AIDS and ARC and can be expected to have a large proportion of gay persons at risk for HIV infection.

This advertisement will include the information that we are offering free physical assessment in addition to AIDS prevention (counseling, testing, etc.). All persons, whether or not tested will undergo a brief physical examination (looking for skin lesions, thrush, hairy leukoplakia, and enlarged lymph nodes, for example). High risk persons will be offered tuberculosis skin testing (in accord with recent CDC recommendations) and VDRL serology. In addition, we are expanding the capabilities of our facility to permit us to assess persons with symptoms or signs of sexually transmitted diseases and expect to have the ability to offer screening and vaccination (at cost) for Hepatitis B.

Once negotiations are complete with the gay community around anonymous testing, we hope to enlist the Seattle Gay Clinic as an additional site for study registration and initial participation. We have already made contact with owners and managers of several gay baths in Seattle and obtained their permission to station on their premises our personnel to enlist persons in the study with and without HIV antibody testing. We expect to begin using gay bath sites for study registration during August, 1986.

All persons will be counseled to consider referral of sexual partners to the project, as in our original proposal. Although this will be voluntary, we will place strong emphasis on the value of counseling for all sexually active gay men and especially for the partners of those men likely (or know through HIV testing) to be seropositive.

We have experienced that roughly half of the men already seen in our AIDS Assessment Clinic who wish to refer their partners are reluctant to contact them personally and would prefer to have us do so. Since this would require identifying information, we anticipate the need for extreme caution, lest we create concerns within the gay leadership causing them to withdraw their support. We will develop carefully worded letters of notification for those who would prefer to notify their partners by anonymous letter, rather than give us the names. Such letters will be coded so that we may assess the value of this approach.

We have developed a flow chart for AIDS Prevention Project services, to highlight and graphically display the options for gay cohort study involvement. (See Appendix U)

Cross-sectional studies:

As indicated above, all participants will initially be recruited for the longitudinal gay cohort study; however, because follow-up will not be complete, many of the cases can be considered as part of the cross-sectional studies.

We have previously proposed to obtain cross-sectional comparison data from control groups of heterosexuals attending our sexually transmitted disease (STD) clinic at Harborview. This will begin sometime after we complete the training of our new nurse practitioner and health educator (communicable disease investigator) staff, but well after we get the gay longitudinal cohort study going. Finally, we will need to negotiate and develop the appropriate data collection instrument with CDC investigators. We will attempt to begin the study within the current funding year.

Additional data of use in assessing sexual behavior of gay men and controls consists of numbers of persons presenting with other STDs (gonorrhea, syphilis, chlamydia, etc.). The STD Control Program routinely collects these data by sexual orientation (for clinic attendees and by anatomic site of infection for cases reported from the private sector). Appendix J contains a sample of these data for gonorrhea among males in the current funding periods and recent past.

Studies in IV drug abusers:

Although Leo Sanders' letter to Dr. Handsfield of June 9, 1986 suggests that we consider adding to the project a strategy aimed at preventing the spread of HIV among IV drug users and to their sexual partners and offspring, this strategy was already a part of our proposal of September, 1986. Only one of 214 Aids cases reported to date in Seattle/King County has so far had IV drug abuse as the sole risk factor; nevertheless, we are aware of additional seropositive IV drug users and are well aware of that source of spread as a growing concern on the East Coast and in West Coast cities to the south of us. Two initiatives have already been undertaken: First, we have developed guidelines (see Appendix K) for testing at other Department of Public Health clinics, including testing of pregnant women who may have been exposed through sexual contact to IV drug abusers (and bisexual men). Second, we have arranged to study seroprevalence among the 60-90 IV drug abusers who die each year and come to the attention of the Medical Examiner. (See Appendix L for the details of this study). In meetings with the King County Alcoholism and Substance Abuse Division, we have encountered great interest in AIDS issues, and willingness to allow us access to the drug treatment centers for client education and recruitment of study subjects.

In addition, the AIDS Project has recently moved into a facility part of which it will share tenancy with the Center for Addiction Services, a private agency providing services to intravenous drug abusers. This proximity will afford us valuable opportunities for developing future studies among needle sharers and other substance abusers.

Remaining to be done are: creation of appropriate data collection instruments and development of educational strategies.

Population-based studies:

In our previous application, we mentioned the possibility of working with Drs. Blumstein and Schwartz of the University of Washington's School of Sociology. Through funding from the Centers of Disease Control, they have begun a pilot study to look at the feasibility of obtaining population data on behaviors and attitudes related to AIDS. Because this is only a pilot study, however, too few data will be collected to be of substantial use in estimating true prevalences of behaviors and attitudes among the risk (or control) groups of interest.

We are proposing in the supplemental funds section (below) doing a population based seroprevalence survey in the two King County hospitals of Group Health Cooperative, a large health maintenance organization serving about 350,000 persons in the Puget Sound area. This study is patterned after a request for proposals issued earlier this year by the Centers for Disease Control to look at prevalence of HIV infection within the general community.

CHICAGO COMMUNITY DEMONSTRATION PROJECT

DESCRIPTION

The educational and risk reduction education programs will proceed in three phases. The first phase of the program will consist of Data collection and analysis to determine seroprevalence of antibodies to HTLV-III among selected risk groups as well as the general population and to assess knowledge and attitudes regarding AIDS among both the general population and populations at increased risk for AIDS.

The second phase will consist of the outreach and educational programs themselves. Educational programs and materials will be targeted toward several selected populations at risk as well as to the larger low-risk population. Obviously, the content and purpose of the materials will vary depending upon the target audience. In addition to the general population, educational materials and programs will be targeted to homosexually and bisexually active men, IV drug users, female prostitutes, and "street people". The term "street people" includes homeless and runaway adolescents, some female prostitutes, IV drug users, and indigent minorities. It is expected that this heterogeneous group will include persons who engage in risk behavior but who are either unaffiliated with existing networks within risk populations or do not self-identify as a member of a risk group. These individuals will not be reached with risk reduction information that relies solely on existing mechanisms for its distribution.

An important component of all educational programs will be outreach to minorities, both within the populations at risk and the larger population. There are specific components designed to promote these programs among Chicago's large, and largely disadvantaged black population. In addition, educational materials will be available in both English and Spanish, to facilitate access by Chicago's large Hispanic community.

Finally, the educational programs will be evaluated as to their effectiveness in improving understanding of the syndrome as well as in eliciting desired behavioral change. The ultimate goal of risk reduction education is to slow the spread of HTLV-III infection, as will be measured through a decrease in the seroconversion rate. However, a more immediate means to evaluate the effectiveness of the educational programs is through repeated surveys of the selected populations to reassess knowledge and attitudes toward the syndrome and frequency of potential HTLV-III transmitting and receiving behaviors among persons at various levels of risk. This will be accomplished through immediate evaluations of specific materials as well as through general knowledge and behavior assessments repeated regularly throughout the study period.

LONG BEACH HEALTH DEPARTMENT COMMUNITY DEMONSTRATION PROJECT

DESCRIPTION

Groups targeted for community health education

Individuals presenting for HIV testing at the city's two sites (The Center; LBHD), including gay, bisexual, and straight males and females, and IV drug users.

Gay males who have been HIV-antibody tested, who fall into specific subgroups, and who qualify for inclusion in health education/behavior change groups:

- a. Seropositives (The Center)
- b. Symptomatic seropositives (The Center)
- c. Seronegatives (The Center)
- d. HIV testers in couples relationships (The Center)

Other homosexual males, including bisexual males who identify with the gay community, for whom interventions will be developed and tested for presentation at the following sites or for whom specific programs will be developed, sites yet undetermined:

- a. Gay churches (CSULB).
- b. Gay student unions on college campuses (CSULB), with subsequent years; activities to be directed at homosexual adolescents.
- c. Gay-identified Alcoholics Anonymous groups (CSULB), with subsequent years' activities to be directed towards community and agency-based programs.
- d. Bars, restaurants, and businesses frequented by gays (LBHD)
- e. Black and Hispanic gay males (CSULB)
- f. Male prostitutes (LBHD)
- g. Males who frequent X-rated movies, "adult" bookstores, etc. (LBHD)
- h. STD Clinic patients (LBHD)

Intravenous drug users and their partners

- a. Gay-identified Narcotics Anonymous groups (CSULB), with subsequent years' activities to be directed towards community and agency-based programs.
- b. Hospital-based substance abuse programs (CSULB)

- c. STD Clinic patients (LBHD)
- d. IV drug users in in-patient programs (CSULB), health department programs (LBHD), and community programs (LBHD).
- e. Female sexual partners of IV drug users (CSULB; LBHD).
- f. Male sexual partners of IV drug users (CSULB; LBHD)

Heterosexual males (including bisexual males who identify predominantly with the heterosexual community):

- a. Those accessed through above intervention activities such as substance abuse programs, STD clinic, patrons of bookstores, movies. (CSULB; LBHD)
- b. General population of college students (CSULB)
- c. General population of adult males: employed, unemployed and collecting benefits; and street people (LBHD).

High-risk women:

- a. Low-income female patients of obstetrical/gynecological clinics at Harbor/UCLA Medical Center, including many likely to transmit AIDS to their infants (UCLA).
- b. Female sexual partners of bisexual men (CSULB; LBHD).
- c. Female prostitutes (LBHD).
- d. Women attempting "informal" artificial insemination (LBHD).

Women less at risk in the public's view:

- a. Women becoming sexually active, such as students, young women with subsequent years' activities directed toward adolescents (CSULB).
- b. Newly separated/divorced/widowed women (LBHD; CSULB).
- c. Patients of Women/Infant/Child Clinic and other public treatment facilities within the city (LBHD).
- d. Women in the general college population (CSULB).
- e. Women in the general population (LBHD).

Health care and social-service personnel:

- a. Physicians and other health-care professionals who work with any of the above groups (LBHD; UCLA).
- b. Staffs of human-service agencies which work with any of these groups, including those which refer these groups to other services (LBHD).

3. THE AIDS/SCHOOL HEALTH PROGRAM

The CDC has also begun a nationwide project of assisting schools in developing AIDS education and prevention programs. Through its Office of School Health at the Center for Health Promotion and Education, it collects a database which can be accessed by computer. It further maintains and evaluates a collection of educational materials (printed and audiovisual).

The following pages summarize these activities.

Two school curricula (one from Indiana, the other from California) are attached in full to the present report.

AIDS School Health Education Subfile on the COMBINED HEALTH INFORMATION DATABASE

The Combined Health Information Database (CHID) is a computerized bibliographic database of health information and health education/health promotion resources developed and managed by the U.S. Public Health Service. CHID contains subfiles on arthritis, diabetes, digestive diseases, and high blood pressure from the National Institutes of Health; health information (Healthfinder series) from the Office of Disease Prevention; patient education from the Veterans Administration's Patient Education Network; and health education from the Centers for Disease Control (CDC). The CDC is now adding an AIDS School Health Education subfile as part of CHID.

The AIDS School Health Education subfile contains programs, curricula, guidelines, policies, regulations, and materials. Anyone wishing to share information on this topic would submit the AIDS School Health Education information to the

Centers for Disease Control
Center for Health Promotion and Education
Division of Health Education
Attn: AIDS School Health Education Subfile
Atlanta, Georgia 30333

or call

404/329-3492, FTS 236-3492 or 404/329-3824, FTS 236-3824

If a person or organization wishes to search CHID to locate AIDS School Health Education information, the person should request a password from BRS Information Technologies (Telephone 800-345-4277 or write BRS, 1200 Route 7, Latham, NY 12110). There is no charge for obtaining a password, but searches you conduct from your telecommunicating computer terminal will be billed to you through your password. The cost per hour for searching depends on the BRS search service you use (BRS Afterdark, BRS Colleague, BRS BRKTHRU, or BRS full service). At this time these search services range from \$10 to \$45 per hour, but search charge rates are continuing to decrease. Training on bibliographic database searching is offered in most cities and regionally by BRS, by other bibliographic database companies, and by medical and other libraries. For information about BRS training in your area, call 800-345-4277.

**Brief Description of the
AIDS/School Health Program**

CDC's AIDS/School Health program is administered by the Office of School Health, Division of Health Education, Center for Health Promotion and Education. The program, a mix of technical and financial assistance to existing education agencies and organizations, is designed to help youth, school and college populations receive information about AIDS and how to prevent infection with the AIDS virus. To accomplish this goal, the program will implement the following broad actions:

1. CDC will work in collaboration with national education and health organizations to convey accurate information about AIDS and AIDS education to educators and others who must determine the most effective and appropriate strategies to teach youths about AIDS.
2. Relevant national private-sector organizations will be assisted in helping schools and colleges across the Nation provide effective education about AIDS. A national coalition for school health education about AIDS will be established to help relevant public and private-sector organizations coordinate their respective activities.
3. State departments of education will be assisted to work with State departments of health to ensure that accurate information about AIDS is provided by each school; and to help local education agencies implement programs of AIDS education that are appropriate to the student's stage of development and acceptable within the community.
4. Local departments of education in cities with the highest cumulative incidences of AIDS will be assisted to work with local health departments and other agencies that serve youth to assure that accurate information about AIDS is provided for youths at the appropriate stage in their development and that such programs are acceptable within the community.
5. Departments of education in several cities and one State with high cumulative incidence of AIDS will be assisted to develop a regional training/demonstration center. Support will be provided for representatives from other cities and States to attend the training demonstration centers to learn about the most appropriate and effective programs for young people who attend, and who do not attend, schools and colleges in their respective jurisdictions.
6. A compendium of information about AIDS-related educational materials and programs will be developed to assure that educators and others who must determine the most appropriate and effective educational methods to teach youths about AIDS have a wide range of educational options from which to choose.
7. Results of research relevant to school health education about AIDS will be compiled, synthesized, and disseminated. Relevant national, State, and local agencies will be assisted to assess the effects of their efforts.

Further information about the program can be obtained by writing or calling Jack T. Jones, Public Health Advisor, Centers for Disease Control, Division of Health Education, 1600 Clifton Rd., N.E., Atlanta, Ga. 30333, Phone: 404-329-3824.

THE FEDERAL INFORMATION/EDUCATION PLAN

While the recommendations of the Surgeon General and the National Academy of Sciences quoted above are waiting to be fully implemented, the federal government has taken another important step by publishing a comprehensive Information/Education Plan to Prevent and Control AIDS in the United States.

This very recent publication of March, 1987, is undoubtedly the most informative federal document relating to the American AIDS prevention efforts. It involves not only the Centers for Disease Control but also all other relevant federal organizations from the Public Health Service and the National Institute on Drug Abuse to the National Institutes of Health and the Food and Drug Administration.

The plan carries a forward by the Secretary of Health and Human Services, Dr. Otis R. Bowen, and incorporates some suggestions made on the level of President Reagan's cabinet.

Because of its enormous importance and model character, the plan is attached in full to the present report. All necessary details about the scope, intent and methods of implementation are contained in this booklet and therefore do not have to be repeated here. Still, it seems useful to reprint at least the executive summary on the following pages:

AIDS

Information/Education Plan to Prevent and Control AIDS in the United States

March 1987



U.S. Department of Health and Human Services
Public Health Service

EXECUTIVE SUMMARY

As of March 2, 1987, deaths in the United States due to acquired immunodeficiency syndrome (AIDS), total almost 18,385. In 1985, AIDS became the 11th leading cause of years of potential life lost, and in 1986 it is expected to be eighth. The report of the Public Health Service (PHS) Coolfont Conference in June 1986 projected that by the end of 1991 the cumulative total of AIDS cases would exceed 270,000, with more than 179,000 deaths. AIDS will remain a serious problem for the nation for some time to come.

At this time, the best hopes for prevention rest on a strategy based on public information and education. Knowledge about AIDS has already proved to be effective in changing behavior among homosexual men.

The 22 Public Health Service (PHS) Guidelines on the prevention of AIDS issued between 1982 and 1986 have provided a foundation for informational and educational efforts to prevent this disease (see Appendices A & B). The Public Health Service Plan for the Prevention and Control of AIDS (1985), the Report of the PHS Coolfont Conference (1986), and the Surgeon General's Report on AIDS (1986) all focus on developing information, education, and risk reduction programs.

Successful implementation of this plan requires action from and cooperation among State, county, and municipal governments, professional and services organizations, the private sector, and the Federal Government. It is expected that funds appropriated by Congress in any given year for information and education will be multiplied manyfold by the efforts and resources of others.

The information/education effort consists of four major components:

1. The Public

Everyone must be aware of behavior that puts them at risk of infection.

2. School and College Aged Populations

Schools and colleges provide an effective channel for appropriately instructing the young people of our nation about AIDS before, and as, they reach the ages that they might engage in behaviors that place them at risk of infection. The Public Health Service will provide national, State, and local educators with up-to-date, factual AIDS information. State and local school boards, along with families, community, and parent groups have the primary responsibility for educating the young.

3. Persons at Increased Risk or Infected

The highest priority for AIDS information and education efforts are those groups at increased risk of acquiring or transmitting the AIDS virus because of certain behaviors or circumstances: gay and bisexual men, IV drug abusers, hemophiliacs, female sex partners of those at risk and who may become pregnant and infect their offspring, and prostitutes and their clients. Persons known to be infected must receive information to prevent their transmission of the virus to others.

4. Health Workers

Members of this group have direct responsibility for patient care, for counseling AIDS patients or persons with laboratory evidence of infection, and for providing leadership in informing and educating the public. By virtue of their occupations, there is some risk, albeit small, of infection.

Following are examples of some of the major projects included in the PHS plan:

The Public.

- Produce a mass media campaign under contract with a leading advertising agency (TV and radio spots, print materials).
- Form a coalition of public and private sector groups to exchange and coordinate AIDS information efforts.
- Set up a clearinghouse on AIDS information to serve State and local AIDS program personnel and the public.
- Support toll-free hotline on AIDS (since 1983).

School and College Aged Populations.

- Convene national school health coalition on AIDS and work with national organizations.
- Stimulate the development of programs for Black and Hispanic youth.
- Help State education departments and colleges of education provide AIDS education.
- Work with State and local areas with highest incidence of AIDS to assist in providing educational programs in schools.
- Develop compendium of materials, programs and resources; instruments to measure quality and outcomes of this education.
- Help provide AIDS education to college students, assist especially in areas where AIDS incidence is high, work with other groups to reach youth not in school.

Persons at Increased Risk or Infected.

- Demonstrate effective ways of educating those at increased risk.
- Help States build their own capacity for conducting programs (counseling, health education, minority programs, hotlines, coordination).
- Expand drug abuse treatment services, counseling, and antibody testing and develop new strategies for preventing and treating drug abuse.
- Add educational programs to regional hemophilia centers.
- Provide information on behaviors that reduce perinatal transmission of the AIDS virus.
- Demonstrate effective programs to reduce perinatal transmission.

Health Workers.

- Survey physician counseling practices and develop appropriate materials.

- Train physicians and other health workers through training center programs and out-reach programs.
- Provide information and materials to professional organizations.
- Provide training in up-to-date laboratory techniques.
- Educate health professionals to assess women and counsel them, including minority women.

In June 1986, the Public Health Service convened some 85 experts on AIDS to update PHS plans for the prevention and control of the disease in light of new knowledge and of demographic projections through 1991. A major section of the final report from this Coolfont Planning Conference dealt with needed AIDS information and education initiatives. The information/education plan summarized here responds fully to these recommendations.

FEDERAL POLICY ON HIV-ANTIBODY TESTING

As soon as HIV-Antibody testing became available, it was widely recommended by federal authorities, including those at the Centers for Disease Control. However, from the beginning, they also insisted on two conditions for the test: (1) voluntariness and (2) confidentiality.

There was a general consensus that mandatory testing, the marking of those testing positive or any other resulting discrimination, would undermine the entire prevention effort and thus pose an additional threat to public health.

This consensus was illuminated and supported in two major conferences held at the CDC in Atlanta, Georgia. The results of the first conference (March, 1985) were published under the title Guide to Public Health Practice: HTLV-III Screening in the Community. The most important recommendations of this guide were the following:

RECOMMENDATIONS

1. The HTLV-III antibody test is not a test to diagnose Acquired Immunodeficiency Syndrome (AIDS).
2. The HTLV-III antibody test is a useful tool that can assist in protecting the nation's blood supply, and is a valuable test to assist research efforts into the AIDS problem.
3. At the present time, the HTLV-III antibody test has extremely limited utility for purposes other than stated above, and is not a useful screening test for AIDS. The test does not have applicability except in specific medical circumstances. The HTLV-III antibody test should not be used for generalized screening or as a precondition for employment, evidence of insurability, or admission to school or the military.
4. Because of the serious potential for harm to the individual resulting from the HTLV-III antibody test results, great care must be taken to inform the public and health care professionals about limitations in current understanding of the test results and of the entire disease process labeled Acquired Immunodeficiency Syndrome.
5. Information gathered from the testing or counseling of individuals should be kept strictly confidential.
6. State and local health departments, working in concert with the private medical and hospital communities, university systems, blood banks and plasma centers should establish a network and referral system (where not previously established) of physicians and other health care providers with expertise in dealing with AIDS.

The entire publication is attached to the present report.

A second, much larger conference addressing the same issue, was held in February, 1987, also at the Centers for Disease Control in Atlanta, Georgia. This conference, the results of which have not been published, again confirmed the longstanding consensus and firmly rejected mandatory or mass testing as unsuitable methods of fighting AIDS.

In the absence today of an official conference report, the following pages offer some journalistic summaries:

Feb. 26, 1987

Questions About Widespread Testing

Big Issues, Big Crowd at AIDS Talks

By Randy Shilts
Chronicle Correspondent

Atlanta

When the national Centers for Disease Control said three weeks ago that it would convene a conference to study the wider use of the AIDS antibody test, it expected a collegial gathering of 200 health officials.

Instead, 900 health officials, AIDS doctors and gay leaders converged on Atlanta for the meeting this week, followed by reporters from more than 100 news organizations.

As CDC spokesman Don Berth dodged television camera crews yesterday, he said, "This definitely isn't what we imagined. People have gone crazy over the testing issue."

The CDC conference came as a number of events — including the death of pianist Liberace — have conspired to push the 6-year-old AIDS epidemic to the forefront of national consciousness. There is also increased awareness of the threat the AIDS epidemic poses to heterosexuals.

Despite the brouhaha, Dr. James Curran, director of the CDC's AIDS Activities Office, cautioned that the gap between proposing pol-

icies and putting them into action has often been vast and insurmountable.

The conference's recommendations, issued yesterday, contained a new resolve toward wider use of the AIDS test, and further proposals that might keep that resolve stalled in the realm of ideas.

"These are ideas we have been discussing for two years," says Curran. "What will be crucial in the coming months is whether they continue to be just that — ideas."

Only one issue seemed settled. Virtually every significant health official in the nation opposes mandatory AIDS testing.

CDC officials' suggestions that the test might be required for people applying for marriage licenses were widely criticized as too costly and unlikely to do much to halt AIDS. CDC officials then denied ever seriously considering such an option.

"That trial balloon got blasted totally out of the sky," said Dr. David Werdegard, San Francisco's director of public health.

Conference workshops agreed on a number of other key issues that face a contentious future:

- All people seeking treatment at venereal disease clinics or drug centers should be encouraged to be tested as part of routine procedure.

- The test should be routinely offered to all pregnant women seeking prenatal care in clinics or at obstetricians' offices. Those in high-risk groups, such as intravenous drug users, would be a special focus.

- Women of child-bearing age should be routinely tested at family planning centers so that women infected with the AIDS virus can be advised on "options" they can take to avoid bearing an AIDS-infected child.

- Federal and state health officials should "be in the forefront" of those demanding both strict guarantees of confidentiality of AIDS test results and legislation banning discrimination against people infected with the virus.

- Because AIDS testing has been found to have a profound psychological effect on people who are infected, all the workshops agreed that any attempt to encourage more widespread testing be accompanied with extensive counseling programs.

Federal AIDS researchers want wider use of the antibody test. Testing, they argue, can allow them to determine how far the AIDS virus has penetrated into America. Health officers also believe testing will help them thwart the spread of the disease.

The recommendations do not have the force of policy. However, they will be written into a report that ultimately will be used to formulate national recommendations for state and local health agencies. These guidelines are expected to be influential in establishing policy throughout the country.

It is on two key points — counseling, and legislation to assure confidentiality and avoid discrimination — that the momentum for wider antibody testing might stall. Ironically, the most significant impediment to the federal government's desire for wider AIDS testing may be the federal government itself.

For example, a number of local health officials indicated they would not pursue aggressive testing unless the counseling component was in place. However, counseling is costly, and local and state health agencies say that they will need federal funds to pay for it.

CDC spokesmen concede that they do not have the funds to finance the counseling in either this year's budget or the proposed CDC budget for the next fiscal year.

"Getting money is not an easy process," said Dr. Walt Dowdle, the deputy CDC director in charge of AIDS.

Most health authorities involved with the fight against AIDS also acknowledge that testing will not become common until people do not have to worry that they will lose their jobs or insurance if they test positive for the AIDS virus. However, legislation assuring AIDS test confidentiality and banning discrimination may also be politically unfeasible.

For example, CDC director Dr. James Mason said he would propose such federal legislation, but he acknowledged he may not find support within the Reagan administration. The Justice Department ignored CDC opinions last year when it issued a ruling saying discrimination against AIDS sufferers did not violate the law.

"We try to provide advice as to what would best promote sound public health policy, but we are not always heeded," Mason said yesterday.

On the state level, the movement also goes against the stringent safeguards of confidentiality that public health officers support. A number of legislatures, including California's, are considering bills to require AIDS testing and allow the release to public health agencies of names of those infected with the virus.

Perhaps the most explosive issue involves the testing of women at prenatal clinics.

"Nobody wants to use the word abortion, but that's what we're really talking about here," said Dr. Sheldon Landesman of the Downstate Medical Center in Brooklyn. "We're going to be telling women who are infected that they should consider

aborting their fetus. That has a lot of social implications."

The issue is particularly painful for family planning centers that already are being criticized for informing women of the option to abort for other reasons. As one doctor active in family planning groups said, "This is one new problem we don't need."

Meanwhile, gay groups remained critical of AIDS testing plans, saying the federal government is not providing enough money for research and treatment although it is considering costly widespread AIDS testing.

"This is another round of public health puntting," said Michael Callen of the National Association of People With AIDS. "They throw out a crazy idea like mandatory testing and kick it around. While they debate the finer points of premarital testing, we're on the roller coaster of suffering. We need more attention to basic issues of treatment and research."

Taken together, such complexities frequently have left AIDS policy mired in indecision and inaction. As the conference closed yesterday, some experts warned that procrastination may no longer be tolerated by a society that appears to be awakening to the AIDS epidemic.

"We're going to see a huge onslaught of pressure to do wider testing," said Dennis Birmhall, associate director of the University of California at San Francisco Medical Center. "If we think we can brush away the issue of testing because we don't think we can provide enough counseling, we're living in a fool's paradise ... There's a different mood out there."

New York Times, March 1, 1987

A New Strategy Against AIDS

Homosexual rights groups and television crews streamed into Atlanta last week to eavesdrop on a meeting convened by the Federal Centers for Disease Control. What drew the crowds were suggestions that the agency was preparing to advocate mandatory testing for the AIDS virus, which homosexual groups intensely oppose.

Public health officials have almost no weapons but the AIDS antibody test to combat the deadly disease, and the agency wanted to hear their views on how the test might best be used. Despite disruptions, the tension between the two groups gradually ebbed: the health officials made clear they want wider voluntary use of the test, but are almost unanimously opposed to mandatory testing.

From the Atlanta meeting emerged a new public health strategy against AIDS, but one that requires the Reagan Administration to reverse course and provide the necessary legal framework.

□ **Mandatory testing.** With no cure or vaccine for AIDS, the only way to prevent spread of the virus is to persuade people to change behavior. The test for antibody to the AIDS virus has proved effective in screening blood donations. Why not make the test mandatory at hospitals and V.D. clinics so that carriers can be identified and encouraged not to spread it? Because *mandatory* testing would frighten away those who most need to be reached. Unless confidentiality and freedom from discrimination can be better assured, those who test positive have reason to fear loss of housing, jobs and health insurance. Hardly a single public health official at the conference favored mandatory testing.

□ **Voluntary testing and counseling.** Almost all the authorities favor encouraging more people to take the test voluntarily, provided that it is purely an adjunct to counseling. Counseling, both before and after the test, is what seems most likely to

make people avoid high-risk behaviors. That's the rationale behind New York State's large new expansion of voluntary counseling and testing.

□ **Broad-based testing.** Is it worth encouraging voluntary testing for everyone? Probably not; screening the 37 million people admitted to hospitals each year would not be cost-effective. The 1.5 million Americans now estimated to carry the virus are predominantly homosexuals and intravenous drug addicts. Testing should be routinely offered, and informed consent obtained, at V.D. clinics and drug treatment centers. Many health officers now consider it worthwhile to trace and offer counseling to the sexual partners of those who test positive.

Wider counseling and testing could save many lives. But it has little chance of being fully effective without firmer assurances of confidentiality and guarantees against discrimination. State laws that provide such protections are not always enforced. Instead of setting an example, the Justice Department last June *denied* AIDS carriers the protection of the law shielding the handicapped from discrimination. It ruled that a Federal employer could cite fear of AIDS as a reason for dismissal. By repudiating that opinion, the Administration would help create the framework for public health officials to make most effective use of counseling and testing.

A vigorous public education program should be the second part of its strategy. Third, equally important, drug addicts seeking detoxification need to get treatment immediately and not after the wait of months, even years, they now face in New York and elsewhere. An Administration that pursued those goals could be said to be taking the AIDS epidemic seriously.

THE NEED FOR STRONGER NATIONAL LEADERSHIP

As the above summaries demonstrate, the United States federal government, through various agencies, has tried to meet the challenge suddenly posed by the AIDS epidemic, and, to a considerable extent, has succeeded in assuming a leadership role.

Not only the CDC in its various functions, but also the Surgeon General, Dr. Koop, have been highly visible as proponents of speedy, well-considered and effective prevention measures.

Nevertheless, on both the state and the local levels many medical experts and public officials still consider the federal effort to be wholly inadequate. In particular, President Reagan is increasingly being criticized as having abdicated the responsibilities of his high office by failing to address the issue of AIDS in any adequate fashion. It is widely felt that he, personally, should have spoken out forcefully years ago, and that he should have taken the initiative of establishing some sort of national AIDS commission. Such a commission was, in fact, very emphatically proposed in the Report of the National Academy of Sciences of October, 1986 (see above). In addition, there has been, for quite some time, a move in the United States Congress to establish such a commission. However, so far, there has been little encouragement from the White House. Today, perhaps the most prominent proponent of a U.S. National AIDS Commission is the Republican Senator from California, Pete Wilson, who is increasingly gaining support from his congressional colleagues.

The growing congressional pressure, in turn, now seems to be prompting the President to preempt this proposal by establishing a panel, commission or advisory group of his own, which would not be quite as independent as that envisioned by Congress.

The United States Senate, for example, would like to see a commission composed of members from religious, business (for example, the insurance and pharmaceutical industries), labor, public health and scientific groups, especially those from the National Academy of Sciences, which wrote the above-mentioned report.

No firm decision on any of these issues has been reached at this time. However, there is little doubt that, in one form or another, a U.S. National AIDS Commission will have to be established in order to better coordinate existing programs, to further strengthen federal leadership, and to keep the issue of AIDS removed as far as possible from partisan politics.

At the present time the whole problem is still being debated. As the outcome is uncertain, it is not possible here to provide some definite documentation. Instead, the following pages reproduce some newspaper reports. It is quite certain, however, that the proposal of a national commission is of the utmost importance. Indeed, the further success of the already existing federal programs may ultimately depend on how this very question is resolved.

Wilson Seeks Panel for AIDS Policy

Feb. 26, 1987

By Larry Liebert

Chronicle Washington Bureau Chief

Washington

Senator Pete Wilson called yesterday for a "medical war cabinet" to marshal forces against the AIDS epidemic.

Wilson, a California Republican, led a bipartisan group of senators introducing legislation to create a national advisory panel on AIDS.

"There is a fragmented response to the AIDS crisis," Wilson said. He proposed a prestigious panel of experts that would receive \$3 million a year in federal funds for five years to set national policy in combating the fatal disease.

The senator said that the panel,

which would be set up by the Institute of Medicine at the National Academy of Science, would end "unnecessary and wasteful duplicative effort" while encouraging the adoption of the most promising research and treatment.

In a significant provision likely to be welcomed by gay leaders, Wilson's bill would study "potential violations of the civil rights of individuals having acquired immune deficiency syndrome, including possible violations of rights of privacy and confidentiality."

Wilson said that contacts with the Reagan administration made him "optimistic" that the president would support the measure.

Wilson's co-sponsors in the Sen-

ate include Republicans Alfonse D'Amato of New York, Lowell Weicker of Connecticut and David Durenberger of Minnesota and Democrats Alan Cranston of California, Daniel Patrick Moynihan of New York, Lloyd Bentsen of Texas and Frank Lautenberg of New Jersey.

San Francisco's Mayor Dianne Feinstein also has worked with Wilson on the new legislation.

The bill for a national AIDS task force reflected the increasing sense of urgency in Congress with reports that AIDS is spreading to the general population and is no longer confined to those who are exposed to the virus through homosexual acts, intravenous drug use or tainted blood transfusions.

Senate Seeks Presidential Panel on AIDS

By Randy Shilts

The U.S. Senate has voted unanimously to ask President Reagan to establish a 14-member presidential commission on AIDS.

The resolution was authored by minority leader Senator Robert Dole, R-Kan., and was co-sponsored by a bipartisan group of 41 senators from every part of the political spectrum.

Although it gained little attention when it was adopted as a non-binding "sense of the Senate" resolution last Friday, it was welcomed yesterday by AIDS researchers as a "huge step forward."

"Such a commission can write the nation's war plan for the AIDS epidemic," said Dr. Marcus Conant, chairman of the California Department of Health Services AIDS Task Force. "It's the kind of thing that should have been done five years ago, but thank God it looks like it might be happening now."

The White House press office had no comment on the resolution yesterday, saying, "Nobody here knows anything about it."

The idea of a presidential commission on AIDS was proposed several years ago, but gained momentum on Capitol Hill last year after the National Academy of Sciences released a scathing report criticizing the Reagan administration's handling of the AIDS epidemic.

Saying that the federal response has been slow, inadequate and poorly coordinated, the academy proposed a presidential commission of experts to forge a coordinated national policy against the epidemic.

In recent months, Republican Senators Pete Wilson of California and Ted Stevens of Alaska have proposed legislation calling for such a commission.

A Dole aide said last night that

the senator proposed the resolution so the Senate could "expedite" the message to President Reagan without going through the formalities of passing legislation.

Dole will send a personal message to Reagan today, the aide said, asking the president to move quickly to establish the commission. A resolution similar to the one passed by the Senate will soon be proposed in the House.

Yesterday in San Francisco, Wilson said: "The commission will be a driving force to get responsibility fixed for this epidemic."

Wilson proposed such a commission to President Reagan a year ago, but the White House rejected his suggestion.

The Senate resolution calls on Reagan to appoint the commission by July 10. Commission members would include leaders from religious, business, labor, public health and scientific groups. The bill also specifies the inclusion of representatives from the National Academy of Sciences and the insurance and pharmaceutical industries.

The commission, as proposed by the Senate, would be mandated to study every aspect of public policy involving AIDS, including AIDS prevention education, how AIDS care should be financed and safeguards to protect AIDS patients' confidentiality and civil rights.

The commission also would be empowered to study coordination of federal scientific research and how to strengthen international efforts to fight the AIDS epidemic worldwide.

Under the Senate resolution, the stated federal policy goal would be to "make a major commitment of resources consistent with the recommendation of the National Academy of Sciences." The academy has called for the federal government to spend \$2 billion a year on AIDS research and prevention programs.

"I think this represented a growing awareness by our elected representatives that we have a growing problem that needs a firm national policy," said Dr. Mervyn Silverman, president of the American Foundation for AIDS Research.

The vote comes at a time that AIDS is becoming increasingly visible as a national issue, with both liberal and conservative politicians staking out their positions.

After years of virtual silence on the AIDS epidemic, President Reagan has begun discussing the problem in recent weeks. Vice President George Bush last week endorsed mandatory AIDS testing for all people seeking marriage licenses.

The Senate resolution drew an unusual array of co-sponsors, ranging from conservatives such as Republican Senators Strom Thurmond of South Carolina, Orrin Hatch of Utah and Warren Rudman of New Hampshire to such liberal senators as Democrats Edward Kennedy of Massachusetts and Alan Cranston of California.

Also co-sponsoring the bill were possible Democratic presidential contender Bill Bradley of New Jersey and announced candidate Joseph Biden of Delaware. Dole is expected to be a candidate for the Republican presidential nomination. Wilson is up for re-election to the Senate next year.

"The strong bipartisan support is indicative of the interest and determination of Congress to provide direction in the fight against AIDS," said Dole when he introduced the measure.

Other observers viewed the bipartisan support as reflecting growing public concern over the epidemic nationally.

In a speech in San Francisco last week, White House pollster Richard Wirthlin said that when he asked six months ago what was the most important problem facing the United States, not one person in 2,000 mentioned AIDS.

But in a more recent survey, completed earlier this month, seven out of every 100 people cited AIDS as the No. 1 problem.

Reagan Weighs A Special Panel On AIDS Crisis

Administration Seeks to Stall Congress Moves

By STEVEN V. ROBERTS
Special to The New York Times

WASHINGTON, April 25 — President Reagan is expected to approve creation of a special commission to study the AIDS crisis and suggest ways for the Administration to respond to what he has called "Public Health Enemy No. 1," according to senior White House officials.

The concept of such a commission was recommended to the President earlier this month by his domestic policy advisers, and he is likely to announce his approval in the next week or two, the White House officials said.

The Administration has been sharply criticized on Capitol Hill and in public health circles as responding too slowly to the outbreak of the deadly acquired immune deficiency syndrome. Mr. Reagan made his first detailed policy statement on the issue earlier this month, when he told a meeting of physicians in Philadelphia that abstaining from sexual relations was the best way to prevent the disease.

However, White House officials say the rising public alarm over AIDS is now forcing Mr. Reagan and his advisers to focus more attention on the matter. "The President is very much concerned — he wants to do something," said Gary L. Bauer, one of Mr. Reagan's advisers on domestic policy.

Concern Over Growing Data

In addition, the Administration wants to establish a panel to head off similar proposals being floated on Capitol Hill. "We wouldn't want Congress to set the terms for a Presidential commission," Mr. Bauer said.

Another factor motivating the White House is the research data being developed by scientists of the Federal Centers for Disease Control and other scientists who are studying AIDS. Mr. Bauer called the reports "nightmarish" and said that researchers expected the AIDS virus to develop new strains that would be easier to transmit and harder to cure. "Getting these reports and not doing anything would be irresponsible," he said.

AIDS attacks the body's immune system, making the victim susceptible to many life-threatening maladies. About 19,000 deaths have been caused by the disease in the United States.

The disease can be transmitted through intimate sexual contact, mainly between homosexual men, through the exchange of such bodily fluids as blood or by sharing hyperdermic needles. There are now growing fears that the disease can also be spread through heterosexual relations.

Effect on Public Policy Issues

The thinking behind the concept of a Presidential commission is that AIDS is likely to have an increasingly large influence on a wide range of public policy questions and the President should have the advice of "people from all walks of life who are pondering these things," Mr. Bauer said. No names for the panel have been suggested yet, he added.

"When the country is facing something with these potential ramifications, it's useful to get a second opinion," Mr. Bauer said.

One major policy question is the effect of AIDS on the Federal budget. According to Mr. Bauer, about \$450 million will be spent this year on research into the disease. Another \$350 million would be spent on caring for AIDS victims, primarily through the Medicaid program of health care for the poor.

The total, about \$1 billion, is up from \$8 million five years ago, Mr. Bauer said. Projections indicate that five years from now the Federal Government could be spending as much as \$20 billion a year, primarily on the treating the growing number of patients with AIDS.

Another issue that the panel would probably consider is how and when individuals should be tested for the AIDS virus. Mr. Bauer and other conservatives in the White House would favor mandatory testing at certain points in a person's life, for instance, when the person applies for a marriage license.

But this is a highly sensitive issue, with many implications for individual civil rights and personal privacy, and it is not clear that Mr. Reagan will go along with such a recommendation.

An issue like testing would probably be handled on a state-by-state basis rather than through Federal legislation, Mr. Bauer said. But he added that Mr. Reagan, with the advice of the commission, would have a responsibility to make a recommendation on such a critical matter. "What the President says about these things is as important as any bill," Mr. Bauer argued. "Washington does have a role in trying to direct thinking in this area."

AIDS as a Campaign Issue

AIDS has already become an important issue in many political campaigns and has generated a spreading debate in the capital. One key question is how campaigns to educate the public about the AIDS threat should be handled.

Conservatives like Mr. Reagan have maintained that education about the disease cannot be separated from moral values, and that young people should be counselled to abstain from sex outside marriage.

"I think that young people expect to hear from adults ideas of what is right and wrong," the President told reporters earlier this month.

Others, including Dr. C. Everett Koop, the Surgeon General, have argued that the health crisis is so acute that education should focus on practical techniques like using condoms to prevent the spread of AIDS.

According to Mr. Bauer, liberals on Capitol Hill see the AIDS crisis as a chance to expand publicly financed sex education, while conservatives see it as a chance to promote their belief in value-based instruction. "A lot of agendas are getting wrapped up in this tragic situation," he said.

V. AIDS PREVENTION AT THE LOCAL LEVEL

Two Cities Compared

Important as the various federal AIDS prevention efforts are, the actual battles are fought at the state and local levels. Especially the city governments first had to rely on themselves in fighting the epidemic, and some cities were clearly better prepared to do so than others. Moreover, in the United States cities vary greatly in the ethnic and economic mix of their inhabitants. It is not surprising, therefore, that different cities experienced the onslaught of the epidemic at different times and in different degrees of intensity. Consequently, they had to develop their own approaches, and again, some city governments responded faster than others.

As is well known, the American cities that were hit first and hardest were New York and San Francisco. Each of these two cities developed its own response at its own speed, and their prevention programs differ to this day in several significant ways.

It may be useful to insert here a brief discussion of these differences since they illustrate various problems likely to reoccur elsewhere. As a matter of fact, a study of these differences may be useful even to some European municipal governments.

In April, 1986, two San Francisco researchers, Peter S. Arno, and Robert D. Hughes, wrote a paper on this very subject titled: Local Responses to the AIDS Epidemic: New York and San Francisco.

In this paper, the authors documented and examined the different responses of New York and San Francisco with regard to general financial expenditures, allocation of funds, services available, and length of hospital stays. As the exact calculations of these figures are rather complex, only a few the major findings can be mentioned here:

- In New York City, AIDS patients were hospitalized on the average about 25 days compared to about 11 days in San Francisco. As a result, the average hospital cost was more than twice in New York (over \$20,000) what it was in San Francisco (under \$10,000).
- San Francisco also had, at an earlier time, a much more comprehensive and coordinated system of services for its AIDS patients and major risk groups. In New York, it was mainly one publicly supported volunteer group, the Gay Men's Health Crisis, which had to provide the bulk of community service programs. In contrast, San Francisco had several such organizations, of which the most important were the San Francisco AIDS Foundation, the Shanti Project, and Hospice of San Francisco. It was largely due to these organizations that San Francisco was able not only to serve its patients and high risk communities better, but also to keep the costs down at the same time.
- There was also a difference of philosophy in the New York and San Francisco Health Departments. New York did not want to combine all of its programs into one powerful coordinated effort or develop them in any aggressive fashion. Rather it took a "wait and see" attitude, trying to step in only where and when other initiatives failed.
- In contrast, San Francisco coordinated its efforts early on and also made considerable funding available. An important factor in this decision was the a relatively well-organized and politically powerful "gay community" which had no truly equivalent counterpart in New York. Indeed, well before the arrival of AIDS the San Francisco Department of Public Health maintained a special Office of Lesbian and Gay Health which now had no trouble reaching the ears of the city administration. Furthermore, the San Francisco Bay Area had a well-recognized "gay" medical association called Bay Area Physicians for Human Rights (BAPHR) with over 200 members. Finally, one of the eleven city

supervisors, Harry Britt, had been elected as an openly gay candidate. As a result of these and other factors, San Francisco was able to develop its response to AIDS more quickly, more efficiently and more comprehensively than any other city in the world.

- It is also worth noting that San Francisco's mass media (two daily newspapers and five major television stations) reacted much more quickly and appropriately to the threat than the New York Times or the New York television stations. As a consequence, the general population in San Francisco showed fewer reactions of public hysteria than that in New York and also was more supportive of the policies pursued by its Health Department.

It is very important to keep these local differences in mind when studying the reports on the AIDS prevention efforts in New York and San Francisco. Exact comparisons are not possible, as one is really comparing "apples and oranges". This does not mean that valuable lessons cannot be learned from the example of either city. However, on balance, the programs in San Francisco provide better models for other cities which want to avoid costly mistakes, unnecessary duplication and public controversy.

[The paper by Arno and Hughes discusses these and other factors in detail. The full text can be obtained from Peter S. Arno, Ph.D., Institute for Health Policy Studies, School of Medicine, University of California, San Francisco, 1326 Third Avenue, San Francisco CA 94143.]

VII. AIDS PREVENTION IN NEW YORK

In order to describe AIDS prevention in any American city, it is useful to consider at least three elements: (1) the response of the State health agencies, (2) the response of the municipal health agencies, and (3) the example of community-based volunteer organizations.

1. THE STATE OF NEW YORK

The State of New York has coordinated its response to AIDS in a new office called "AIDS Institute". A personal visit to this office introduced the author to a young, dynamic and apparently very capable staff. In personal conversation this staff reported a very ambitious and sufficiently funded program on the order of about \$16 million for the coming fiscal year. The plans include "alternate" testing and counseling sites all over the state, professional and public education, cooperation with other agencies and organizations, etc.. However, even upon repeated requests, the AIDS Institute of the State of New York proved either unwilling or unable to provide even a single scrap of paper that would have documented its information. Current budget figures were declared to be confidential and even mere proposals did not seem to be available. One explanation offered for this curious deficiency was the newness of the program combined with its alledged sudden and enormous expansion. The author, being impressed by the personalities of his interview partners, tends to take these assertions at their face value. However, he cannot help but notice the enormous contrast to the State of California, for example, where all such information is readily at hand in every state office. The author further noted some verbal criticism of the AIDS Institute on the part of the Gay Men's Health Crisis (see below).

In sum, what appears to be either an unnecessary secretiveness or lack of organization may simply be the unavoidable side-effect of the belated and hasty funding of New York State AIDS prevention programs. Even so, as this experience indicates, there may be some continued lack of communication and cooperation between the various groups fighting AIDS in New York.

2. THE NEW YORK CITY DEPARTMENT OF HEALTH

In contrast to the state, the City of New York finds it much easier to document its activities in the area of AIDS prevention. The City Department of Health not only regularly publishes its AIDS Surveillance Update but has also produced a handy reference manual AIDS -- A Resource Guide for New York City. This guide, which lists a great number of community resources, is attached in full to the present report. The various resources listed convey a detailed picture of New York City public and private services and thus also demonstrate the complexity of the problem.

However, the author again did not succeed in obtaining a detailed general plan or even approximate budget figures. This confirmed his impression that for some unknown bureaucratic reason the New York state and city administrations are not as forthcoming with financial information as other cities, especially San Francisco.

The New York City Department of Health has also published some useful and readily available guidelines under the title HIV Counseling and Testing Policy, March 1987. These guidelines reflect the general American consensus that "HIV-antibody testing should not be used for general screening or as a precondition for employment, admission to healthcare facilities, or admission to school." The guidelines also insist on the availability of pre- and post-test

counseling. Because of their concise and informative nature these guidelines are also attached in full to the present report.

The following pages, by way of a simple overview, summarize briefly the current AIDS prevention efforts of the New York City Department of Health:

AIDS EDUCATION

The Department of Health translates epidemiologic information about AIDS into meaningful preventive information for the at-risk populations, as well as for health and social service professionals and the community at-large. As more cases of AIDS are diagnosed, public awareness and education on this issue become more and more important. A brief summary of current educational activities follows.

AIDS HOTLINE: 1-718-485-8111

- 9AM to 9PM, Monday to Saturday
- Anonymous and confidential telephone information services on all aspects of AIDS
- Calls from people at-risk for AIDS, persons with AIDS, the worried well, health and social service professionals, and the general public
- Over 1000 calls per week since August 1985
- Counseling offered to callers who are considering the HIV antibody test
- Person-to-person counseling and group educational workshops for people concerned about antibody test results

COMMUNITY PRESENTATIONS

- Programs designed to empower the audience with materials and information about AIDS
- Over 15 requests for education sessions received per week
- Over 1500 people reached per month
- Phone 212/566-8290 to request programs

SPECIALIZED TRAINING PROGRAMS

- Developed for various professional groups to aid participants in incorporating information into work responsibilities
- Using innovative educational techniques, including role-playing, demonstrations, videos, etc.
- Groups trained include Board of Education personnel, health care and social service workers, drug treatment professionals, probation and corrections officers
- Phone 212/566-8290 to request programs

COMMUNITY-BASED PROGRAMS

- Public Health Educators posted in local areas with the highest incidence of I.V. drug use
- Promote AIDS awareness and prevention
- Assisted by outreach workers (funded by CDC) who specialize in teaching risk-reduction techniques to individuals and family members

(over)

AIDS FORUM

- Monthly meetings since early 1982
- Information exchange among city officials, representatives of voluntary organizations and others concerned about AIDS
- Helps maintain an effective dialogue, raises concerns and recommends action
- Phone 212/566-7103 for schedule

AIDS MONTHLY CLINICAL INVESTIGATORS MEETING

- For health professionals
- Last Wednesday of each month at 12:00 noon, 125 Worth Street, Second Floor Conference Room
- Forum to disseminate to the medical community accurate and current information about clinical research and disease surveillance
- Continuing Medical Education credits available for physicians and physicians assistants

EDUCATIONAL MATERIALS

- Brochures, flyers, and wallet cards in English and Spanish available in single copies or in bulk to community agencies
- "AIDS: A Resource Guide for New York City"
- "A Special Report on AIDS," prepared for New York City schools
- "AIDS Education & Training Resources Catalogue"
- Other materials in production
- To order, phone 212/566-7103

SPECIAL PROJECTS

In addition to the activities listed above, the Department of Health has developed other innovative techniques to communicate information about AIDS. These include:

- Supporting the Gay Men's Health Crisis in its outreach and education efforts, especially to gay men
- Supporting ADAPT (Association for Drug Abuse Prevention and Treatment) in its outreach to those at-risk through I.V. drug use
- Developing videotapes and educational literature for special audiences

The Department of Health works with many city-wide and local organizations to develop AIDS prevention programs. Providing technical assistance in understanding the epidemiologic information, as well as designing effective educational programs, is a major focus of the Department's work.

For more information about AIDS, or to find out how to reach other city services, phone:

AIDS HOTLINE
1-718-485-8111
Monday to Saturday
9:00 AM to 9:00 PM
All calls confidential

11/86

3. THE GAY MEN'S HEALTH CRISIS

New York City has one large community volunteer organization fighting AIDS which was founded in August, 1981, under the name Gay Men's Health Crisis (GMHC). As the name indicates, it is the result of an initiative taken by various gay men who had become concerned about AIDS and the lack of an adequate municipal, state and federal response. In its initial phase of development the organization underwent considerable strain as it tried to find its way between antagonism and accommodation vis a vis various officials and politicians. In spite of its enormous difficulties, however, the GMHC was able to take a leading role in educating health professionals, the general public, and populations at high risk in providing extensive patient support services and raising funds for research. Today the staff is joined by over 1500 volunteers who provide various services to AIDS patients, their families and the community at large.

From the beginning to this date, GMHC had focused on three main areas of activity: (A) education, (B) clinical services, and (C) research.

A. EDUCATION

Public education about AIDS has been and is the most important task undertaken by the GMHC. It conducts public forums, symposia for community groups and seminars for health professionals. Its staff, clients and volunteers also make themselves available to the press, radio and television.

GMHC also maintains a telephone hotline answering more than 6000 calls monthly. Finally, and very importantly, GMHC trains its own volunteers. For this purpose, it has developed a GMHC volunteer manual which serves as a resource for those who have been trained. Since this manual is highly instructive, it is also attached in full to the present report.

B. CLINICAL SERVICES

GMHC volunteers work under the supervision of professional staff members and deliver a large variety of services to persons with AIDS and AIDS related complex (ARC), their lovers, family and friends. These services are offered free of charge in an atmosphere of caring and absolute confidentiality. The spectrum of services provided by GMHC is listed in a Client Services Directory, which is attached to this report.

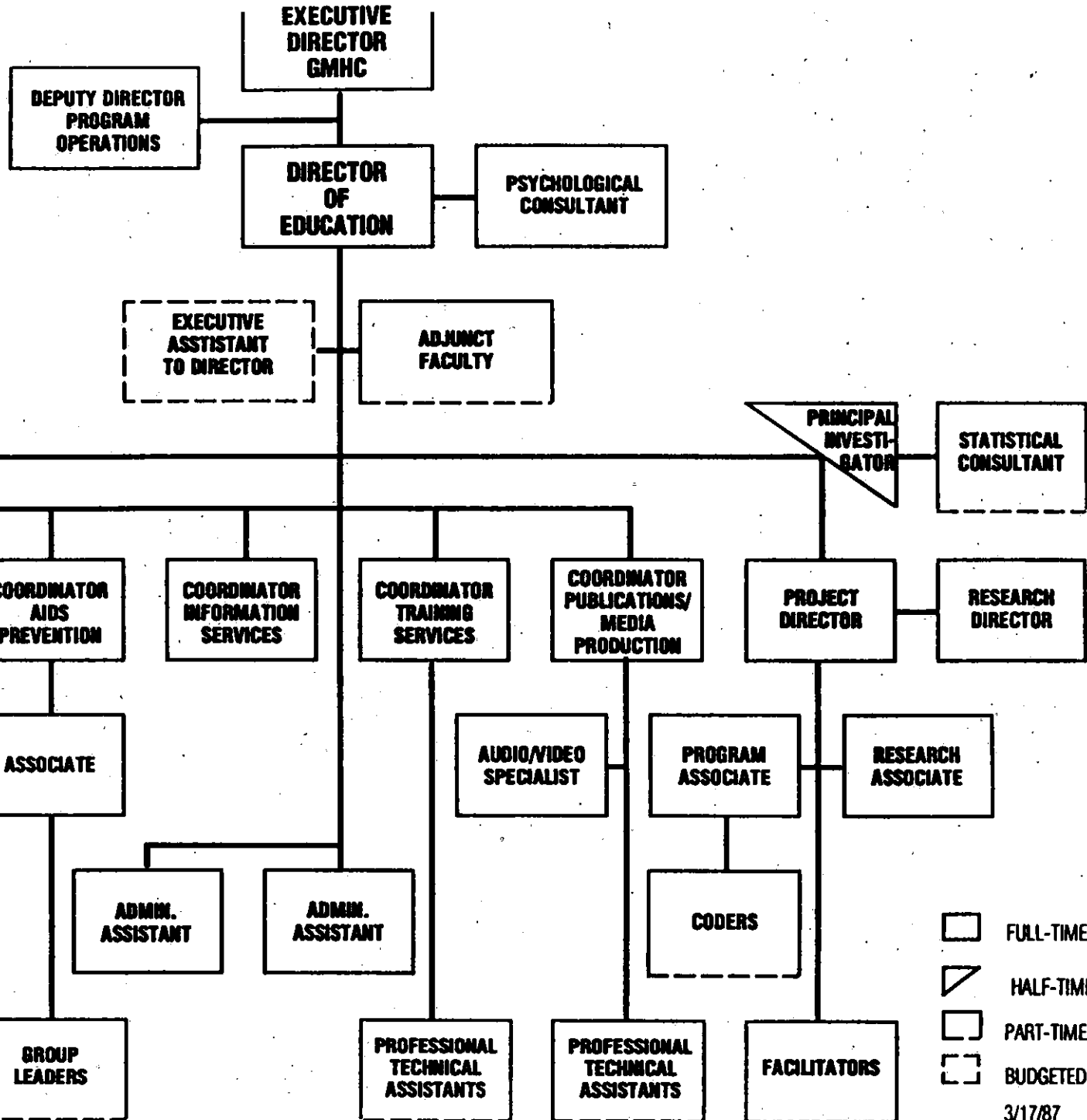
C. RESEARCH

In the beginning, GMHC occasionally directed funded medical research on AIDS. Today it mainly plays the role of advocate, urging greater research efforts on all levels of government and in the private. This advocacy role is extremely important, especially since it combines with considerable hard-earned expertise in caring for a variety of clients. Its name notwithstanding, GMHC has broadened its mandate and is now trying to serve the entire community, male and female, healthy and sick, rich and poor, gay and straight, and from all ethnic and racial backgrounds.

Illustrating the financial support of GMHC and the present organizational structure of its education department, the following pages reproduce an organizational flow chart of its education department and a budget summary for the current fiscal year.



EDUCATION DEPARTMENT
 Box 274, 132 W 24TH STREET
 NEW YORK, NY 10011
 212•807•7517



44

- FULL-TIME
- HALF-TIME
- PART-TIME
- BUDGETED

3/17/87

GMHC BUDGET
EXPENDITURES
7/1/86 - 6/30/87
FUNDING SOURCE

	TOTAL	AIDS INSTITUTE	NYSDOH	NYCDOMH	NYCHRA	CDC	GMHC
ADMINISTRATION	684323.56	63389.79					620933.77
EDUCATION	1000727.05	95810.20	180000.00	100000.00		239962.85	384954.00
CLINICAL SERVICES	603031.00	419302.30					183728.70
FINANCIAL SERVICES	241700.71				176473.05		65235.66
LEGAL SERVICES	97240.00	90000.00					7240.00
PUBLIC INFORMATION	74732.50						74732.50
DEVELOPMENT	636419.00						636419.00
VOLUNTEER OFFICE	124796.32	96497.71					28298.61
TOTAL	<u>3462978.14</u>	765000.00	180000.00	100000.00	176473.05	239962.85	2001542.24

*INCLUDES 60,000 RESTRICTED DONATION

56

VII. AIDS PREVENTION IN SAN FRANCISCO

As in the case of New York, the following will consider three aspects of the local response: (1) the State health agencies, (2) the city health department, and (3) community-based volunteer organizations.

1. THE STATE OF CALIFORNIA

The state of California contains two cities which were early on severely affected by the AIDS epidemic: San Francisco and Los Angeles. While Los Angeles experienced enormous difficulties organizing a systematic prevention effort, San Francisco soon took the lead and established its programs which by now have been recognized as models throughout the world. The city did this without much initial help from the State.

In the meantime, however, the epidemic is beginning to spread throughout the state, reaching even distant rural counties. Under the circumstances, pressure is growing on the California State Assembly and Senate as well as on the Governor to prepare the state as a whole for the expected public health crisis.

At the present time there is a considerable number of proposals pending in the legislature, of which the most important is a comprehensive AIDS bill sponsored by the San Francisco Assemblyman Art Agnos. This bill would establish a California State AIDS Commission, it would strongly encourage AIDS education in schools and, most importantly, would try to prevent any discrimination because of AIDS or positive HIV-antibody test results.

The State of California is already maintaining a statewide system of so-called 'alternative' test sites where citizens can be tested anonymously and free of charge.

One year ago the political extremist, Lyndon LaRouche succeeded in putting a statewide initiative on the ballot which would have required the State to deal with AIDS as with the "classical" infectious diseases, possibly leading to mandatory testing of certain population groups and to the isolation (quarantine) of others. This ballot initiative was vigorously opposed by the California Medical Association, the majority of politicians, virtually all public health officials and the California Catholic bishops, among others. As a result of this opposition and an accompanying vast public education campaign, LaRouche's initiative was soundly defeated on November 4, 1986, by more than 2/3 of the California voters.

The State Assembly and Senate also twice passed legislation intended to protect AIDS victims against discrimination by employers, landlords and insurance companies. This legislation was twice vetoed by the Governor who declared it superfluous. However, in the meantime, too many cases of discrimination have come to light for this position to remain credible. Therefore, the comprehensive bill proposed by Assemblyman Agnos may now have a very good chance of passing.

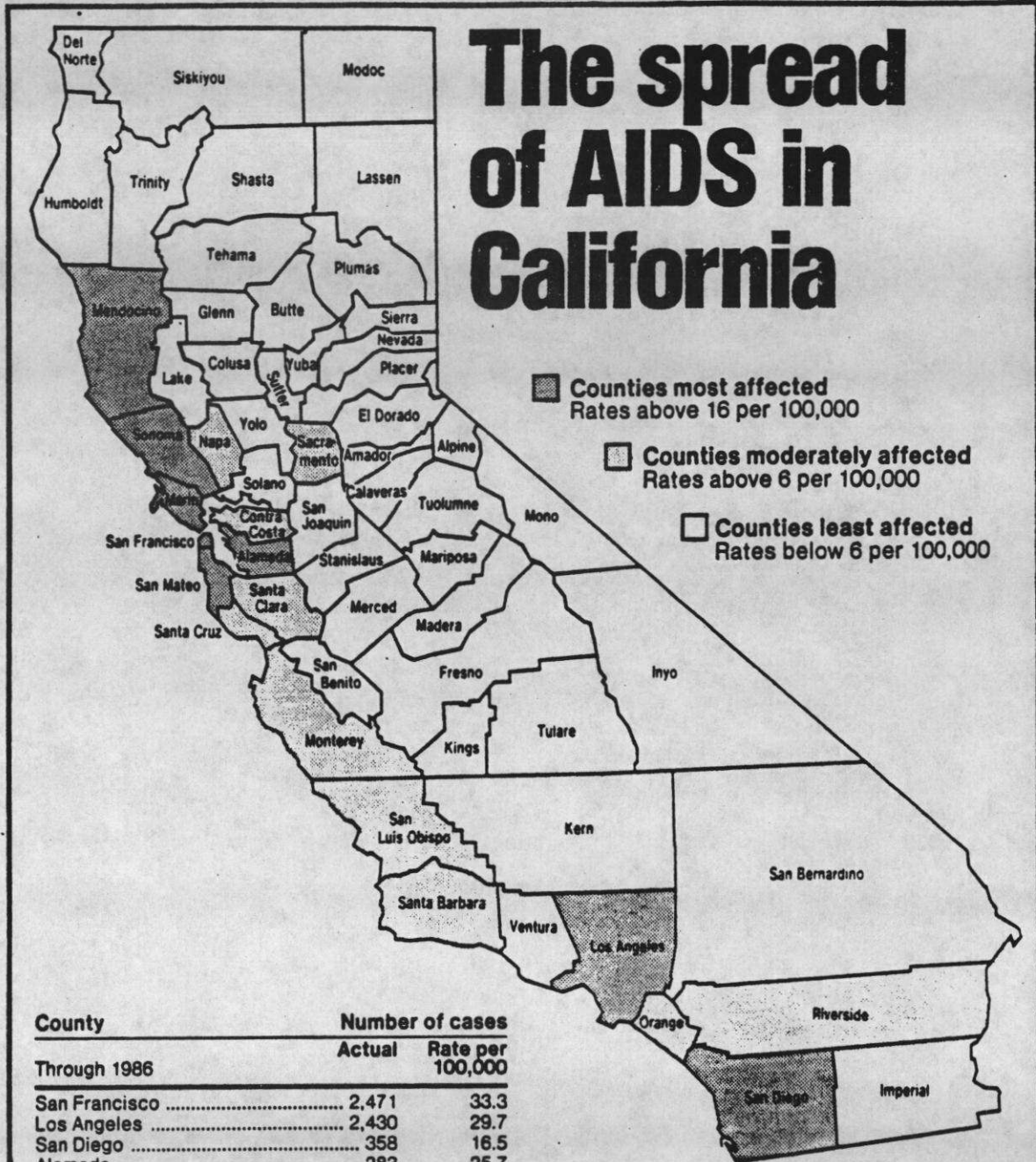
In this context it is highly significant that the U.S. Surgeon General, Dr. C. Everett Koop, made a personal appearance before the California State Legislature supporting Agnos' bill. It is widely hoped that California's example will be followed by other states, and that this in turn will prompt the federal government to adopt the same stance.

The current total of State expenditures on fighting AIDS could not be obtained in time for the completion of this report.

The following pages first show a map illustrating the spread of AIDS in California and then document the present legislative maneuvering.

S.F.
 Examiner
 March 8
 1987

The spread of AIDS in California



County	Number of cases	
	Actual	Rate per 100,000
Through 1986		
San Francisco	2,471	33.3
Los Angeles	2,430	29.7
San Diego	358	16.5
Alameda	283	25.7
Orange	245	11.4
Santa Clara	133	9.4
San Mateo	109	17.6
Riverside	107	12.7
Sonoma	103	30.3
Contra Costa	92	12.7
Sacramento	72	7.9
Marin	63	27.7
San Bernardino	49	4.4
Santa Barbara	39	11.5
Monterey	31	9.3
Ventura	25	4.1
Fresno	24	4.1
San Joaquin	18	4.2
Santa Cruz	18	8.2
Solano	17	6.0
Kern	14	2.8
Mendocino	13	17.4
San Luis Obispo	13	6.7
Napa	11	10.5
El Dorado	7	6.5
Lake	5	10.5
Shasta	4	3.0
Stanislaus	4	1.2

County	Number of cases	
	Actual	Rate per 100,000
Through 1986		
Yuba	4	7.3
Butte	3	1.8
Imperial	3	2.7
Merced	3	1.8
Placer	3	2.1
Siskiyou	3	7.0
Yolo	2	1.6
Glenn	1	4.3
Humboldt/Del Norte	1	0.7
Inyo	1	5.4
King	1	1.1
Madera	1	1.2
Plumas	1	5.1
San Benito	1	3.2
Sutter	1	1.6
Trinity	1	7.3
Tulare	1	0.3
Totals	6,789	25.5

Source: California Department of Health Services

Counties with zero cases: Alpine, Amador, Calaveras, Colusa, Lassen, Mariposa, Modoc, Mono, Nevada, Sierra, Tehama, Tuolumne.



Associated Press

U.S. Surgeon General C. Everett Koop, right, with Assemblyman Art Agnos in Sacramento

Top doctor's AIDS talk in Legislature

By Steven A. Capps *word 6*
EXAMINER SACRAMENTO BUREAU '87

SACRAMENTO — Describing himself as a "grim courier," U.S. Surgeon General C. Everett Koop told a joint session of the Legislature that until a vaccine or cure is found for AIDS, sex education is the only way to fight the spread of the killer disease.

"If we adults know something that could save the life of a child, then children have a right to that information," he said in a speech to the Senate and Assembly on Thursday. "And we have an obligation to tell them."

"If it makes us uncomfortable, if it is awkward to do, if it appears to conflict with other information we might have, those are problems that we have to resolve in a way that enables us to nevertheless tell our children what they need to know and have a right to know," Koop said.

Not everyone agreed with his call for education, including Sen. John Doolittle, R-Citrus Heights, who has fought sex-education proposals. He wants mandatory blood tests for suspected carriers

of the acquired immune deficiency syndrome virus.

"Young people have been educated already about sex and the dangers of syphilis and so on, and that hasn't changed their conduct," Doolittle said. "In fact, we've seen more cases of syphilis and other sexually transmitted diseases. So what basis do we have to believe that educating about AIDS is going to change their conduct?"

Koop and Dr. David Baltimore, a Nobel Prize-winning scientist and leading researcher on AIDS, were invited to speak to the Legislature by Assemblyman Art Agnos, D-San Francisco, one of the Legislature's experts on the subject.

Baltimore said, "There is no question that universal monogamy and drug avoidance would prevent AIDS's spread, and both goals are eminently worthy. But the reality is otherwise and must be admitted."

"We have to institute programs that will provide sterile needles to intravenous drug users," he said. "We must provide easy access to condoms and encourage their use. Condom dis-

persers belong in every restroom, both men and women. Most important, we must use our schools to educate students on how to protect themselves."

Agnos took the occasion to unveil the details of his bill, AB87, which would establish a state-level AIDS commission to deal with issues related to the disease. The measure also would require students to take a class about AIDS in order to graduate from high school, he said.

In addressing the Legislature, Koop said he had delivered the same message many times in the past few months "but it doesn't get any easier."

"It's essentially a grim message and I guess I'm something of a grim courier," he said.

Koop acknowledged that his report on AIDS published last October created a furor because it recommended that AIDS education be conducted in "early elementary school."

"Some people were unduly alarmed by that phrase — 'early elementary school.' Would that include kindergarten? I'm afraid so," he said.

San Francisco Chronicle

THE VOICE OF THE WEST

RICHARD T. THIENOT
Editor and Publisher

WILLIAM GERMAN
Executive Editor

JACK BRIBART
Executive News Editor

ROSALE M. WRIGHT
Features/Sunday Editor

ALAN D. MUTTER
City Editor

PHELPS DEWEY
Assistant to the Publisher,
Administration

KENNETH E. WILSON
Assistant to the Publisher,
Systems

JERRY BURNS
Editorial Page Editor

Founded 1865 by Charles and M.H. deYoung
George T. Cameron, Publisher 1925-55
Charles deYoung Thienot, Publisher 1955-77

Marketing and Operations conducted by the San Francisco Newspaper Agency

ROBERT M. McCORMICK
President/Chief Executive Officer

W. LAWRENCE WALKER JR.
Executive VP/Business Manager

EDITORIALS *March 9, '87*

Moving Against The AIDS Threat

U.S. SURGEON GENERAL C. Everett Koop is both forthright scientist and sensitive human being. Confronted with the intractable disease that is AIDS, Koop's first duty has been to try to stem this scourge with the medical knowledge available. But he also recognizes that he is dealing with anguished people — not just stained slides and disease graphs and a necrology that grows with appalling swiftness.

So we listen when he urges an education campaign throughout the country, particularly in the schools. And we take it seriously when he says that in the fight against AIDS this country must take particular care to preserve "fundamental values of personal freedom, mutual assistance and national unity."

In addressing a special joint session of the state Legislature, Koop took pains to praise the omnibus AIDS bill introduced by San Francisco Assemblyman Art Agnos as "the model of what ought to be passed across the nation," and added he would be "delighted" if it was enacted. So would we.

THE MEASURE was written in cooperation with Koop and the National Academy of Sciences and would, among other things, establish a 21-member state commission to monitor the AIDS epidemic and encourage the best and most appropriate response possible. It would also encourage education and accord proper protection to those suffering from the disease.

We trust these legislators will take the surgeon general's words to heart and pass the Agnos legislation (AB87) with due alacrity.

Koop and the AIDS Crisis

The Top Doc's Changed Image

By Larry Liebert
Chronicle Washington Bureau Chief

Washington

C. Everett Koop looks every bit the hard-line moralist, with his stern goatee and the military uniform that comes with his job as surgeon general of the United States.

When the pediatric surgeon from Philadelphia was chosen by President Reagan in 1981, his record of public campaigning to ban abortions and his allegiance to traditional "family values" made him a favorite of Moral Majority-style conservatives.

The 70-year-old Koop says his views have not changed, but the AIDS crisis — and his pragmatic, far from moralistic reaction to it — have turned his image topsy-turvy.

Many of his old conservative friends want Koop's scalp for urging AIDS education in the schools and condom advertising on television. Gays and liberals consider him a national hero for opposing mandatory AIDS tests and speaking out against discrimination toward AIDS carriers.

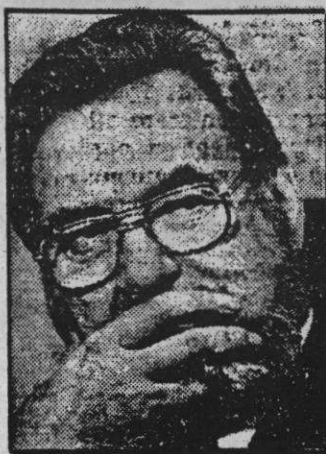
Obviously enjoying the difficulty people are having in pigeon-holing his brand of public health, Koop recently told an interviewer, "I take that as sort of a compliment, I guess."

Koop's unique role will be illustrated dramatically tomorrow, when he addresses a joint session of the California Legislature in Sacramento.

His speech will be nonpartisan, but his hosts will be the Legislature's liberal Democratic leaders. They are unabashedly hoping to capitalize on Koop's prestige in their effort to pressure Republican Governor Deukmejian. They want the governor to spend more than the \$21.4 million he has proposed for the year ahead to fight AIDS and to sign legislation he had previously vetoed that would ban discrimination against AIDS victims.

Koop is untroubled by such ma-

SURGEON GENERAL'S ADVICE ON AIDS



Surgeon General C. Everett Koop

- AIDS education as early as elementary school "so that children can grow up knowing the behavior to avoid to protect themselves."
- An end to the networks' self-imposed ban on condom ads because "the threat of AIDS is so great, it overwhelms other considerations."
- No mandatory testing for exposure to the AIDS virus and no quarantines "because AIDS is not spread by casual contact." No tattoos of those who are infected, as some conservatives have suggested. "AIDS should not be used as an excuse to discriminate against any group or individual."

neuvering.

"The public health issues become more important to him than anything else," said one of Koop's top advisers. "He's not interested in the local politics. He is a man with a mission."

Jim Brown, Koop's aide, said Koop's seemingly liberal stand on AIDS, embodied in a report he issued last October, stems simply from his strong sense of duty.

"He is the surgeon general of everyone in this country," Brown

said. "He has a lot of old-fashioned values — abstinence until you're married and a faithful, monogamous relationship. But there are people who will not listen (to such advice), and he thinks you have to tell them how to protect themselves from catching AIDS. He has to take into consideration that people could die if they didn't know what to do."

It is that attitude that has earned Koop his surprising new collection of friends — and enemies.

"He's been incredibly good, and we really didn't expect it at all," said Urvashi Vaid of the National Gay and Lesbian Task Force. "He came out of what we thought was a right-wing, Christian background. Once he started meeting with people and preparing his report, he came to his own conclusions. It's made a tremendous difference."

By contrast, Robert Grant, chairman of the evangelistic Christian Voice group, described Koop as a good man getting some bad advice.

"Dr. Koop is taking an Alice-in-Wonderland approach to coping with the worst epidemic in world history," said Grant. "It calls for drastic measures, not for putting a Band-Aid on cancer, which is what condoms are to AIDS. He should recommend abstinence. The sexual revolution is over. It's come to a screeching halt. People must become adults and get their drives under control."

Koop said recently that no one in the Reagan administration has demanded that he curb his comments or leave his job. And he has not backed off from his fundamental message.

"This is not an age for the faint of heart or of soul," he recently told a convention of religious broadcasters. "If you regard homosexual behavior as sin, please remember that one of your fundamental teachings has been to 'separate the sin from the sinner.'"

"You may hate the sin," he said, invoking a biblical teaching for his conservative audience, "but you are to love the sinner."

Surgeon General's Visit May Nudge Reagan on AIDS

By Randy Skilts

U.S. Surgeon General C. Everett Koop's three-day tour of Northern California was billed as a strictly "nonpolitical" event.

But the trip, which ended yesterday, will have political repercussions in Washington, Sacramento and San Francisco for months to come.

Koop, a rock-ribbed conservative appointed by President Reagan, came to California with the expressed purpose of raising national consciousness about AIDS and broadening the political consensus about AIDS policy.



The first person to feel the brunt of this mission could be President Reagan.

On Wednesday, his first day in San Francisco, Koop said openly what many administration health officials have been saying privately when he called on Reagan to "assume a role of leadership" in fighting the epidemic.

The comment came as behind-the-scenes maneuvering has increased in Washington to get Reagan to make some gesture of concern about the epidemic, which has claimed more than 31,000 victims in America.

Administration health officials wrote a paragraph expressing concern about AIDS for Reagan's latest State of the Union speech, but the words were never read. Reagan has publicly alluded to the epidemic only once, and only in answer to a reporter's question more than 13 months ago.

Officials of the U.S. Department of Health and Human Services have privately complained that they can never mobilize the government on AIDS issues until the president adds the symbolic weight of his concern to the battle against the epidemic. Nobody in government, however, has had the temerity to say this publicly.

Koop's statement puts more heat on the president to say something about AIDS. Moreover, Koop effectively gave the president a deadline to speak, noting that he was meeting with Reagan soon and that the

Although Koop cannot endorse specific legislation, the law is little more than a codification of proposals he outlined in the AIDS report he prepared for Reagan last year. Edging as close as he can to an outright endorsement, Koop said he would "be delighted" if the bill passed.

In the past, Governor Deukmejian and Republicans in the Legislature have been cool to Agnos-authored AIDS legislation. Last year, the governor vetoed two of Agnos' AIDS discrimination bills.

Now that the centerpiece of Agnos' AIDS legislation has the all-but-official stamp of approval from Koop, such opposition may prove more difficult.

There is probably no other figure in American public health who could have this effect in either Washington or Sacramento. As a leader in the anti-abortion movement, he can hardly be accused of being a bleeding-heart liberal out to coddle homosexuals. Because his rhetoric largely avoids talk of civil rights and instead focuses on what is best for the public health, he rises above the political fray of debates on AIDS policy.

president might say something by the end of the month.

Koop's revelation that the federal government is weighing plans to send AIDS information pamphlets to every household in America also will increase pressure on the federal government to perform.

Such dramatic initiatives by federal health agencies have been discussed before, only to be lost in the labyrinth of Washington bureaucracy. This will be far less likely to happen now that the surgeon general has publicly acknowledged the plan and given it his imprimatur.

Assemblyman Art Agnos, D-San Francisco, said he organized Koop's tour as part of a "calculated strategy" to "lift AIDS issues beyond the level of party politics and depoliticize the issue."

Koop's appearances came days after Agnos had introduced his omnibus AIDS bill in the Assembly. The bill would outlaw discrimination against AIDS sufferers, mandate AIDS education in all public schools and establish a 21-member state commission to guide California AIDS policy.

The immediate political beneficiary of the three-day Koop visit undoubtedly is Agnos, who was never far from the surgeon general's elbow. Agnos, who plans to announce his candidacy for mayor of San Francisco later this month, hopes the leadership role he has forged on AIDS issues will not be forgotten by gay voters, a key part of his political base.

In his San Francisco appearances yesterday, Koop called for more educational programs geared specifically toward ethnic minorities. At a breakfast speech with 250 staffers from AIDS service groups, he also lauded the gay community's volunteer efforts on AIDS.

Thoughts of politics were far from Henry Everitt's mind yesterday when he shook the surgeon general's hand on the last stop of Koop's Northern California visit. Three weeks ago, Everitt was diagnosed as having AIDS, the reason why he was on the AIDS ward at San Francisco General Hospital for Koop's tour of the facility.

"The visit makes me feel like I'm not lost and by myself," Everitt said. "It makes me feel like people care."

March 7, '87
Chronicle

2. THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

As repeatedly emphasized, of all American cities San Francisco has developed the earliest, most comprehensive and most effective AIDS prevention program. This is reflected in the good communication between all elements involved in this fight. The overall leadership resides in the city's Department of Public Health which operates within the framework of a comprehensive plan.

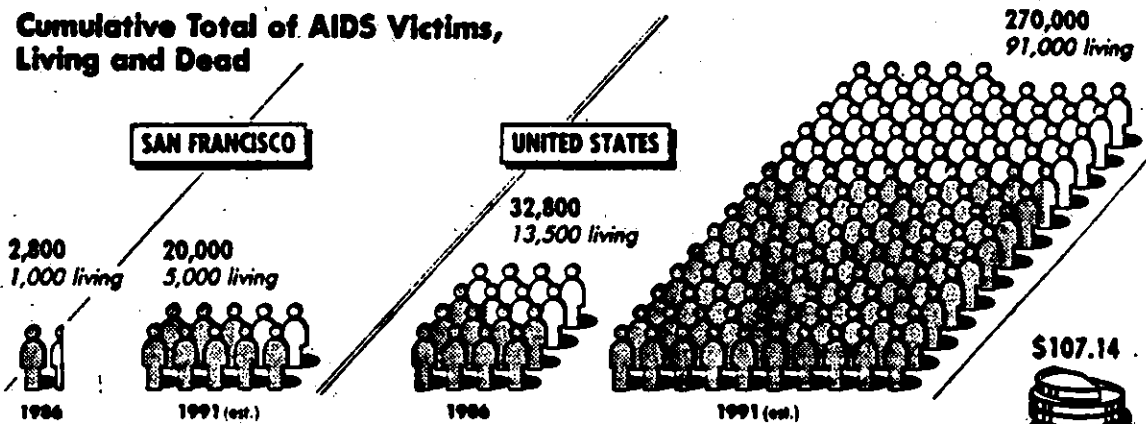
This plan, which combines all aspects of AIDS prevention and involves all concerned public and private agencies, is perhaps the most instructive single document available anywhere with regard to AIDS prevention. Because of its enormous importance, it is attached in full to the present report.

Since the overall structure of this report is so clear, and since it provides all necessary organizational and budgetary details, it seems unnecessary to paraphrase any of its contents here. Instead, the reader is urged to consult the plan itself.

However, the following pages may serve as an introduction as they first reproduce some graphs relating to the overall San Francisco AIDS budget and future budget projections. This is followed by a summary of the current San Francisco AIDS services.

TOLL OF A DEADLY DISEASE

Cumulative Total of AIDS Victims, Living and Dead



How San Francisco AIDS Spending Needs Could Grow

Year	City AIDS budget in millions	City general fund in millions	AIDS as a percent of general fund
1986-87	\$13	\$700	1.9%
1987-88	15	740	2.1
1991-92*	75	1,000	7.5

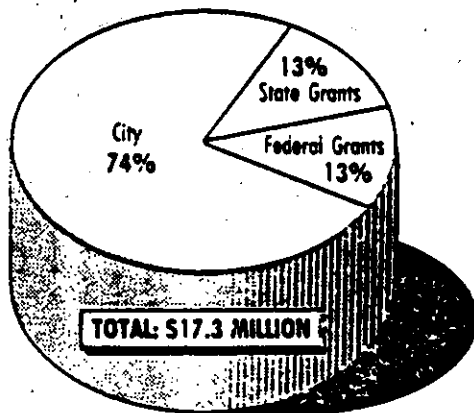
AIDS SPENDING PER CAPITA

*1991-92 figures are estimates based on unofficial projections by the city Department of Public Health and the mayor's budget office. AIDS spending is assumed to grow proportionately with the expected number of cases. It could grow substantially less or more, depending on political decisions, the availability of funds and changes in the disease and its treatment.



Who Finances San Francisco's AIDS Programs?

(1986-87)



Sources: U.S. Centers for Disease Control, San Francisco Department of Public Health

Where the City Money Goes

	1986-87	1987-88*
Research	\$44,455	\$199,455
Public education	693,633	917,222
Provider education	156,238	362,395
Clinical screening and acute medical care	8,211,386	12,729,866
Chronic care and related support services	2,574,304	2,778,600
Mental health services	804,977	1,133,258
Substance abuse services	126,341	669,219
Administration support and coordination	322,553	487,628
TOTAL	\$12,933,887	\$19,277,643

*1987-88 figures reflect budget requests by the San Francisco Department of Public Health, revised March, 1987. The department anticipates \$2,835,360 of the 1987-88 revenues it is seeking will be offset by other revenues, for a total net request of \$16,442,283.

BY ERIC LUNGERMAN/CHRONICLE ART

CURRENT SERVICES

Since current service budgets are generally organized around cost centers defined by educational vehicle, the following discussion is organized around educational vehicles. Services whose principal target population is substance abusers and whose principal link to DPH is through Community Substance Abuse Services (CSAS) are discussed in the section on Substance Abuse Services.

1. Media advertising

The San Francisco AIDS Foundation develops advertisements primarily for display on public transportation vehicles, on billboards and in community newspapers. Messages and placement vary and are generally coordinated with the themes being promoted in community forums and literature being distributed. Since most of the advertisements (no matter what the theme) are designed to encourage people ultimately to get more information, the impact of certain campaigns can be measured by the increase in calls to San Francisco's AIDS Hotline on the topic the campaign promotes awareness of (e.g., the risk of sharing needles, the risk to heterosexuals). The Foundation reports that over half of their media advertising budget in—1986-87 will be used for campaigns targeted to women, members of racial and ethnic minorities or needle users.

2. News and feature coverage:

Both the Department of Public Health and the San Francisco AIDS Foundation employ liaisons to work with print and electronic media to promote accurate and constructive coverage of the AIDS epidemic in news stories as well as printed feature stories, panel discussions, talk shows and documentaries. The Foundation estimates that over 40% of media liaison work in 1986-87 will focus on issues related to women, people from racial and ethnic minority groups, heterosexual transmission and needle users.

3. Pamphlets and collateral materials:

The AIDS Foundation develops and distributes a wide variety of materials for different target populations in different settings. In some instances, a particular piece for a targeted population will stand on its own; in others it is part of a comprehensive package which may include a video, brochures or posters designed for a sustained and comprehensive educational effort in a particular setting (e.g. a large corporation). Materials are sometimes developed in collaboration with specific independent groups (e.g. Forensic Services AIDS Project, the Women's AIDS Network). Materials are available in Spanish, Chinese and Tagalog as well as English. They are distributed on request, at Foundation-sponsored forums and workshops and through a network of distribution sites as well as street intercepts.

In FY 86-87, San Francisco's Instituto Familiar de la Raza and the Bayview Hunter's Point Foundation received funding directly from California DHS to provide AIDS education targeted to racial and ethnic minority groups. Some of this funding will be used for materials development and distribution.

4. Telephone Information and Referral:

The AIDS Foundation recruits, trains and supports volunteer counselors who operate the AIDS Hotline approximately 70 hours a week. It is a resource for people who are ill with AIDS/ARC as well as for those seeking information about AIDS risk, transmission, prevention and AIDS antibody testing. The service is anonymous, non-judgmental and easily accessed. Spanish-speaking counselors are available during a limited number of shifts per week. Spanish and Cantonese recorded messages are available at all other times. Their equipment includes a TDD hookup for the deaf. The service currently accommodates approximately 32,000 calls a year.

All AIDS service organizations receive and handle calls for general information about AIDS and referral to AIDS services.---

5. Forums, workshops and classes

- a. The AIDS Foundation's Educational Events Program is a centralized resource which provides speakers and coordinates AIDS educational events for a wide variety of groups. Speakers provide easy-to-understand, specific, detailed information about AIDS to specialized groups ranging from San Francisco dentists to employees at the Levi Strauss Company. The program also provides informational booths at diverse community events such as the Martin Luther King Day Parade and the Japantown Fair. Programs are tailored to fit their audiences; some provide basic or more advanced medical information about AIDS, while others focus on issues of casual contagion, infection control and the emotional issues which surround working with someone who has AIDS.

Program staff recruit, train and supervise volunteer speakers, many of whom are health care professionals and coordinate the speaking requests received. Staff also produce educational events, where a need for such an event is determined by research surveys.

The program provides sign language interpretation upon request and can provide speakers in a variety of languages. Special effort is made to integrate AIDS educational events into other occasions which draw audiences at high risk or with a specific need for AIDS information, such as neighborhood street fairs. During FY 86-87, 290 events will be organized through this program.

The Foundation anticipates that well over half of their staff time in this program will focus on the concerns of racial and ethnic minorities, women and substance abuse.

- b. DPH's Bureau of Family Health (BFH) is working in cooperation with the San Francisco Unified School District (SFUSD) to develop and implement a comprehensive AIDS education curriculum for San Francisco Schools. The curriculum will be piloted in several classes during FY 86-87 but the main focus this year will be the development, delivery and evaluation of a training program for middle and high school teachers, which is discussed at greater length under Provider Education.
- c. In FY 86-87, San Francisco's Instituto Familiar de la Raza and the Bayview Hunter's Point Foundation received funding directly from California DHS to provide AIDS education targeted to members of racial and ethnic minority groups. Some of this funding will support forums and workshops.
- d. The Women's AIDS Network (WAN) and the California-Prostitutes Education Project (CAL-PEP) are two all-volunteer groups who also sponsor and provide speakers for forums and workshops on AIDS.

6. Individual health education and counseling:

San Francisco's program for anonymous HIV antibody testing was initially called "the alternate test site program" (alternative sites to blood banks). They are now generally referred to as "anonymous test sites". This program is a comprehensive effort that brings together media advertising, pamphlets and collateral materials, small group education and individual health education and counseling. The focus, however, is on the opportunity for dialogue and counseling for which the test serves as a catalyst. Since the testing is not done in the context of a more general medical examination, it is valued more as an opportunity for education than clinical screening. The DPH policy to offer this testing without assembling personal identifying information on any participants is supported by State law. At current rates, approximately 10,500 individuals will be tested and counseled through this program in FY 86-87. Of those tested, approximately 11% are expected to be women and 15% members of racial and ethnic minorities.

The basic safeguards of anonymous testing are: (a) no personal identifying information on program participants is sought or recorded; and (b) staff of the testing program have no job-related responsibilities which are likely to put them in contact with those tested outside the testing program. The purpose of (b) is to provide reasonable assurance that staff members will not be able to identify a person tested because of knowledge gleaned from job-related interactions outside of the testing program itself.

DPH has contemplated offering antibody testing with a prevention education focus to clients of substance abuse and STD treatment programs at substance abuse and STD treatment settings. This program was to be different from anonymous testing to the extent that at least one staff member from the treatment program would, as the on-site educator/counselor for antibody testing, have personal knowledge of which clients were tested and what the results were. The proposal was based on the assumption that procedures could be developed which would adequately protect individuals participating in the program and the record of their test results. In the absence of a general consensus that sufficiently rigorous safeguards could be designed for such a program, the proposal has been tabled. Instead, substance abuse and STD treatment programs will provide some general education about antibody testing and refer those who are interested to an anonymous testing site. A similar scenario of individual education and referral to an anonymous testing site will be developed for women who are patients of family planning, pregnancy testing and prenatal clinics.

The University of California San Francisco (UCSF) AIDS Health Project and Pacific Mental Health Services (PMHS) Operation Concern also provide individual health education and counseling as part of assessing potential participants in the peer support groups described below. As was noted in Section IV, epidemiologic research projects provide participants with opportunities for education and counseling as well.

DPH's Forensics AIDS Project staff offer individual education and counseling to inmates, in addition to circulating materials, rotating posters and training jail staff about AIDS.

7. Peer support groups

The Stop AIDS Project is an interpersonal communications campaign which seeks to organize a community-at-risk (primarily self-identified gay and bisexual men) in San Francisco to achieve the goal of ending transmission of the AIDS virus. The major strategy of the campaign is to shift prevailing community norms about sexual behavior, to make "safe sex" and the social interactions which support safe sex the norm. The Project's main focus is not the individual, but the group. It is viewed as a movement for social change with major health-promotion goals.

Street intercepts, door-to-door canvassing and outreach to strategically placed opinion leaders are used to attract participants to volunteer-facilitated small group meetings of 10-15 per single session group. Participants are encouraged and empowered to communicate with their sex partners and friends about the campaign to end transmission of the AIDS virus. Stop AIDS meetings are held nearly every day of the week, including weekends, in the homes of volunteer hosts throughout the City.

The single-session group efforts of the Stop AIDS Project, as presently constituted, have been scheduled since July 1986 to "wind down" by June 1987. The program was designed to provide a particular kind of educational "push" at a specific point in the history of the gay community's response to the epidemic. The designers of the program and DPH staff agree that the need for such a program will have been largely met by June 1987. By that date, approximately 8,000 San Franciscans will have participated in a Stop AIDS group, 3,500 in FY 86-87 alone. In light of experience to date, approximately 20% will have been from racial and ethnic minority groups. Three percent will have been women.

The UCSF/AIDS Health Project and PMS/Operation Concern work together in providing one-time individual health consultations and closed, eight-week group support services. The target population for the services is people who are apprehensive about their prospects of acquiring AIDS and want to identify and find support for new behaviors likely to reduce their risk. Additionally, the project offers both drop-in and closed groups specifically for people with ARC in an attempt to help these individuals deal with their illness and reduce behaviors that may put others or themselves at greater risk. The majority of clients served in this program to date have been gay-identified males; 15% of clients served have been from racial and ethnic minority communities. Groups for special populations (e.g. members of racial and ethnic minority groups and women) are also organized: two groups exclusively for people from racial and ethnic minority groups have been conducted to date; women who have felt at risk have been seen predominantly for health consultations only. Taken together, 3,500 San Franciscans are expected to participate in individual assessments and group sessions in FY 86-87.

The all-volunteer California Prostitutes Education Project (CAL-PEP) offers a monthly support group for prostitutes and other sex workers with an AIDS prevention focus.

8. Volunteer participation in AIDS organizations/services:

To varying degrees, all of DPH's AIDS service contractors provide opportunities for meaningful volunteer participation. There are, in addition, a number of community organizations who depend entirely on volunteers (e.g. WAN and CAL-PEP).

H. POLICY REAFFIRMATION

1. The focal point of coordination of AIDS education (both public education and prevention support) in San Francisco should be the San Francisco Department of Public Health.
2. The design and content of AIDS education and intervention efforts should be based on epidemiologic research as well as careful assessments of targeted audiences' understanding about AIDS and its transmission and of the obstacles which prevent adoption or maintenance of new behaviors.

3. Educational materials should utilize language and visuals which the audience(s) targeted are most likely to understand and respond to. Judgments about the propriety of materials produced and distributed with public funds should be made by local public health authorities and should be based on careful assessments of the needs of local audiences.
4. The organizational bases from which AIDS education efforts in San Francisco are launched should be diversified. There should be a wide range of community settings and community-based organizations whose goal is to educate the general and at-risk public about AIDS and its prevention. Particular attention needs to be paid to programs which will communicate effectively with groups not yet well addressed by established programs (i.e. programs targeted to hard-to-reach gay men, substance abusers, racial and ethnic minority groups, youth and heterosexuals with multiple or at-risk partners).
5. Anonymous antibody testing should be available to anyone fourteen years of age or older in the community who wishes to know his/her antibody status and is willing to participate in a pre- and post-test education and counseling program.
6. Confidential antibody testing should be promoted as a health education tool only if and when there is substantial community sentiment that procedures have been developed which adequately protect individuals participating in the program and the records of their test results.

3. THE SAN FRANCISCO AIDS FOUNDATION

The San Francisco AIDS Foundation was organized in April, 1982, by a group of community leaders and physicians in response to the AIDS epidemic.

At first just a few volunteers provided basic medical information and referrals for homosexual and bisexual men who had become concerned.

Very soon, however, these volunteer services found wider recognition, and, as a result, the Foundation entered into a contractual relationship with the San Francisco Department of Public Health. In the meantime, the Foundation's educational programs have expanded to include educational seminars, a speaker's bureau, a toll-free telephone hotline, the development and distribution of brochures and other literature, media relations and media advertising. In addition, the Foundation provides direct services to people with AIDS and AIDS-related complex (ARC). These services include assistance with basic needs such as shelter, financial assistance, and a food bank. Finally, the Foundation, under contract with the California Department of Health Services, conducts referral services and educational programs in other counties of Northern California. The goals of this activity are to promote comprehensive AIDS program development, to foster resource sharing, and to provide Northern California residents with toll-free access to the Foundation's hotline information and referral services.

The San Francisco AIDS Foundation has especially excelled in three areas: (A) the production of printed information and educational materials, (B) the organization of innovative, even daring safe sex seminars "on location" (churches, gay bath houses, sado-masochistic sex clubs, etc.), and (C) preventive AIDS education in the workplace.

A. A complete list of educational materials produced by the San Francisco AIDS Foundation can be found in its catalogue, which is attached to this report.

B. The most successful safe sex seminars were conducted in cooperation with the Sexologists' Sexual Health Project, a group of faculty members at The Institute for Advance Study of Human Sexuality. The Institute has also produced several accompanying booklets and videotapes. However, it is in the nature of these seminars that there is no specific written material available. In fact, the courses are designed to vary according to different audiences. Still, as a means of partial illustration, one of the available booklets, The Complete Guide to Safe Sex is attached to the present report.

C. Another innovative, effective and highly useful program is called "AIDS in the Workplace". It was started by the San Francisco AIDS Foundation together with several large local corporations such as Standard Oil, BankAmerica, Levi-Strauss, Apple Computers, and others. As part of this program, an information team from the San Francisco AIDS Foundation is invited by a business or company to provide information and prevention education at the workplace, where the entire staff, from the executive director to the receptionist can participate. The important feature of this approach is the fact that the companies themselves pay the San Francisco AIDS Foundation for their own education. As the success of this program has demonstrated, this investment on the part of business is a wise one, since it helps to keep peace in the workplace and to allow for humane and economically sensible solutions to potential problems. As a rule, companies which have participated in this program allow their employees with AIDS to continue their work as long as their health permits. Their co-workers, having been thoroughly educated about the lack of danger in social and professional contact readily accept this policy, and indeed become very supportive of those colleagues who become ill as a result of an HIV infection.

This entire program is well documented by several workbooks and a videotape. A flier describing these materials is attached to the present report. A German translation of most of this material will be available soon in a new handbook edited by Erwin J. Haerberle and Axel Bedürftig. AIDS--Beratung, Betreuung, Vorbeugung: Anleitungen für die Praxis Berlin, de Gruyter, June 1987.

The following pages provide a brief summary of the Foundation's services as well as some budget samples from the 1985 annual financial report (the latest one available). The Foundation's services and budgets have again experienced considerable growth since then. However, in principle, the details and figures given here still provide sufficient basis for assessing the overall operations.

THE MISSION

of the San Francisco AIDS Foundation:

- Preventing the transmission of AIDS through the provision of education.
- Ensuring accessibility to social services for people with AIDS and AIDS related conditions.
- Advocating the promotion of an optimal medical, financial and social climate for people affected by AIDS.
- Participating in efforts against discrimination resulting from the AIDS crisis.
- Supporting research aimed at the prevention and cure of AIDS.

The underlying purpose of the Foundation is to provide quality AIDS-related education and direct service programs in San Francisco and Northern California.

SAN FRANCISCO AIDS FOUNDATION SERVICES

EDUCATIONAL SERVICES

The Education Department

- Telephone Services**
A well-trained and supervised volunteer body staff the AIDS Hotline Monday-Friday and weekends 11-5.
- Educational Events**
Speakers are provided to diverse audiences requesting AIDS information, forums are organized to address specific areas of concern, and in-depth seminars are held for health care professionals.
- Media Advertising**
Educational messages are developed and placed in various advertising vehicles to increase AIDS awareness throughout the community.
- Materials Development and Distribution**
Literature and audiovisual materials are designed to address specific target audiences and are distributed in areas where they receive maximum attention.
- Media Relations**
Accurate AIDS related information is disseminated through the mass media by acting as a central-resource referral point for media professionals.

DIRECT SERVICES FOR PEOPLE WITH AIDS/ARC

The Social Services Department

- Social Services Program**
The Social Services Program meets critical social service needs of people with AIDS or ARC. Social workers assist clients with disability benefits, housing, and employment concerns.
- Emergency Housing Program**
The Emergency Housing Program is a short-term interim housing program which directly serves people with AIDS/ARC.
- Food Bank**
The Food Bank is a privately funded, community-supported program, which assists low-income people with AIDS/ARC with grocery supplementation.

NORTHERN CALIFORNIA EDUCATIONAL SERVICES

Northern California Service Department

- 800 Toll-Free AIDS Information and Referral Hotline**
This volunteer staffed Hotline serves 44 counties in Northern California.
- Direct Educational Services in Counties without Education Programs**
Staff provide forums, literature, media education and media advertising to health care providers, people at risk and the general population in specified counties where no such services exist.
- Program Assistance**
In order to foster resource sharing among AIDS agencies and other local departments of public health, staff consult on program development, forums, materials development and distribution, media relations and advertising in specified counties in Northern California.

BALANCE SHEET AS OF JUNE 30, 1985

	<u>NOTES</u>	
ASSETS		
CURRENT ASSETS:		
Cash and equivalents		\$ 21,181
Due from restricted fund		133,486
Other assets		17,611
Total current assets		<u>172,278</u>
BOARD-RESTRICTED RESERVE FUND:		
Cash	1	15,000
Due from restricted fund		60,000
Total board-restricted reserve fund		<u>75,000</u>
PROPERTY AND EQUIPMENT—Net of accumulated depreciation and amortization of \$13,273	2,3	<u>57,583</u>
RESTRICTED FUND ASSETS:		
Cash	1	61,969
Grant receivable		193,486
Due to unrestricted fund:		
General		(133,486)
Board-restricted reserve fund		<u>(60,000)</u>
Total restricted fund assets—net		<u>61,969</u>
TOTAL ASSETS		<u>\$366,830</u>
LIABILITIES AND FUND BALANCES		
CURRENT LIABILITIES:		
Accounts payable		\$ 86,653
Accrued vacation liability		7,275
Current portion of capital lease obligation		5,898
Other liabilities		1,168
Total current liabilities		<u>100,994</u>
CAPITAL LEASE OBLIGATION	3	<u>12,654</u>
Total liabilities		<u>113,648</u>
FUND BALANCES:		
Unrestricted:	1	
General		116,213
Board-restricted		<u>75,000</u>
Total unrestricted		191,213
Restricted		61,969
Total fund balances		<u>253,182</u>
TOTAL LIABILITIES AND FUND BALANCES		<u>\$366,830</u>

**STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED JUNE 30, 1985**

	PROGRAM SERVICES	SUPPORTING SERVICES	TOTAL
Salaries and Employee Benefits	\$337,640	\$ 83,841	\$ 421,481
Research, Development and Production	263,163	14,446	277,609
Advertising	48,425	8,496	56,921
Consulting, Accounting and Legal	32,581	22,772	55,353
Contract Services	46,194	8,167	54,361
Rent and Building Maintenance	32,410	10,066	42,476
Supplies	27,736	13,681	41,417
Telephone	25,409	1,688	27,097
Food Bank and Emergency Housing Programs	21,608		21,608
Leased Equipment Expense	17,545	1,974	19,519
Utilities	16,050	1,973	18,023
Postage and Freight	9,537	2,473	12,010
Depreciation		9,758	9,758
Travel	3,316	4,991	8,307
Dues, Fees and Licenses	2,707	983	3,690
Other	7,293	12,992	20,285
Total Expenses	\$891,614	\$198,301	\$1,089,915

**STATEMENT OF SUPPORT, REVENUE, AND
EXPENSES AND CHANGES IN FUND BALANCES
FOR THE YEAR ENDED JUNE 30, 1985**

	NOTES	UNRESTRICTED	
		GENERAL	RESERVE TOTAL
PUBLIC SUPPORT AND REVENUE:			
Public support:			
Grants	1,2		
Contributions:	1,2		
Organizations		\$123,435	\$123,435
Individuals		111,097	111,097
Fund-raising event		41,145	41,145
Total public support		<u>275,677</u>	<u>275,677</u>
Revenue:			
Interest		3,581	3,581
Other		16,564	16,564
Total revenue		<u>20,145</u>	<u>20,145</u>
Total public support and revenue		<u>295,822</u>	<u>295,822</u>
EXPENSES:			
Program services	1		
Supporting services:			
Management and general		161,297	161,297
Fund-raising		37,004	37,004
Total supporting services		<u>198,301</u>	<u>198,301</u>
Total expenses		<u>198,301</u>	<u>198,301</u>
EXCESS OF PUBLIC SUPPORT AND REVENUE OVER EXPENSES		97,521	97,521
TRANSFER TO RESERVE FUND	1	(75,000)	\$75,000
FUND BALANCES, JULY 1, 1984		93,692	93,692
FUND BALANCES, JUNE 30, 1985		<u>\$116,213</u>	<u>\$191,213</u>

THE SHANTI PROJECT and HOSPICE OF SAN FRANCISCO

A major factor in the San Francisco fight against AIDS is the counseling and care of AIDS patients. As already mentioned, the city of San Francisco supports the wish of these patients to keep their hospital stay as short as possible. However, this goal can only be reached by a continued expansion of homecare services. Two major organizations are active in this field: the Shanti Project, a volunteer organization, and Hospice of San Francisco, a professional agency that also uses volunteer help. The constantly growing number of AIDS patients in San Francisco could not be properly cared for if these two organizations did not exist.

Hospice, in cooperation with family or other attending physicians, provides professional care for the dying at home and is supported by a number of volunteers who act as friends and emotional supporters to the patient. Hospice also maintains a residence for some of its patients in a former convent which was provided by the Catholic Archdiocese of San Francisco. Hospice will shortly publish a handbook describing its activities, which will also serve as an instructional tool for those who want to establish similar programs elsewhere.

The Shanti Project is a mainly a volunteer organization which trains its own members in a special 40-hour program. Shanti members act as emotional support to AIDS patients to whom they are individually assigned and with whom they stay throughout the illness. Shanti also maintains several residences for AIDS patients, who, for financial or other reasons, are unable to maintain their original homes. Shanti is still rapidly growing, but because of the nature of its work, not much written material about it is available. However, most of its training material, as well as the brief history, will shortly appear in German translation in the new handbook edited by Erwin J. Haeberle and Axel Bedürftig, AIDS--Beratung. Betreuung. Vorbeugung: Anleitungen für die Praxis Berlin, de Gruyter, June 1987.

VIII. AIDS PREVENTION AND THE PRIVATE SECTOR

As the volunteer organizations in New York and San Francisco demonstrate, the American private sector is already heavily involved in the fight against AIDS, if only as providers of financial support. All the organizations mentioned rely on mixed financing, i.e. they need both public and private monies in order to meet their constantly growing obligations.

Occasionally, as in San Francisco's "AIDS in the Workplace" program, private industry directly cooperates with and pays organizations which themselves are both publicly and privately funded.

A number of research and prevention programs in various parts of the United States are also funded by private foundations, of which the two most prominent are the American Foundation for AIDS Research and the Robert Wood Johnson Foundation.

1. THE AMERICAN FOUNDATION FOR AIDS RESEARCH

The American Foundation for AIDS Research, under the chairmanship of the movie actress Elizabeth Taylor, began with relative modest means augmented by about \$250,000 from the estate of the late movie actor Rock Hudson, who died of AIDS. Since then, Miss Taylor has been extremely active, increasing the endowment through various benefit dinners and other fund-raising activities. The Foundation's president is Dr. Mervyn F. Silverman, the former director of the San Francisco Department of Public Health. Miss Taylor's prominent name has further attracted a great number of other well-known personalities to the board as is shown by the Foundation's letterhead (reproduced on the following page). Last year it was able to distribute about \$1.5 million to various American research and education programs.

NATIONAL CHAIRMAN

Elizabeth Taylor

PRESIDENT

Mervyn F. Silverman, M.D.

BOARD OF DIRECTORS

CO-CHAIRS

Michael S. Gottlieb, M.D.

Mathilde Krim, Ph.D.

Sheldon Anderson, Esq.

Burt Bacharach

Warren Beatty

Jonathan Canno

Peter Carpenter

Phil Donahue

Harvey Fineberg, M.D., Ph.D.

David Geffen

Harley Hackett

George Hamilton

William Haseltine, Ph.D.

Arnold Klein, M.D.

Barry Kross

Elizabeth Kummerfeld

Helen Kushnick

Philip Lee, M.D.

Carole Bayer Seeger

Peter Scott, Esq.

Wallace Shein, C.P.A.

Loriva Streusand

Elizabeth Taylor

Rosemary Tomich

Mrs. Lew Wasserman

Abigail Van Buren

Joel Weisman, D.O.

TRUSTEE EMERITUS

Mrs. Albert D. Lasker

NATIONAL COUNCIL

Woody Allen

Leonard Bernstein

Rosalynn Carter

Douglas Fairbanks, Jr.

Harvey Fierstein

Katherine Graham

Manlym Home

Mrs. Lyndon Baines Johnson

Arthur B. Krim, Esq.

The Rt. Rev. Paul Moore

Tony Randall

Jonas Salk, M.D.

Liz Smith

Michael I. Sovern

Joel Valenti

2. THE ROBERT WOOD JOHNSON FOUNDATION

An even more important private initiative was started by the Robert Wood Johnson Foundation, sponsored by the Johnson & Johnson Pharmaceutical Company. The Foundation has set up an AIDS Health Services Program, whose director is again Dr. Mervyn F. Silverman, director also of the earlier-mentioned Foundation for AIDS Research. However, in his capacity at the Robert Wood Johnson Foundation, Dr. Silverman was able to help distribute \$17.2 million on AIDS-related services.

This example of a private initiative by a major corporation deserves to be emulated as widely as possible, especially in Europe. In order to provide some information about the intent and scope of this initiative, the Foundation's original prospectus is reproduced on the following pages.

**AIDS
HEALTH SERVICES
PROGRAM**

The
Robert Wood Johnson
Foundation

The AIDS Health Services Program offers \$17.2 million in grants to support the establishment of specialized comprehensive health and supportive services for victims of AIDS and AIDS-related disorders.

By emphasizing community-based, out-of-hospital care, the aim of the Program is to help bring needed medical and supportive services to AIDS patients; demonstrate that care can be provided to them more humanely and at reduced cost; and help relieve the burden that caring for AIDS patients has placed on many urban hospitals in the absence of alternative, community-based services.

Hospitals, local health departments, major voluntary organizations, or consortia of health care organizations in the 21 metropolitan areas with the largest AIDS case loads are eligible to apply (see Table 1). Up to ten grants will be made under the Program. The grants will be for four years, and to encourage projects covering the largest possible geographic areas, only one grant will be made in each city. If an anticipated federal grants initiative for similar purposes materializes, the Foundation and the Department of Health and Human Services are planning to coordinate the two programs as closely as possible, including a joint review of applications.

Background

Acquired Immune Deficiency Syndrome (AIDS) has been termed the nation's number one public health priority. Though some other diseases currently claim more victims, no disease in recent memory has so strained the ability of our political, social, and health care institutions to respond, nor created so much concern—sometimes bordering on panic—in the general public.

Since the first five cases in the United States were reported in mid-1981, the number of cases nationwide has surged to over 15,000 as of December 1985, and is expected to double to more than 30,000 cases by the end of 1986. An estimated 1 million or more Americans have already been infected with the AIDS

virus, and while it is not clear how many of them will ultimately develop AIDS, it is expected that as many as 200,000 may develop the AIDS-Related Complex (ARC), an often debilitating syndrome of persistent node swelling, fever, weight loss, and multiple complications that occasionally prove fatal even without progressing to the formal Center for Disease Control (CDC) definition of AIDS described below.

AIDS cases have been reported from all 50 states, the District of Columbia and 3 U.S. territories, and 21 metropolitan areas have now reported over 100 cases (see Table 1). Moreover, while most of the cases thus far have been reported from New York, California, New Jersey, Florida, and Illinois, the rate of increase has recently become more rapid in other states, suggesting that AIDS cases will become more evenly distributed nationally over time.

The costs of caring for AIDS patients are substantial. In an initial study, the CDC has estimated that the average total number of hospital days for AIDS patients exceeds 150 days, and the average cost per patient—exclusive of outpatient support services, tests, medications, home care, or counseling—is in excess of \$140,000. The total cost of care for the first 10,000 AIDS patients was estimated at over \$1.4 billion. This estimate did not take into account the additional costs of caring for ARC patients, who, according to several AIDS researchers, may outnumber the CDC-defined AIDS patients by as much as ten to one.

Epidemiology of AIDS

Through research, an enormous amount has been learned since the first AIDS case was reported in mid-1981. The cause of the disease is now known, why it is so lethal can be explained, modes of transmission are known, the populations at risk can be identified, and the availability of serological tests makes it possible to estimate not only the potential numbers who may develop AIDS or some variant of the disease, but the number of individuals who are likely to be infectious.

Table 1

AIDS cases reported to Center for Disease Control as of December 20, 1985, and estimated ARC cases by Standard Metropolitan Statistical Area*

	<u>AIDS</u>	<u>ARC**</u>
New York City	4,923	49,000
San Francisco	1,730	17,000
Los Angeles	1,306	13,000
District of Columbia	483	4,800
Miami	475	4,700
Houston	402	4,000
Newark (New Jersey)	373	3,700
Chicago	323	3,200
Philadelphia	284	2,800
Dallas	236	2,300
Atlanta	223	2,200
Boston	221	2,200
Jersey City (New Jersey)	179	1,700
Nassau County (New York)	159	1,500
Ft. Lauderdale	153	1,500
San Diego	147	1,400
Seattle	141	1,400
New Orleans	125	1,200
West Palm Beach	122	1,200
Anaheim	114	1,100
Baltimore	114	1,100

*Includes SMSA residents only.

**Because AIDS-Related Complex is not designated as reportable, official totals are not available. The numbers are approximations based upon estimates by clinicians and

researchers in the field that the ratio of ARC to AIDS cases is approximately 10 to 1. A substantial number of ARC patients, but not all, require treatment and/or monitoring.

Not all that is known is encouraging, however. Partly because the LAV-HTLV-III virus that causes AIDS appears to keep changing, any vaccine effective against one strain may not be effective against many of the variants. Further, antibodies do not appear to have much effect on the virus, and most serious of all, the virus infects so-called T-4 lymphocytes which play the critical role in modulating much of the immune system. Thus, the virus infects and destroys the very cell that ordinarily would set in motion a defense against an invading organism. There are few anti-infection agents that are completely effective without an immune response, and this means that unless an agent is found that can kill the virus, there will be a recurrence when a drug that simply inhibits growth of the virus is stopped.

The disease defined as AIDS appears to be fatal; however, not all of the milder but often very serious forms of infection with the AIDS virus known as ARC will necessarily progress to the fatal form. Because of the long latent period between infection and the clinical manifestation of the disease (estimates range from 2 to 20 years), it is not known what percentage of the estimated one million individuals testing positive for the AIDS virus will actually become ill, but it is quite likely that not all will. This means that some who are infected may remain clinically well, but it also means that the reservoir of persons likely to infect others is much larger than previously supposed. The best current estimates are that from 4 to as much as 34 percent of those who test positive for the virus will develop full-blown AIDS.

Nevertheless, infection is preventable and there is at present no evidence to suggest that casual contact with persons having AIDS or carrying the virus can cause the disease. Even the health workers in daily contact with patients appear to be at little risk, provided that they take reasonable precautions not to puncture themselves with contaminated needles.

The AIDS virus has been identified in a variety of body fluids, but the major carriers of the virus are blood and semen. Thus, the disease is prevalent among homosexual men, intravenous drug users, hemophiliacs who require human blood factor VIII,

and children born of mothers who are infected with the virus. The availability of a serological test for AIDS makes it possible to screen blood donors so that blood transfusions are no longer a cause for concern. The virus can be killed by heat, and safe preparations of factor VIII are now available for hemophiliacs. But that means that several high-risk groups remain: homosexual men who have multiple sexual partners and practice so-called "unsafe sex," drug addicts and drug users who share needles, infants born of mothers infected with the virus, and heterosexual men and women who have many sexual partners or partners from one of the risk groups.

Some researchers also see the potential for AIDS to spread more broadly to the general population. This prediction is based, in part, on the fact that in central Africa and in the Caribbean about as many women as men are infected. It is also based on the significant percentage of homosexual men (more than 20 percent) who report contact with female sexual partners. Moreover, in Newark and New York City, approximately 50 percent of new AIDS cases are intravenous (i.v.) drug users. This suggests the potential for increasing numbers of children born to female intravenous drug users to be infected with AIDS. In the New York area alone, estimates place the number of children who have died or are dying of AIDS at more than 120.

Clinical aspects of AIDS

AIDS itself usually begins with a series of symptoms ranging from extreme tiredness, fever, swollen glands, and weight loss to heavy coughing, purple or discolored growths on the skin or mucous membranes, and unexplained bleeding. Over 80 percent of the AIDS patients studied eventually develop one or both of two rare diseases: pneumocystis carinii pneumonia, a parasitic infection of the lungs with symptoms similar to other forms of pneumonia; and/or a rare type of cancer known as Kaposi's sarcoma. AIDS patients may also develop unusually severe infections with yeast, cytomegalovirus, herpes virus, and

parasites such as toxoplasma or cryptosporidium. A significant number of AIDS victims—30 percent according to one estimate—show symptoms of brain disease or spinal cord damage. Typically, AIDS patients suffer long, debilitating courses from infections until eventually they waste away in a manner somewhat similar to cancer patients, losing weight and strength until they are bedridden for the last months of their lives.

Since at present there is no cure for AIDS, treatment is directed at the specific opportunistic infections or cancers that attack AIDS patients. As the disease progresses, AIDS patients become increasingly reliant on in-home and other supportive services to provide assistance with the basic tasks of daily living. AIDS patients can also use highly specialized ambulatory care, high-technology home health services, and skilled nursing care on a regular basis to provide treatment for their cancers and infections as they develop. In the final stages of the disease, the large percentage of AIDS patients without family support need a hospice-type environment. Yet, in most big cities, few if any of these services—in-home, ambulatory, skilled nursing, and hospice care—are widely available as an alternative to hospital care. This, in large part, is because of the fear of infection from AIDS patients as well as the very high level of care they require. Moreover, some AIDS populations—i. v. drug users, for example—are particularly hard to reach with services.

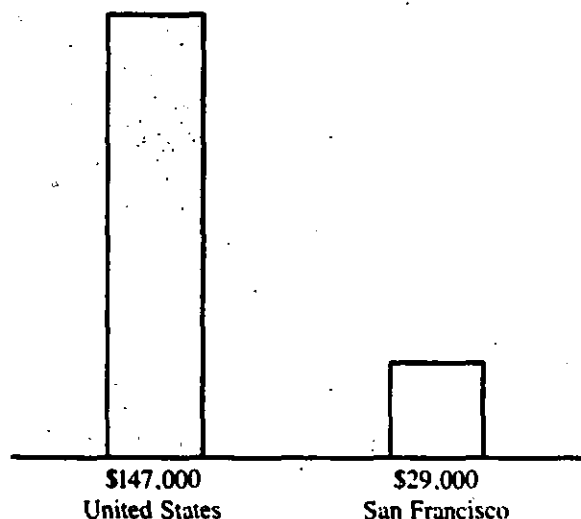
The health care needs

Since neither an effective vaccine nor treatment is likely in the near future, even with the accelerating pace of research the reservoir of infection is likely to grow, and with it the pressure on the health care system. The chief of the CDC's AIDS Branch has advised cities whose antibody prevalence (which measures the extent of infection in the population) is what New York's or San Francisco's were four years ago to initiate planning and resource allocation now if they are to avert overwhelming demands on their health care systems four years hence.

By far, the biggest access problem for AIDS patients today is in the area of out-of-hospital services. As noted, for the nation as a whole, in part because such services are still limited, the average total cost for hospitalization per AIDS case has been estimated at about \$147,000. By contrast, in San Francisco, in part because out-of-hospital services are more fully developed, the average cost for all hospitalizations combined is estimated at \$29,000 per AIDS case (Figure 1).

Figure 1

Average total cost of hospitalization for AIDS patients in the United States and San Francisco



Sources: Arno, Peter S., and Robert G. Hughes. "Local Policy Response to the AIDS Epidemic: New York and San Francisco." Presented at 1985 annual meeting of the American Public Health Association.

Hardy, A., K. Rauch, D. Echenberg, W. Morgan, and J. Curran. "The Economic Impact of the First 10,000 Cases of AIDS in the U.S." *Journal of the American Medical Association*, in press.

San Francisco's program, a model community-based system that seeks to avoid hospital care whenever possible, includes:

- a dedicated inpatient unit at San Francisco General Hospital to provide inpatient services;
- a highly specialized AIDS outpatient clinic based at the same hospital, staffed by oncologists and infectious disease specialists, nurses, social workers, and volunteers who deal exclusively with AIDS;
- high-technology home health care services such as i.v. antibiotics and chemotherapy;
- a community-based counseling and supportive service program staffed primarily by volunteers who provide assistance to AIDS patients in shopping, cooking, cleaning, paying bills, and other basic activities of daily living, as well as emotional counseling and support for AIDS patients and their immediate families and friends;
- skilled nursing facilities and hospice care; and
- an education and prevention program for high-risk groups; transportation services; and emergency residential facilities for AIDS patients who can no longer afford housing.

Virtually all of the experts consulted during the Foundation's study of the problem agreed that what is needed in big cities with large AIDS and ARC populations is a coordinated system of out-of-hospital care for these patients. The development of such systems of care is a major recommendation of the American Foundation for AIDS Research, a newly-formed national organization that includes distinguished scientists and clinicians from the United States and around the world among its board members.

The Program

Up to \$17.2 million has been allocated under this program to support as many as ten projects in the 21

metropolitan areas with the largest AIDS case loads (see Table 1). Four-year grants will be made to hospitals, local health departments, major voluntary agencies, or consortia of such organizations. Where a consortium submits an application, a single organization must be designated as responsible for the receipt and management of the grant funds on behalf of the overall effort.

Applicants in each of the three metropolitan areas with the largest case loads—Los Angeles, New York, and San Francisco—are eligible for grants up to \$2 million (i.e., up to \$500,000 a year). Applicants in the remaining cities are eligible for grants of up to \$1.6 million over the same period. Within both these parameters, however, the size of grants will be tailored to the level of need in each of the funded areas.

Although there will be only a single application process in this program, funding will be in two 24-month grant cycles. Funding for the second 24-month period will be contingent on performance under the first grant and the potential for the project to be sustained after Foundation support has concluded.

All grantees will be required to organize or develop comprehensive networks of out-of-hospital services for AIDS patients (in all instances in this prospectus, references to AIDS includes ARC). Because Foundation funds will not be sufficient to support the full array of necessary services, services not supported by the Foundation must already be in place or be provided for with public or other private resources.

The comprehensive networks must include the following service components:

1. comprehensive, AIDS-specific ambulatory care services that would result in improved diagnosis, earlier treatment and intervention, and reduced utilization of costly inpatient services. These should be staffed by highly specialized multidisciplinary teams of physicians and nurses, backed by subspecialists in infectious disease, oncology, pulmonary disease, and other subspecialties, as appropriate. Such facilities should also offer counseling and psychosocial support services for AIDS patients and families, if

these are not offered through another community-based setting. Ideally, these facilities would be based at or closely linked to major academic health centers involved in clinical research on the treatment of AIDS. This would enable them to serve as much needed settings for clinical research and enable AIDS patients who use them to have access to the latest treatments for the disease.

2. a continuum of in-home medical and supportive services coupled with long-term care and hospice services to maintain AIDS patients in the most humane and least costly setting possible. These include:
 - skilled and intermediate nursing facilities and hospice services to provide treatment and management for cancers, infections, organic brain disease, and other problems when hospital care is not needed but more than home care is required, or simply to help the patients manage the final days of life.
 - home health care services and in-home practical assistance with basic tasks of daily living to help maintain AIDS patients in their homes as long as possible. In-home practical support services would mainly be provided by volunteers, and Foundation funds could be used to develop this volunteer effort.
3. case management services, usually provided by social workers or trained volunteers. Case managers help patients and families navigate through the service and public benefits systems. Case managers could be based at the ambulatory clinics of voluntary community organizations.

In order to encourage the development of truly comprehensive AIDS services, high priority will be given to applicants that are able to link these services to a dedicated AIDS inpatient hospital unit, and a portion of Foundation funds would be available to support the development of such units, if necessary.

A portion of the Foundation's funding may also be used to support new, project-related education and

prevention activities for members of potential risk groups whose behavior professionals feel can be modified to a significant degree. A variety of education and prevention techniques may be used, including direct outreach and counseling as well as mass-media public education. Not more than 20 percent of the Foundation's funds could be used for this purpose. Plans for, or the presence of, such efforts as part of the overall project, whether proposed for support by Foundation funds or not, would be an important factor considered in the review of applications.

In the few metropolitan areas where the number of pediatric AIDS cases is sufficiently large to warrant a major Foundation investment, priority under the Program will be given to applications that include the development of a comprehensive service system for children with AIDS.

In keeping with the Program's aim to support area-wide projects, priority will also be given under the Program for the ability to reach the largest possible number of AIDS patients, and to applicants that have a strong track record of managing complex, multi-service projects.

All applicants will also be required to establish a metropolitan area advisory committee to endorse the application and to provide broad oversight and leadership for the project. The members of this committee must include representatives of the health profession and health care institutions, the major voluntary organizations and religious groups, and relevant city and/or county and state agencies dealing with AIDS. Where they already exist, city-wide AIDS task forces may be used to serve this function, provided that the above listed constituency and professional groups are represented.

The Foundation recognizes that AIDS populations, political environments, and existing health care delivery arrangements vary across the country. As a result, no single service model may fit in every instance, and thus applicants are encouraged to make a case for departures from the service arrangements described above where they feel other approaches are needed in their locale.

Use of grant funds

Foundation funds may be used for salaries and for other essential purposes in support of the delivery of services and management of the overall service project. In keeping with existing Foundation policy, however, grant funds may not be used to construct new facilities; to renovate existing facilities; as a substitute for funds currently being used to support similar services; to reduce ongoing deficits from pre-existing operations; or as recurring revenue (and therefore as a reduction of third-party reimbursements).

Eligibility and selection criteria

Applicants must represent one of the 21 metropolitan areas with the largest number of AIDS cases listed in Table 1. They must be a public entity or a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code and not be a private foundation as defined under Section 509(a).

Applicants must:

1. develop an overall strategy for reaching as many AIDS (and ARC) patients as possible within the metropolitan areas;
2. develop or organize a comprehensive, coordinated network of out-of-hospital AIDS health and supportive services as previously described to include:
 - specialized ambulatory care;
 - a continuum of in-home medical and supportive services and long-term care and hospice services;
 - case management services;
3. establish a broad-based project advisory committee.

In addition to these requirements, priority will be given to applicants for:

- the inclusion of a dedicated, specialized inpatient unit as an integral part of the overall project;
- the potential number of AIDS and ARC patients to be reached through the project; and
- the inclusion of new and innovative education and prevention efforts targeted on high-risk groups.

In reviewing applications, special considerations will also be given for:

- the ability of the project to network with other AIDS service sites in their metropolitan area;
- the active involvement and participation of state and local government;
- the commitment and ability to coordinate other state, local, or private funds to expand the scope of the project; to add services such as emergency housing or transportation; to improve access to public benefit programs; and to sustain the project after the termination of Foundation support; and
- the demonstrated ability of the applicant to manage a multi-service, coordinated effort of this kind.

Administration of the Program

Technical assistance and direction for the Program is being provided by the Institute for Health Policy Studies of the University of California, San Francisco. The director of the Program is Mervyn F. Silverman, M.D., M.P.H., who is a senior program consultant to the Foundation and former director of health in San Francisco. At The Robert Wood Johnson Foundation the responsible officers are Drew Altman, Ph.D., vice president, and Paul Jellinek, Ph.D., program officer.

A national advisory committee will assist in the initial review of applications, participate in site visits to selected applicants during the review process, make grant recommendations to the Foundation staff, assist in monitoring the ongoing operation of the Program.

and otherwise provide technical assistance to the Program and the selected applicants. Final decisions on the awarding of grants will be made by the Foundation's Board of Trustees. The National Advisory Committee is chaired by Philip Lee, M.D., professor of social medicine at the University of California, San Francisco, and president of the San Francisco Health Commission.

Evaluation and monitoring

An evaluation of the AIDS Health Services Program may also be funded by the Foundation. It would be conducted by an independent research group focusing on the key health services and policy questions regarding the impact of the Program on the problems it seeks to resolve. All grantees, as a condition of accepting grant funds, will be required to participate in the evaluation.

Application procedures

Major health care institutions, public agencies, and voluntary organizations in the 21 eligible metropolitan areas are being notified of the Program. The first step for those wishing to apply is to send a letter of interest (not to exceed two pages) to Dr. Silverman identifying the parties involved or to be involved in the development of the application, and the general intent of the proposed project. The letter should identify a contact person to serve as principal liaison during the application process. Upon receipt of the letter, application materials and instructions will be mailed.

At the time this prospectus was being prepared, there was a possibility that federal grants for similar purposes would be announced later in 1986. If the federal initiative materializes as expected, the Foundation and the Department of Health and Human Services are planning to coordinate the two programs as closely as possible, including a joint review of applications and the coordination of funds for maximum effect. If this occurs, any necessary adjustments in the terms or procedures of the Foundation's Program will be communicated to applicants in the affected metropolitan areas.

All inquiries and communications should be addressed to:

Mervyn F. Silverman, M.D., M.P.H.
Director
AIDS Health Services Program
Institute for Health Policy Studies
University of California, San Francisco
School of Medicine
1326 Third Avenue
San Francisco, California 94143
(415) 666-4921

Program timetable

Deadline for receipt of letters of intent:	March 17, 1986
Deadline for receipt of proposals:	June 17, 1986
Completion of proposal review and site visits:	August 29, 1986
Announcement of grants:	October 1986

IX. DOES AIDS PREVENTION WORK? -- Program Evaluation

GENERAL OBSERVATIONS

The effectiveness of AIDS prevention programs is very difficult to assess. First of all, the exact ways and means of transmission of the HI virus are still not fully understood. Second, the exact length of the latency period (time between infection and appearance of symptoms) cannot be exactly determined at this time for each individual. It may range from a few weeks to five, seven, ten or more years. Moreover, the clinical definition AIDS covers only a small part of the various health problems and diseases that can result from an HIV infection. As a consequence, even simple epidemiological surveillance is unusually difficult. The difficulties are increased by the fact that an HIV infection can easily result and in fact often has resulted in social discrimination and isolation. This, in turn, undermines the willingness to cooperate on the part of those at high risk for infection.

Nevertheless, in the United States, public health officials are reasonably confident that prevention measures can be effected, provided they are on the one hand massive enough and on the other hand detailed and specific enough for various population subgroups.

Generally speaking, the United States prevention efforts involve four major components:

1. Information
2. Education
3. Training
4. Risk Reduction

All of these elements have to work together and in some way depend on each other. However, they involve very different public agencies, private organizations and individuals from extremely different backgrounds. It is obvious, therefore, that success depends a great deal on timely and proper coordination and cooperation.

In order to understand the complexity of the problem, the four prevention components will now be briefly discussed separately.

INFORMATION

The term information in this context refers to the broad effort of instructing the general public.

Its aim is a sufficient public awareness of the dangers posed by the virus and a sufficient understanding of how it is transmitted. At the same time, and just as importantly, the public must be informed about how the virus is not transmitted. In other words, ideally the entire population is made to understand that there is no danger of infection through everyday social contact in the family, at the workplace, at school, in restaurants or any public places. On the other hand, ideally the entire population also understands that it can protect itself from infection in situations where it could actually occur, i.e. during sexual contact and as a result of sharing drug-injecting needles.

This kind of information can and is being transmitted by means of telephone hotlines, billboards, newspaper advertising, radio and television spots, journalistic reports, public

congresses, conferences and workshops, books, brochures, leaflets, and visiting speakers in the workplace or in schools.

How far these information campaigns go and how many people they reach depends mainly on the financial resources available. The amount of financial support in turn depends on the greater or lesser awareness of public health authorities, politicians and ultimately, the general public itself.

Thus, it is evident that a certain circular mechanism is involved: the general public can only be informed to the extent that it wishes to be informed, and this wish, in turn, depends on a sufficient level of information in the first place. On the other hand, once the circle has been set in motion, it self-generates a constantly growing awareness, finally approaching the desired result of the campaign.

In San Francisco and, to a lesser extent, in other cities such as New York, Los Angeles, Chicago, Houston etc., public awareness is already relatively high. However, this is not true of the rest of the country where much less energy and money has been spent.

EDUCATION

The term education in this context refers to the teaching of students at all grade levels from kindergarten to graduate school (university).

Unfortunately, at the lower grade levels, even including high school, this is a very controversial area. Very often many parents and religious leaders are on one side of this controversy with public health officials finding themselves on the other side. In many cases the stalemate or bland compromise results with the students remaining essentially uneducated.

As the epidemic worsens the controversy is bound to grow with potentially very destructive social results. Many parents and churches feel very strongly that the best protection against sexual infection is complete premarital abstinence and that, therefore, nothing but "traditional moral values" should be taught. The public health officials, on the other hand, feel equally strongly that "safe sex practices" including the use of condoms should be taught to all students at least after puberty, because failing to do so would put their very lives in jeopardy. In the United States this clash of opinions is highlighted and in some way symbolized by the disagreement between the Secretary of Education, Dr. Bennett, and the Surgeon General, Dr. Koop.

At this time it is unclear whose arguments will finally prevail. As cited earlier in this report, some public school education materials reflecting the Surgeon General's position are already available (attached to this report). The remaining question, however, is if, when, where, and how widely these materials are going to be used. Ultimately this is a political, not a medical question.

TRAINING

The term training in this context refers to the instruction of so-called providers i.e. medical professionals, and other health care workers, counselors, teachers, etc.

As repeatedly mentioned in this report, the United State Federal Government through the CDC, various states and many cities have begun programs of "training the trainers". Indeed, in the overall picture of American prevention efforts, this component may be the best developed and most effective to date. There is no doubt, however, that it needs to be expanded and strengthen further, since few other efforts are likely to produce as many beneficial results as quickly.

For details on some of these programs the reader is referred to pages 34 through 78 of this report as well as to pages 47 through 53 of the attached Status Report and Plan for 1987 & 1988 of the San Francisco Department of Public Health.

RISK REDUCTION

The term risk reduction here means the reduction of the risk of infection through changes in sexual and drug use behavior.

Efforts in this regard are directed at the general public, at certain populations defined by their behavior, populations defined by community and at populations defined by place.

The general public has to be addressed since it is not known which individuals are running a risk through their behavior. While it may be true that large segments of the public run no risk at all, those that do may not be reachable any other way than by a broad "scattered" approach.

However, there are certain populations that can be defined and targeted more narrowly, although even here it remains uncertain how many of them can really be reached, as they may be "hiding" in the general population. Thus, they may be missed just because they have been especially targeted. Some of the special target populations defined by their behavior are:

- Men who have sexual contact with other men
- IV drug users/needle sharers
- People whose sexual activity is disinhibited by drug use
- People with multiple sexual partners
- Sexual partners of members of all the above groups
- Sexual partners of hemophiliacs and other recipients of infected blood or blood products

Populations identified by community could be:

- Racial or ethnic minorities
- Members of the "gay scene" or subculture
- Swingers (heterosexuals engaged in sharing or exchanging partners)
- Sadomasochists
- Other sexual minorities

Populations identified by place can be found in:

- Prisons
- Schools
- the work place
- Clinics or other treatment settings

Community groups
etc.

The above groups are not to be considered exclusive. In fact, a great deal of overlapping must be taken for granted since many individuals belong to more than one group or can be reached in more than one location. Therefore, a certain redundancy in prevention efforts is unavoidable and should be accepted.

The methods chosen to reach and address these groups will have to vary greatly. For example, risk reduction education in a public high school will use different vocabulary and different printed and audiovisual materials than a comparable course in a sado-masochistic sex club. Curiously enough, it may be easier to achieve the goal of prevention in the latter place than in the former. The more public the risk reduction efforts are, the more they become subject to political scrutiny. Religious and other social pressures can then result in the "censorship" of explicit or "obscene" sexual instruction materials.

The materials attached to this report provide ample documentation of the various approaches. In the final analysis, the scope of risk reduction programs again depends on the funding available, which in turn depends on political decisions. Such decisions can only be made if the electorate is sufficiently informed. Thus, the link of the "risk reduction component" to the general "information component" is quite obvious.

TWO SPECIAL POPULATIONS -- WOMEN AND IV DRUG USERS

The following addresses the problems connected with achieving risk reduction in two special populations: (1) women and (2) IV drug users. Hitherto, these two groups have been rather neglected in the general prevention effort, and thus their discussion may serve to illustrate particularly clearly the difficulties in reaching all of the groups.

The concept of women as a special target group for risk reduction efforts is somewhat artificial since women are found in many other so-called risk groups and can probably be reached best by targeting these different groups. However, since about 7% of all AIDS cases nationwide are women and since this percentage is growing, there is now an effort underway to "slice the pie differently" once again in the hope of reaching more individuals who otherwise would "fall through the cracks". Therefore, many cities and states have formed special task forces dealing with AIDS prevention among women.

Until now most of the women with AIDS have become infected through the use of shared needles when shooting drugs intravenously. Other women have become infected through heterosexual intercourse with infected men. Furthermore, the vast majority of pediatric AIDS cases are infants born to these women. Thus a certain overlap between the various "risk populations" is again obvious.

Taking all of this into consideration, American public health authorities now prefer to speak of "risk behaviors" rather than of "risk groups". This approach indeed promises to promote new levels of effectiveness within the existing programs.

This has to be kept in mind when considering "risk group oriented" materials such as the following text describing certain model programs in San Francisco and the State of California. By way of further illustration, the paper is followed by a special edition for women of the San Francisco safe sex guidelines.

CALIFORNIA MODELS FOR WOMEN'S AIDS EDUCATION AND SERVICES

by

Nancy S. Shaw, Ph.D.
Women's Project Development Coordinator

San Francisco AIDS Foundation
333 Valencia Street, Fourth Floor
San Francisco, CA 94103

(415) 864-4376

CALIFORNIA MODELS FOR WOMEN'S AIDS EDUCATION AND SERVICES

Introduction: The AIDS Epidemic

To say that the AIDS epidemic continues to grow is to repeat an obvious fact. Yet the growth must be observed and understood in order to develop policies and programs which can meet and respond to the specific groups (including certain subsets of women) affected by this serious new illness.

Between January 1979 and December 1984, a five-year period, 8,954 AIDS cases were reported to the CDC. The case reports multiplied at a steady rate, as indicated in Table 1. As of June, 1985, 49% of those stricken had died.

Date of diagnosis	No. of cases	No. of deaths	Case fatality rate
1979	Jan.-Jun.	1	100%
	Jul.-Dec.	10	80%
1980	Jan.-Jun.	19	79%
	Jul.-Dec.	28	100%
1981	Jan.-Jun.	81	88%
	Jul.-Dec.	174	83%
1982	Jan.-Jun.	353	76%
	Jul.-Dec.	626	71%
1983	Jan.-Jun.	1163	68%
	Jul.-Dec.	1507	65%
1984	Jan.-Jun.	2256	53%
	Jul.-Dec.	2728	34%

Table 1: Number of reported AIDS cases by half-year of diagnosis. 1979-84. Data from Centers for Disease Control, June 3, 1985. Surveillance Report.

The number of cases per million has risen steadily. Between January and June of 1985 alone, the number of cases per million nationally has risen from 35.1 to 46.9. In San Francisco the rate has climbed from 287.9 to 384.2. (1) The illness has also spread to new locations and populations. Initially concentrated in a few major metropolitan areas, it is now in all 50 states. The percentage of total cases in the major cities is shrinking and the proportion in more rural states and districts is growing. Table 2 indicates this trend during the first six months of 1985.

SMSA or ResidenceDates of Diagnosis

	<u>1/1/81 - 1/21/85</u>			<u>1/1/81 - 6/3/85</u>		
	<u>N</u>	<u>%</u>	<u>cases p. million</u>	<u>N</u>	<u>%</u>	<u>cases p. million</u>
New York, N.Y.	2855	36	313	3615	33.9	396.4
San Francisco, Ca.	936	12	287.9	1249	11.7	384.2
Miami, Fl.	305	4	187.6	368	3.4	226.4
Newark, N.J.	217	3	110.4	270	2.5	137.3
Elsewhere	3668	46	14.7	5176	48.5	23.9
Total U.S.	7981	100	35.1	10678	100.0	46.9

Table 2: Comparison of AIDS cases by Standard Metropolitan Statistical Areas in January and June, 1985. Source: CDC Surveillance Reports of 1/21/85 and 6/3/85.

N = no. of diagnosed cases

% = % of total U.S. cases

cases p.

million = no. of cases per million inhabitants

Although the cities with the highest rates of AIDS cases continue to have more illness diagnosed (e.g., the case per million rate in San Francisco has jumped from 284.9 to 384.2 between January and June of 1985), the distribution is broader. The cities listed in Table 2 (among the top five in terms of cases per million at both countings) now have a lesser share of the total number of cases than they did in January. This change demonstrates the continuing rapid spread of the epidemic. The implication for preventive education and for services is that these also must become more widely distributed outside the major metropolitan areas.

While AIDS has always affected both men and women and persons of all sexual orientations, its sexual spread has previously been more rapid among gay men than among the heterosexual population. Epidemiological evidence indicates, however, that as a sexually transmitted disease AIDS is currently spreading among heterosexuals at a progressively faster pace. As Table 3 indicates, the number of AIDS diagnoses for which heterosexual contact was the primary risk factor rose from 59 in January 1985 to 97 by June 1985, a 64.4% increase. The number of cases where homosexual contact was the suspected route rose from 5,748 to 7,732, an increase of 34.5%. The heterosexual rate of increase was 1.86% times that of the homosexual contact rate of increase.

Suspected Route of Transmission

<u>Date</u>	<u>Male-Male Contact</u>	<u>Male-Female Contact</u>
1/21/85	5748	59
6/3/85	7732	97
Numerical Increase	1984	38
% Increase	34.5%	64.4%

Table 3: Number of AIDS diagnoses by suspected route of sexual transmission. Data source: CDC Surveillance Reports, 1/21/85 and 6/3/85.

Interestingly enough, the rates of increase in diagnoses for men and women during the same period are both around 34%, although the rate is slightly higher for women. The difference is not statistically significant.

<u>Date</u>	<u>Gender (Adults & Adolescents)</u>	
	<u>Male</u>	<u>Female</u>
1/21/85	7375	511
6/3/85	9869	689
Numerical Increase	2494	178
% Increase	33.8%	34.9%

Table 4: Rates of increase in reported AIDS diagnoses for men and women between 1/21/85 and 6/3/85. Source of data: CDC Surveillance Reports. Calculations by author.

Comparisons of Tables 3 and 4 indicate that the rise in AIDS diagnoses attributed to heterosexual contact is not simply a matter of more women being diagnosed. It reflects more heterosexual transmission for both women and men.

The incubation time between infection and the emergence of AIDS-defined illnesses can be from a few months to many years. The lengthy incubation-healthy carrier phenomenon, combined with a lack of AIDS awareness in the general population, means that the illness rates are only the tip of the iceberg of AIDS infection among heterosexual men and women.

In response to the spread of AIDS, including the rise in heterosexual cases and the steady increase in numbers of women and infants with the illness, this report will concentrate on the impact of AIDS on women. It will include an outline of prevention strategies utilized in California, which may be able to slow the increase of cases, and lessen the morbidity and mortality for those women who are exposed to or infected by the HTLV-III virus.

I. Women and AIDS: Transmission and Demographics

As of June 3, 1985, 738 females in the United States had been reported to the CDC as having AIDS. The best estimate of women with AIDS-Related Conditions (ARC) is approximately six to ten times greater than the number with AIDS, 4,428 - 7,380. The best estimate of those with the virus in their system is 60 to 80 times the number with AIDS: 44,280 - 73,800. (2) Women comprise 7% of the national population of AIDS patients and probably a similar proportion of those with ARC or the virus. If the category "gay and bisexual men" is excluded, as many as 20% of AIDS cases are female. Still, as the figures cited above indicate, there are thousands of women already infected. They, their sexual partners, and their infants are at immediate risk of developing the fatal illnesses associated with AIDS.

Sources of Transmission

Table 5 indicates the major routes of transmission for AIDS for women.

AIDS Diagnoses Among Women

<u>Patient Groups</u>	<u>U.S.</u> ¹		<u>California</u> ²		<u>San Francisco</u> ³	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
I.V. Drug User	374	50.7	5	21.7	2	22
Hemophiliac	3	.4	-	-	-	-
Heterosexual Contact	88	11.9	2	8.7	1	11
Transfusion	63	8.5	5	21.7	3	33
Parent at Risk	43	5.8	2	8.7	2	22
None Apparent/Unknown	167	22.6	9	39.0	1	11
Total:	738	100%	23	100%	9	100%

Table 5: Reported AIDS cases among women, by patient group (suspected route of transmission) for U.S., California, and San Francisco since 1981. (On account of rounding, not all percentages add up to 100.)

¹ from CDC Surveillance Report, June 3, 1985

- 2 from California AIDS Activity Office data, 1/7/85. Author's calculations.
- 3 from San Francisco Department of Public Health, 4/30/85. Author's calculations.

General Issues

The most common route of transmission for women is IV drug use and shared needles (50.7%). This is a significant risk factor nationally, in California, and in San Francisco. (Because the state and city numbers are so small, they must be treated with caution when making generalizations and predictions.) Of the other identified routes, heterosexual contact is the next most important nationally. Although a substantial number of women have contracted AIDS through blood or blood products, this risk factor has essentially ceased to be a threat on account of blood bank use of virus antibody tests.

A striking number of women (22.6% nationally, 39% (9) in California, and 11% (1) in San Francisco) are listed as being at risk for "no apparent" or "unknown" reason. The comparable category ("unknown, other") for males is only 5.6% nationally (June 3, 1985 -- CDC). Some of these women may be recent Haitian immigrants. Haitians in Haiti and recently emigrated to the U.S. are reported to be AIDS-antibody positive at a rate of 2%. Haitians are currently listed as "unknown/other", unless in other risk categories. Some women in the "unknown" category may have never been adequately questioned. There may be a sophistication in surveillance with male cases, which came about as the numbers grew, that has not fully developed in the surveillance of female cases. Although women comprise the bulk of health care workers serving patients with AIDS, there are no reported cases of transmission to females (or males) associated with exposure to blood, urine, saliva, or mucous during nursing or other medical care. Neither superficial contact nor more direct contact, including needle sticks with contaminated blood, have resulted in AIDS, or even in positive antibody test results.

Sexual Transmission

More women than men are reported to have contracted AIDS through heterosexual contact. This could be a sign that AIDS is more easily transmitted from males to females. If so, the role of tissue trauma during vaginal and/or anal intercourse might be a factor together with the dosage transmitted via semen. This can be compared to the lesser potential for trauma to the male during intercourse and the more limited opportunity for direct passage of vaginal and cervical secretions into the male's body.

On the other hand, the male-female difference in rates of heterosexual contact leading to AIDS may be a result of the much higher numbers of men already infected with the virus. On the

basis of AIDS diagnoses, we can estimate that there are over 10 times as many men infected with the virus as there are women. While many of these men have contracted AIDS via homosexual contact, a substantial proportion has been infected via drug use. Bisexual males and a number of gay-identified men have sexual contacts with women. But even if one excludes both gay and bisexual men from AIDS statistics, 80% of the diagnosed AIDS cases are male. These figures mean that a woman is much more likely to meet an infected person of the opposite sex than is a man. Consequently, her chances of being exposed to the AIDS virus via heterosexual transmission are currently greater than a man's.

While there is a tendency for some to focus on the risks of prostitution, all women who have multiple sexual partners increase their chances of AIDS virus exposure. Coyote, a national prostitutes' organization, reports that nationally nine prostitutes are known to have contracted AIDS. It is unknown whether these women were also IV users. There is no direct evidence that U.S. prostitutes or other sex workers, such as sex therapists and sex surrogates, have contracted AIDS as a result of their sexual activity. As Coyote argues in Appendix 1, sex workers are often more careful of disease transmission than is the average citizen.

Prostitutes (both male and female) who sell sex to finance IV drug use may be exposed to the virus via shared use of needles. They are then capable of transmitting the virus to others sexually. Historically, female prostitutes have been blamed for the existence and spread of sexually transmitted diseases in the general population, even when there is contrary evidence. Coyote's position paper (Appendix 1) attempts to address this scapegoating phenomenon in such a way that the commonality between those paid and those not paid for sex will be understood. Coyote's goal in this paper is a response based strictly on health concerns.

IV Drug Use and Women

Drug use with shared needles is the most important source of transmission of the virus to women. As Table 5 indicated, it is especially important nationally, although less so in California. Current estimates, however, are that approximately 10% of the opiate using population of San Francisco is HTLV-III antibody positive. (3) If this figure continues to rise, and if the figure is determined to be similar with other, non-opiate, IV drug use, the spread into the general population will accelerate, both through shared needles and through sexual contact. Figures from the San Francisco Department of Public Health from May 30, 1985 demonstrate the important role IV use may play in AIDS infections, regardless of gender or sexual activity. (See Table 6.)

<u>Gender</u>	<u>Reported Drug Use</u>
Male	
Gay	13%
Bisexual	26%
Heterosexual	46%
Female	22%

Table 6: Gender and sexual orientation (where known) of San Francisco AIDS cases with I.V. drug use reported by patient or physician, regardless of suspected route of transmission or primary risk factor. Data from San Francisco Department of Public Health, May 30, 1985.

Prognosis for AIDS is poor in IV users, with a higher death rate (51.7%) than for AIDS cases overall (49%). (4)

IV drug use is more heavily concentrated in non-white communities in the United States than it is among whites. The economics and social consequences of racism, together with criminal justice legislation and enforcement policies have produced a situation in which the poorer Black and Hispanic communities of the United States are suffering from an epidemic of drug use. This epidemic, combined with that of AIDS, is having a devastating impact already in the New York-New Jersey area. With reports that as many as 80-90% of opiate users in Manhattan are antibody positive and knowing that these are not sexually closed populations, we can see the seriousness of the community-wide impact of AIDS on Black and Hispanic populations. Table 7 indicates the ethnic distribution of IV drug users who have been diagnosed with AIDS.

<u>Race</u>	<u>N</u>	<u>%</u>
White	264	19%
Black	692	50%
Hispanic	433	31.1%
Native American	3	.22%
Asian	-	-
Unknown	11	

Table 7: Racial distribution of diagnosed AIDS cases with I.V. drug use as primary risk factor, U.S. Data source: CDC, 2/1/85.

These figures lead us to a general consideration of ethnicity and AIDS in women

Ethnic Distribution of AIDS in Women

Nationally, women of color have been far more likely to be diagnosed with AIDS than are white women. Table 8, which compares California and the rest of the nation, makes this clear.

Female AIDS Cases by Race

<u>Patient</u> <u>Race/Ethnicity</u>	<u>Region</u>		<u>All</u>
	<u>Ca.</u>	<u>Elsewhere</u>	
	<u>N</u>	<u>N</u>	<u>N</u>
White	26	149	175
Black	6	340	346
Hispanic	3	149	152
Other/Unknown	-	9	9
Total:	35	647	682

Table 8: National Distribution of female AIDS cases by race, as of May 28, 1985.

From a quick review of this table, one might incorrectly conclude that AIDS is not especially a problem for ethnic minority communities in California; however, the Pacific Center AIDS Project in Alameda County has found that 17.21% of California AIDS cases are in minority communities. (5) In Alameda County itself, the figure is 32.5% (6). Table 9 indicates that ethnicity varies among the patient groups (another term for "risk categories").

Race

Patient Groups by Risk Factor

	Male Gay/Bisexual		I.V. Use		Heterosexual Transmission				Transfusion		Maternal Transmission		Other/ Unknown		TOTALS By Ethnicity	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
White	992	90	2	25	-	-	1	25	4	80	-	-	1	25	1000	88.9%
Black	43	4	4	50	-	-	2	75	-	-	2	100	2	50	53	4.7%
Hispanic	56	5	2	25	-	-	-	-	-	-	-	-	1	25	59	5.2%
Asian	6	.5	-	-	-	-	-	-	1	20	-	-	-	-	7	.6%
Other (incl. Am. Indian)	4	.3	-	-	-	-	-	-	-	-	-	-	-	-	4	.4%
Unknown	2	.2	-	-	-	-	-	-	-	-	-	-	-	-	2	.2%
Totals (by patient group)	1103	100%	8	100%	-	-	3	100%	5	100%	2	100%	4	100%	1125	100%

Table 9: AIDS patient groups (primary risk factor) by ethnic origin in San Francisco between Jan. 1, 1981 and May 30, 1985. Data Source: from San Francisco Department of Public Health.

142

Furthermore, when one analyzes the ethnic distribution of heterosexually contracted AIDS cases in San Francisco, a broad ethnic spread immediately emerges, as indicated in Table 10.

<u>Ethnic Group</u>	<u>Heterosexual males and all females-</u> <u>AIDS Diagnoses</u>	
	<u>N</u>	<u>%</u>
White	8	36
Black	10	45
Hispanic	3	14
Asian	1	5
Other	-	-
Total:	22	100%

Table 10: Ethnic distribution of AIDS diagnoses in San Francisco among (self-identified) heterosexual males and women (all sexualities), regardless of risk factor. Data source: San Francisco Department of Public Health.

The figures in Table 9 make clear that any educational campaign in San Francisco intended to have an impact beyond the gay community must reach beyond the white population to the Black, Hispanic, and Asian communities. This comment does not imply that the same multi-ethnic approach should not also be used in education and service for gay San Franciscans. I merely wish to emphasize the special importance of multi-ethnic work to reach women, either directly or through their male partners.

Lesbians and AIDS

As of May 30, 1985, there had been no documented cases of sexual transmission of AIDS virus between lesbians. There are, however, a small number of cases of women who define themselves as lesbians who have contracted AIDS through shared IV needles and through heterosexual contact. Until further research on female transmission is complete, the risks of lesbian sexual practices as transmitters of the virus are essentially unknown. The paucity of research on sexually transmitted disease among lesbians makes most projections highly speculative.

If the virus is found in vaginal and cervical secretions, and/or the menstrual blood of infected women (as is to be anticipated), then it is as important for women as for men to avoid these fluids when their partners are infected or possibly infected.

Two studies currently under way, the AWARE project on AIDS seropositivity in women, conducted by Wofsey, et al. at UCSF, and a project at the San Francisco based Lyon-Martin Clinic on

sexually transmitted diseases in lesbians, may help answer some of these questions. For a description of the AWARE projects, see their attached research proposals (Appendix 3).

Donor Insemination

A major issue confronting lesbians as well as some other couples with fertility problems is donor insemination. There have been no documented cases of AIDS virus transmission through donor insemination. This does not mean that semen without "sex" is safe. Rather, it may reflect precautions taken by sperm banks and individuals to avoid donations from persons who might be virus carriers. It may also be related to other factors, such as the minimal tissue trauma or limited dose with planned insemination. However, until more data is collected (and given the knowledge that the virus can be contracted from heterosexual transmission of semen), most physicians and sperm banks advise against insemination with a donor in a risk category. One strategy for protection in donor insemination is use of the antibody test when the donor has possibly been exposed or infected. The Alternative Test Site brochures of the San Francisco AIDS Foundation (Appendix 4) explain why such screening is important.

Pregnancy and Maternal Transmission

Women are unique in their ability to become pregnant and bear children. This special capacity also renders them capable of passing the AIDS virus on to their unborn children. Of the 124 pediatric AIDS cases reported to the CDC by June 3, 1985, 90 (73%) are the result of maternal transmission. The mothers were infected via shared needles or sexual contact. Most appeared healthy during their pregnancies. The maternal infections were passed on, however, to the infants, transplacentally, or at birth, and in some possibly through nursing. The infants with AIDS, the many others with ARC, and those children carrying the virus can anticipate greatly shortened lives with high susceptibility to opportunistic infections and cancers. Prevention of maternal transmission can only be accomplished through education of women at risk for AIDS infection. As will be discussed in the "Programs" section, such education will require the combined efforts of health departments, community service agencies, and health care providers to women. Antibody screening programs for women at risk can only be one component in this process.

Pediatric AIDS is a phenomenon more common to other areas of the U.S. than to California. However, nine cases have been reported in California, two of them in San Francisco. Ethnic minority children comprise a substantial proportion of the cases -- 33% in California and 78% nationally. The pediatric AIDS demographics mirror the female demographics, for obvious reasons.

II. Current AIDS Prevention Programs for Women

It is universally acknowledged that education is the key to stemming the spread and mitigating the effects of AIDS. The

education must include health providers as well as people who have been, or might be, exposed to the AIDS virus. Additionally, multiple services, ranging from information and referral through social service and case management to a full range of medical services, are acutely needed for people with all stages and types of illness and incapacity associated with AIDS. As the previous section indicates, a growing number of women will be needing both education and health services. To date, woman-focussed and/or woman-sensitive AIDS resources have been quite limited.

In this section we will review such resources and programs in Northern California on a county-by-county basis, beginning with San Francisco, where the greatest number of women's educational, resource, and research projects are to be found. Most of these programs can be adapted to other counties and adjustments can easily be made for urban, suburban and rural conditions.

San Francisco City and County

A. Women's AIDS Network

The Women's AIDS Network (WAN) is a volunteer organization grounded in San Francisco. Its active members come from most Bay Area counties (San Mateo, Santa Clara, Alameda, Marin, Sonoma) as well as Sacramento. It draws subscribing members from as far away as New York, Texas and Georgia.

Formed at a national AIDS meeting in 1983, the Women's AIDS Network initially saw itself as a national organization. When this proved impractical, it gradually settled into an educational and advocacy role in Northern California. Its members are predominantly women health professionals (physicians, therapists, educators, nurses, researchers, social workers, etc.) working in AIDS organizations.

For its members, WAN provides a location to exchange information and ideas. Some of the issues which the organization has addressed include:

1. members' experiences as women in predominantly male organizations
2. emotional issues of working with people with AIDS and ARC
3. networking opportunities for referrals, advice, employment, planning
4. recommendations for coordinated, non-duplicative resource development
5. information sharing concerning research, new programs and policies, potential speakers for forums, workshops, etc.
6. resource sharing, e.g., loans of audio-visual media

WAN has provided a variety of services to the broader community by sponsoring educational forums, and by preparing and distributing brochures about women and AIDS. WAN sponsored the first Women and AIDS forum for the general public in the Bay Area in 1983. In 1984, with the assistance of the San Francisco AIDS Foundation, it sponsored and organized its second Women and AIDS forum, this one for health care providers. Continuing Education credit was available for nurses. The syllabus for this forum is attaching in Appendix 5. The brochure "Women and AIDS" was written by two members of WAN, and then funded, printed and reprinted by the SFAF (Appendix 6). Currently (June, 1985) WAN is completing its first newsletter to the general public. The newsletter will have an initial circulation of 3,000 copies.

Funding for WAN activities has been generated by dues, forum fees, and a small grant. The organization is currently planning a

benefit for newsletter expenses and is selling buttons which say "AIDS: Not Just a Man's Issue -- Women's AIDS Network". (See Appendix 7 for WAN membership form.)

WAN provides a model which can have a significant impact on health care providers and on consumers. It developed in an area with many AIDS cases (most of which are male). The region may also have been conducive to organizational creation. The San Francisco Bay Area is a region with an established history of women organizing around health, gay and feminist issues. Still the network approach can be a strategy worth considering in outlying counties, as a mode to generate awareness of AIDS, and as a way of linking the women health workers of the county into an active force around AIDS issues. Major values of this approach are that it is fairly economical, it breaks down isolation, and it can grow indefinitely.

B. Women's Program, San Francisco AIDS Foundation

In October, 1984, the San Francisco AIDS Foundation (SFAF) received a grant from the State Department of Health to develop a pilot program on Women and AIDS. This project is the only government funded educational program in the U.S. which is explicitly focused on AIDS and women. The Foundation hired a half-time development coordinator (the author of this report). Building on earlier work at SFAF, the program has developed an experimental multi-faceted approach to education, referrals and resource development concerning women and AIDS. It has taken San Francisco and nearby California counties as its main focus. Its work between November 1984 and June 1985 is described below.

1. Forums

The November 1984 "Women at Risk" forum for health care providers attracted over 100 participants. The Women's Development Program has also been involved in a number of other forums and workshops. These have been directed at three audience categories: health professionals, women at risk, and the general public.

Forums and workshops for health professionals included Continuing Education credit wherever possible to encourage attendance by nurses and other persons for whom certification credits are important. A forum conducted for the San Francisco Health Department focused specifically on women and AIDS, with special presentations on women and drug use, heterosexual and maternal transmission, and criminal justice concerns. Workshops on "Women and AIDS" were also incorporated into other AIDS and women's health meetings and forums, thus enabling the program to reach a broader segment of care providers, many of whom might not attend a meeting or forum exclusively focused on women or on AIDS or on "Women and AIDS".

Presentations for the general public were conducted at U.C. Berkeley, as part of an all-day forum on AIDS, and to

predominantly lesbian and gay audiences in San Francisco and Santa Cruz.

Presentations to women at risk through IV drug use and/or multiple sexual contacts were prepared in cooperation with the San Francisco Pretrial Diversion Program and a San Francisco Jail Medical Service social worker. The first workshop, held in May 1985 at the County Jail, utilized a slide presentation, brochures, Hotline flyers, and a question and answer format for an audience of 20 female inmates.

The goal of the Women's Development Program in regard to education of women at risk has been to train service agency staff and/or members of the at-risk group to do trainings themselves. At the Family Addiction Center for Education and Treatment (FACET), staff were trained by the program coordinator; at the jail the initial program for inmates involved both jail and SFAF staff. The latter is preferable when developing materials for a new audience, as it gives the program developer more direct opportunity to judge the effectiveness of various educational strategies.

2. Information and Referrals

The women's program also provided up-to-date information on women and AIDS to SFAF Hotline callers, SFAF staff, health care professionals, and researchers. In order to provide such information, an agency or program will need to set aside staff time to collect the information. Existing women's organizations and services should be surveyed in regard to their abilities to provide AIDS services, while existing AIDS organizations must also be reviewed in terms of their service to women. At the SFAF, the women's program coordinator went to the International AIDS conference in Atlanta in May 1985 as one part of this process. Access to a good medical library and knowledgeable individuals are also crucial factors in providing accurate information to the public.

An additional information gathering strategy used by the women's program was the development of an organizational network among professional AIDS researchers working with human subjects. While the research network was much broader in scope than "Women and AIDS", it did include all Bay Area research projects working with women. It was also responsive to research issues affecting female subjects.

Distribution of information can be a time consuming process. The SFAF Hotline, which is a primary source of public information on AIDS in Northern California, uses numerous volunteers. The value of a hotline approach is that individualized education, directly responsive to the concerns of the caller, can be provided. At the SFAF, the Hotline is supplemented with brochures and other materials that can be sent to the caller. Additional mass media and group approaches for more general public education are also pursued by the Foundation.

The SFAF Hotline was developed to serve three basic classes of people: the general public, people at risk for AIDS, and people with AIDS and ARC. The women's program provided additional training and resource lists to the Hotline staff and volunteers to help them respond more accurately and sensitively to women's issues within the three general categories. (See Appendices 8 and 9 for support group and drug rehabilitation resources listings.)

3. Advertising

As a component of the provision of information to the general public, the women's program prepared specific advertising to encourage women and the non-gay-identified population to call the Hotline. (See Appendix 10 for advertising copy.) To reach the multi-ethnic population of women at risk, advertising was prepared in Spanish and English. Ads were placed in the Black, Hispanic, Asian and white press, as well as the gay and lesbian press and in papers read by prostitutes.

4. Multi-Ethnic Outreach

In addition to the bilingual, multi-ethnic advertising campaign for the Hotline, the program distributed "Women and AIDS" brochures in Spanish ("Mujeres y AIDS", see Appendix 11) and recruited Black, Spanish-speaking and bi-cultural volunteers to work on various outreach projects. Consultation and a proposal were also provided to the San Francisco Department of Public Health concerning a possible multi-ethnic educational program for teenagers (see Appendix 12). The Women's Program Development Coordinator also participated in the ethnic outreach committee of the SFAF.

Where specific ethnic and/or racial populations are at risk for AIDS, special advisory committees and outreach work are necessary. Programs should provide routine Spanish-language outreach in advertising, written materials, and educational events wherever there is a significant Hispanic population.

5. Work with Special Groups of Women at Risk

Prostitutes, women in jail, IV drug users, and women facing pregnancy after possible AIDS virus exposure: these groups of women have special needs for AIDS services. The SFAF Women's Program developed separate files general of information, health, social services and legal resources, education programs, and specialists who could work with individuals or groups. The file development was prepared by literature review and contact with organizations working with women in these groups. The files were then available when requests for assistance or resources arrived from health care providers, the general public, and the women at risk.

6. Networking and Volunteers

One person can only accomplish a limited amount. Networking and volunteers can be important extenders. Both approaches were integral to the SFAF Women's Development Program.

Networking was accomplished through the Women's AIDS Network, the San Francisco and East Bay Perinatal Forums, SFAF contacts, Coyote, the Coalition for the Medical Rights of Women, the Bay Area AIDS Research Consortium (founded by the SFAF), and gay and lesbian organizations.

The SFAF volunteer network and volunteer coordinator were used to recruit volunteers. From San Francisco State University, two Women's Studies interns and five Health Education interns donated various amounts of time. One volunteer came through an alternative sentencing program. Several volunteers either had ARC or were otherwise exposed to the AIDS virus. Another worked in an AIDS-related job. Among them, these volunteers contributed over 450 hours of work in six months.

Each volunteer had a clearly defined task which was pursued over several weeks or months. Two developed a multi-ethnic advertising campaign; one prepared translations and typed; another handled a mailing list and information requests; four prepared a grant proposal; and two developed a major listing of women's health care providers. In only one case did a person stop working before a project ended and then the work was substantially complete.

7. Future Plans

The Women's Development Program was charged by the State Department of Health Services with the development of pilot programs and preparation of proposals for future work. It is anticipated that the program will continue its existing educational work, networking, and consultations. The Women's Program also prepared several proposals for future work:

a. Outreach to Women's Health Care Providers

A Program intern prepared a county by county listing of women's health care providers in Northern California. The listing includes all obstetrician/gynecologists, women's health clinics, and women's substance abuse programs in San Francisco, Alameda, Contra Costa, Lake, Solano, Mendocino and San Mateo counties. The listing will be used to contact these providers to begin comprehensive educational programs about women and AIDS in these counties. This plan was begun after it was realized that very few women's health care settings have literature on AIDS and women. Existing literature and patient education programs which touch on sexually transmitted diseases have not yet been updated to include AIDS. The primary goal of this plan is to begin to change this situation. Implementation of the plan will

require extensive local organizing and cooperation. (See Appendix 13 for a partial county by county listing.)

b. "Women and AIDS -- Straight Talk".

A second proposal prepared through the program is a heterosexual education project designed to foster the use of condoms. This proposal, "Women and AIDS -- Straight Talk", was prepared by San Francisco State University Health Education students. It is attached in Appendix 14.

c. "AIDS Teenage Awareness Program"

A third proposal was prepared in draft form for the Community Services of the San Francisco Department of Public Health. This proposal was for a multi-ethnic approach utilizing adult community leadership to educate teenagers about AIDS (see Appendix 12).

These projects are mentioned here, not only because they were generated by the Women's Program of the SFAF, but also because they can be used as models in other cities, counties, or states which are developing AIDS awareness and prevention programs to protect and serve women.

C. AWARE

The AWARE research project is funded through the University of California, San Francisco, out of California AIDS research funds. It is mentioned here because its goal is the generation of knowledge about women and AIDS and because it provides education, counseling and referrals to its research subjects, all of whom are women.

AWARE is the acronym for Association for Women's AIDS Research and Education. The emphasis is on research, with the study essentially focused on seropositivity prevalence among women at risk through heterosexual contact. Copies of the project's research proposals are appended (Appendix 3).

The AWARE project is the first to systematically study women at risk. It is also the product of cooperative planning and interaction among physicians, epidemiologists, health service providers, and advocates for women. It is thus a thoroughly objective but somewhat unusual scientific enterprise. Both its research methods and its style of working with subjects could be usefully replicated in other cities. Additional research projects connected to the AWARE study are investigating the role of donor insemination, the psychological impact of antibody test result information, and the AIDS antibody status of women partners of men with hepatitis B antibodies.

D. AIDS Support Resources for Women in San Francisco

There are a number of health organizations in San Francisco which either serve women primarily or have special programs for women. These organizations are listed in Appendices 8, 9, and 13. Of special note in regard to AIDS services are the support groups for women developed by Shanti and the AIDS Health Project. The AIDS Health Project provides eight-week structured educational support groups in which participants assess their response to AIDS and develop health maintenance strategies.

Both Shanti and the AIDS Health Project were pressed to provide special services for women. Both report a limited demand. It is possible that as AIDS antibody testing becomes more widespread and more women discover they are antibody positive, the demand will increase.

In the area of substance abuse resources, services are limited. The AIDS Health Project provides some out-patient support groups. There are few residential drug rehabilitation programs for women. Many programs will not take children; still others exclude pregnant women. Currently, only one residential program in San Francisco will provide accommodations throughout pregnancy and for women with children. This is the Pomeroy House of the Women's Alcoholism Center. Although Pomeroy House requires that the client's major problem be alcohol, it will admit women with polydrug dependency including opiate use. The staff has also completed a process of in-service training concerning women and AIDS. Pomeroy House provides an important model for education and rehabilitation of women at risk for AIDS on account of IV drug use.

In addition to the special programs for women noted above, all the AIDS organizations in San Francisco -- e.g., Hospice, Shanti, Mobilization Against AIDS, and the SFAF -- make their general services available to women. The SFAF, for example, offers comprehensive case management through a social services department; it also provides a food bank for people with AIDS or ARC, and general referrals. Hospice provides housing services for people confronting death and dying. Shanti provides a variety of counseling and support for individuals and their loved ones facing life-threatening illness and bereavement. Mobilization Against AIDS is an advocacy organization which monitors legislation and secures funding for AIDS research and services.

E. San Francisco Public Health Department

The Health Department has begun to apply traditional communicable disease tracking and education to heterosexual AIDS cases in San Francisco. Persons with AIDS (not persons with positive antibody test results) are asked to notify their recent and current sexual partners. Alternatively, if the patient is uncertain about making the personal contact, a Health Department Communicable Disease Officer will make the contact instead. The goal of the program is

to stem the spread of AIDS through individual education about safe sex practices.

The Department of Public Health also provides extensive funding for general education and for the Alternative Test Site Centers for anonymous antibody testing. This is in addition to its funding for direct medical, mental health and other services needed by people suffering from AIDS-related illnesses.

F. Medical Services in San Francisco

The bulk of Northern California medical services for people with AIDS and ARC is located in San Francisco. This results from several factors: the size of the San Francisco gay community, the local concentration of AIDS cases, and a pre-existing density of health services, physicians, research facilities, and medical schools. If special services for women with AIDS were to develop in California, one would expect them to occur first in San Francisco. To date the number of adult female patients has been low -- seven with AIDS, and an unknown number of women with identified ARC symptoms. Lyon-Martin Clinic, a San Francisco women's clinic originally founded to serve lesbians, has trained its staff, with the help of AIDS outpatient clinic staff from San Francisco General Hospital, to be a pre-screening clinic for AIDS. The AIDS screening clinics in the city's Public Health Centers, as well as all other AIDS medical services, are also available to women. The Lyon-Martin model represents the addition of AIDS-related services within a woman-focussed organization. The Health Center model represents a similar expansion of AIDS services for both male and female clients. In both cases, special training for physicians in diagnosis and treatment is required.

Services for pediatric AIDS patients are limited; referrals are being made to the pediatric immunology service at the University of California San Francisco Medical Center.

Because AIDS is a chronic debilitating disease, specialized supplemental services are required for comprehensive care in addition to the traditional physician services. With women as clients, additional needs, such as those associated with dependent children and pregnancy, must also be addressed. Planning for clinic and other medical services for women should take these special needs into account. Section D, above, describes some of the supplemental services available to women in San Francisco.

Overall, of the Northern California counties, San Francisco has the greatest variety of educational and service programs directed at women. We will now briefly examine some of the outreach and special services to women in other counties. All the counties listed are in the state service area of the San Francisco AIDS Foundation. They receive assistance in program development. Where no organized program exists, the Foundation has provided some direct education.

Alameda County

Aside from services provided through the Health Services Agency, the major AIDS organization in Alameda County is the Pacific Center AIDS Project. The Pacific Center provides an information and referral service, a variety of education programs, and support groups for people with AIDS as well as for friends, family and lovers. The Center has initiated several projects specifically addressing the needs of women:

1. "Women Concerned About AIDS" discussion group -- meets once a week, includes women working in the field, women at risk, and those with friends or family with AIDS.
2. An evening drop-in women's group -- for lesbians, straight and bisexual women.

The Center has also been involved in several outreach projects which touch on the special needs of women:

1. "Talking with Our Kids and Other Parents About AIDS" -- an evening forum.
2. An elimination and prevention of racism project (see "Pacific Center AIDS Project Statement on Racism and AIDS Work", Appendix 12).

Several forums on AIDS in Alameda County have included workshops on women and AIDS.

The Pacific Center AIDS Project is a more typical AIDS organization for California than is the SFAF. It has less AIDS funding and a smaller overall budget. Consequently it provides fewer AIDS-specific services. Similar to many AIDS organizations throughout the country, it is based in an institution which was initially and is primarily focussed on the needs of the gay and bisexual community.

Other Northern California counties with AIDS education projects provide even fewer services and educational programs specifically for women.

Marin:

Marin AIDS Support Network, the Health Department and the AIDS Advisory Committee are the primary AIDS education organizations in Marin. Woman focussed work in the county includes distribution of brochures on women and AIDS.

Marin AIDS Support Network has a female staff member (volunteer) and female board members. The Support Network has publicly raised issues of women and AIDS in educational

and media settings. No special forums concerning women have been held.

Sonoma:

Programs for women have included:

A forum on AIDS for the lesbian community

A section on women and AIDS provided in a recent educational forum on AIDS for health care providers

In July, 1985 River Community Services will be holding a one-day forum on women and AIDS

"Women and AIDS" brochures are distributed regularly

River Community Services has had female staff who have helped focus activities on women as well as men

Contra Costa:

Contra Costa has very limited AIDS services, primarily provided by the Pacific Center and the SFAF. The Health Department in Contra Costa has played a very limited role.

"Women and AIDS" brochures have been distributed

Discussion about women and AIDS has been incorporated into general AIDS education, including several forums for substance abuse professionals

Lake:

The primary AIDS organization in Lake County is the Health Department

Brochures on women and AIDS have been distributed

Discussion about women and AIDS has been incorporated into general AIDS education

Mendocino:

The primary organization for AIDS education is the Health Department

Brochures on women and AIDS have been distributed

Discussion about women and AIDS has been incorporated into general AIDS education

Napa:

The primary AIDS organization is the Health Department

Brochures on women and AIDS are being distributed

Discussion about women and AIDS has been incorporated into general AIDS education

Solano:

The Health Department is the primary AIDS organization in Solano. There is also an active group of lesbian and gay volunteers

Brochures on women and AIDS are being distributed

Discussion about women and AIDS has been incorporated into general AIDS education

As the above survey indicates, when one leaves the Bay Area, educational, social and medical services for women with AIDS concerns thin out quickly.

III. Conclusions and Recommendations

As Part One of this report makes clear, the AIDS epidemic is spreading rapidly into new populations. Women and infants will be affected in increasing numbers. Because progress toward either vaccination or cure is slow, education is one of the most important strategies available to limit the spread of the illness. Yet educational programs for health providers, the general public, and people at risk are extremely limited. With the exception of San Francisco and Alameda counties, where limited women's outreach projects have begun, there are essentially no on-going educational projects specifically designed to educate women and their health providers about AIDS. Few programs exist to involve women or their health care providers in the process of stopping the spread of the illness.

Several California projects which do address these concerns are described in Section II. It is still too early to assess their effects thoroughly. The study conducted in March 1985 by San Francisco State students found that 47 out of 100 women did not know they could contract AIDS. A total of 64% did not know any risk reduction measures. (7) On the other hand, in a focus group of nine women at risk convened in San Francisco in May 1985 and including IV users and sexually active women, all were aware that women could get AIDS and most knew some risk reduction strategies. Most had also changed their behavior on account of AIDS, although few could be said to have completely protected themselves (see Appendix 15). Both these women and those in the San Francisco

State study wanted more information. Research in New York and San Francisco has demonstrated that AIDS education programs can change behavior and consequently reduce the rate of the epidemic. (8)

AIDS education programs for women present special challenges. Women are an aggregate group of individuals. They do not belong to one community, culture, class or location. Instead, their lives are organized through a variety of family allegiances, ethnic groups, residence patterns, and life styles. These differences mean that programs oriented directly toward women will be most successful if they build on and utilize this diversity, rather than attempting to ignore it.

In some cases the educator may be able to reach a woman through ethnic media or social organizations; in another case, her life style of drug use may be the key; for yet another, awareness of sexually transmitted diseases can be the first step to AIDS awareness.

At the same time, efficiency demands that some commonalities be introduced into educational planning. The education of health and social service providers, as well as community leaders, can save time for the AIDS educator. Mass media campaigns (such as the one described in Appendix 14) are also crucial. A "Women and AIDS" program can pass on basic AIDS information to health providers; at the same time, it should provide awareness that special strategies are needed to educate clients, patients and community members in a culturally relevant manner.

Recommendations

The following recommendations are guidelines for developing AIDS awareness and service programs directed at women. They are based on a county/city model. None of these recommendations can be implemented without a basic program of AIDS education and services. Many counties have no organized AIDS programs. As these basic programs are initiated, they should incorporate the following suggestions.

RECOMMENDATION I: Comprehensive AIDS education campaigns are needed on a county-by-county basis. A needs assessment should first be conducted which evaluates community awareness, estimated numbers of AIDS and ARC patients as well as antibody positive individuals. Variables, such as IV drug use, sexually transmitted disease patterns, and out of wedlock pregnancy and teen parent rates, should also be reviewed in order to plan appropriate and effective AIDS prevention campaigns which will reach women as well as men and people of all ages. Public education and health agencies as well as community organizations should be surveyed to assess current service provisions. Assessments concerning women's risks and needs should be incorporated in any broader AIDS-related needs assessment.

RECOMMENDATION II. Local Health Departments should initiate reviews of AIDS education, health, and social services. These reviews should incorporate women's needs.

Questions important to service for women include the following:

Are health care providers educated about AIDS and women?

Do they need additional training?

Is there an AIDS screening clinic or a referral list of knowledgeable physicians, including family physicians, OB/GYNs, and pediatricians?

Are appropriate medical services available for people with ARC and/or AIDS?

What are the special needs of women? Are they being met?

What services, if any, exist for the woman drug user? Are they appropriate?

RECOMMENDATION III: Basic AIDS education Programs for health care providers, for people at risk or with AIDS, and for the general public should be initiated.

Following a needs assessment, an educational strategy can be developed. Planners may find the book Health Education Planning: A Diagnostic Approach helpful. (9) The first step will be the establishment of educational priorities, secondly adequate funding, staffing, authority and coordination must be assured. A basic level of community awareness, i.e., knowledge that the program exists, should be established. Planners should develop a long-term strategy as well as short term realizable goals.

A variety of specific educational strategies for women have been described in Section II. They include:

14) Outreach to health providers (see Appendices 5, 7, 13 and

Development of an advocacy and information network of women working on AIDS issues (see Appendix 7)

Direct media advertising (see Appendix 14 for an educational model incorporating advertising; also see Appendix 10 for advertising models.)

Use of existing community institutions -- including health agencies as well as social service, ethnic, religious or other cultural groupings

Materials development in appropriate languages. In some cases it may be more efficient to incorporate material about AIDS into existing material, e.g., into media concerning sexually transmitted diseases.

Education of community leaders (Appendix 11 presents one model for this approach.)

Specific strategies selected will depend on the community. What is most important is that a planned program be initiated.

RECOMMENDATION IV: Where appropriate, new services should be initiated. This will involve development of a funding base as well as public and private involvement in planning and provision. The types of basic services that will be needed include:

1. Anonymous AIDS antibody testing sites
2. AIDS screening services
3. Low-cost and free medical care for persons with AIDS or AIDS-related illnesses
4. Comprehensive social services, including mental health, welfare, disability, food stamps, SSI, unemployment, housing, legal assistance, nursing care, hospice arrangements, religious support, counseling and support groups for family, lovers and close friends
5. Services should be made available directly or by referral through traditional health care providers. For women, these providers include obstetrician/gynecologists, family practice physicians, pediatricians, and health clinics (see listing in Appendix 13).

RECOMMENDATION V. Because of the diversity that women represent, all educational campaigns and services for them should be sensitive to multi-ethnic, multi-class issues as well as to lifestyle diversity.

RECOMMENDATION VI. Because of women's unique reproductive roles, AIDS programs for women should take reproductive issues into account. The issues include:

1. birth control
2. genitally transmitted diseases
3. donor insemination
4. conception and safe sex
5. antibody screening and pregnancy counseling
6. maternal transmission of the AIDS virus
7. pediatric AIDS, whether caused by maternal transmission or other routes
8. maternal issues with older children, born before the mother's illness
9. reproductive freedom -- including the right to have or reject an abortion

Pursuit of the above recommendations could be a first step in meeting the needs of women and the needs of the larger community, both gay and straight, young and old -- for a safer way of living during the era of AIDS.

Footnotes

1. CDC AIDS surveillance reports of 1/21/85 and 6/3/85.
2. These estimates are based on studies which indicate that for those persons whose blood was antibody positive five years ago, 5 to 10% have developed AIDS; another 20% have developed ARC; while approximately 70-80% remain healthy.
3. Estimates from medical staff at Haight-Ashbury Free Clinic and Bay Area Addiction Research and Treatment (BAART) program serving methadone clients. May, 1985.
4. Data from CDC, Feb. 1, 1985.
5. Pacific Center AIDS Project Statement on Racism and AIDS Work. See Appendix 2.
6. Ibid.
7. Cf. "Women and AIDS -- Straight Talk", Appendix 14.
8. Research and Decisions Corporation, "A Report on: Designing an Effective AIDS Prevention Campaign Strategy for San Francisco: Results from the First Probability Sample of an Urban Gay Male Community," San Francisco, 1984; S. Schultz, S. Friedman, A. Kristal, D.J. Sencer, "Declining Rates of Rectal and Pharyngeal Gonorrhoea among Males -- New York City," MMWR, 33:21, 6/1/1984.
9. This test, by Lawrence W. Green, Marshall W. Kreuter, Sigrid Deeds, and Kay Partridge (Palo Alto, Mayfield Publishing, 1980) provides a practical analytic approach to values, beliefs attitudes and perceptions which can facilitate or hinder personal motivation for change.

List of Appendices

1. "Coyote Convention -- San Francisco, CA, May 30-June 2, 1985"
2. "Pacific Center AIDS Project Statement on Racism and AIDS Work"
3. AWARE research proposals for 1984-5 and 1985-6
4. Alternative Test Sites for AIDS Antibody Test
5. Syllabus -- Women At Risk: Strategies for AIDS Education and Prevention, Nov., 1985
6. "Women and AIDS" brochure
7. Women's AIDS Network membership form
8. "Current Support Groups and Assistance for Women exposed to AIDS -- San Francisco Area," May, 1985
9. "Rehabilitation Resources for Women with IV Drug Dependencies" February, 1985
10. Advertising for AIDS Hotline directed at women and/or general public
11. "Mujeres y AIDS" brochure
12. "AIDS Teenage Awareness Program: A Multi-ethnic Strategy"
13. "Women's Health Services Listing"
14. "Women and AIDS -- Straight Talk"
15. "San Francisco health crisis focus group with women at risk," memo, Research and Decisions Corporation, June 21, 1985

SAFE SEX GUIDELINES FOR WOMEN AT RISK FOR AIDS TRANSMISSION

General Guidelines

If you believe that you or your sex partner(s) may be infected with the AIDS virus, or you are not sure, avoid sexual activity that involves contact with body fluids. The AIDS virus is transmitted through direct contact with infected blood, semen, urine, feces, and possibly vaginal secretions. Although the AIDS virus has also been found in saliva and tears, there is currently no evidence that it is transmissible through these fluids. Body fluids can be exchanged through needle-sharing (blood), or through *unprotected* sexual contact with a person who is infected. Therefore, if you believe that you or your sexual partner(s) may be infected with the AIDS virus, or you are not sure, avoid contact with body fluids. Men who have sex with other men, and men and women who use IV drugs or have received transfusions of blood or blood products *and their sexual partners* are at increased risk of coming into contact with, and possibly becoming infected with the AIDS virus.

Specific Guidelines for Sexual Activity

SAFE

- Massage
- Hugging
- Body-to-body rubbing
- Social (dry) kissing
- Voyeurism, exhibitionism, fantasy
- Touching your own genitals (masturbation)

POSSIBLY SAFE

- Vaginal or anal intercourse *with* a condom
- Fellatio/blow jobs *with* a condom
- Cunnilingus/oral sex *with* a barrier (see back of page for description)
- Hand/finger-to-genital contact *with* a latex or rubber glove or finger cot (mutual masturbation, hand jobs/locals, vaginal or anal penetration with fingers)
- French (wet) kissing
- Water sports (external only)

POSSIBLY UNSAFE

- Cunnilingus/oral sex *without* a barrier
- Hand/finger-to-genital contact *without* a latex or rubber glove or finger cot.

UNSAFE

- Vaginal or anal intercourse *without* a condom
- Fellatio/blow jobs *without* a condom
- Semen or urine in the mouth
- Blood contact of any kind (including menstrual blood and sharing IV needles)
- Rimming (oral-anal contact)
- Fisting (hand in rectum/vagina)
- Sharing sex toys that have contact with body fluids

**IN ANY SITUATION, SEXUAL OR OTHERWISE,
SHARING NEEDLES IS UNSAFE.**

PREVENTIVE MEASURES

About Condoms, Spermicides, Gloves and Barriers

CONDOMS: Condoms have been known for a long time to be effective in preventing sexually transmitted diseases, such as gonorrhea, syphilis, herpes, and chlamydia. Recently, studies have shown that condoms block the transmission of the AIDS virus in the laboratory. Therefore, most researchers believe that condoms, carefully used, will offer some protection from the AIDS virus. Some users report that latex condoms are more flexible and therefore stay on better than natural condoms. It is important to find one that works for you and your partner. A small amount of spermicide or a water soluble lubricant (not Vaseline) inside of the tip of the condom increases sensitivity for the male partner but too much could cause the condom to slip off.

SPERMICIDES: Nonoxynol 9, the active ingredient in most spermicides (foams, creams, jellies), has been found to kill the AIDS virus in some laboratory situations, although we are not certain that it kills the virus in the body. Many researchers believe, however, that it is a good idea to use a spermicide containing nonoxynol 9 as a backup in case the condom slips or breaks. Some lubricants also contain nonoxynol 9, but may not say so on the label. Check with a pharmacist to be sure. **CAUTION:** Some people are allergic to nonoxynol 9. Test the spermicide on the inside of your wrist before using it. If it stings or you get another reaction, try changing brands.

DISPOSABLE LATEX OR RUBBER GLOVES AND FINGER COTS: If you have cuts, scratches or hangnails on your fingers or hands, physicians' disposable latex or rubber gloves, or finger cots, will prevent contact with the AIDS virus during hand-genital or hand-anal contact. Finger cots can be purchased in a drug store; gloves can be purchased in any dental or surgical supply house.

LATEX OR RUBBER BARRIERS ("RUBBER DAMS"): Some sexologists have suggested that cunnilingus may be safe if done using a barrier that prevents the exchange of fluids between the tongue and vulva. Rubber dams are a thin piece of latex that comes in various sizes and is about the same thickness as a physician's disposable glove. Latex barriers come in rolls or sheets and can be purchased at dental and surgical supply houses (they even come with vanilla flavoring). At this time, no research has been done on whether or not they provide protection. People who have tried to use them find them fairly awkward. However, they should be considered if there is a significant risk of transmitting the AIDS virus.

Disclaimer

Condoms, spermicides, latex gloves, and other barriers can prevent the transmission of the AIDS virus in ideal conditions. However, real life is often not ideal. Only you and your sex partner(s) can decide what is a reasonable amount of risk. These guidelines are designed to help you make your own decisions. Given the long incubation period for AIDS only time will tell the effectiveness of these or any other measures.

**For more information call:
The SF AIDS Foundation Hotline at 415/863-AIDS
or COYOTE at 415/552-1849**

**COMPILED BY THE WOMEN'S AIDS NETWORK, COYOTE,
PROJECT AWARE AND THE LESBIAN INSEMINATION PROJECT**

IV drug users, whether male or female, are a particularly difficult target group for AIDS prevention efforts. There have been suggestions that IV drug users should be given free needles for one-time use and indeed there are some experimental, closely monitored programs coming close to this suggestion. In San Francisco, small teams of street workers have tried to gain the confidence of IV drug users distributing free bleach and cleaning instructions to them where they congregate. However, this program has occasionally been hampered by a lack of coordination with the police who have occasionally confiscated the bleach on the spot. (Some police officers have also confiscated condoms carried by prostitutes as evidence.) These and other episodes show that coordination and cooperation at all levels of government is essential if the goal of AIDS prevention is to be met.

Perhaps the most serious obstacle facing the risk reduction effort in the IV drug using population is the lack of detoxification centers. In New York and San Francisco IV drug users who want to be rehabilitated may have to wait several months before they can enter a treatment center. There simply are not enough places available for financial reasons. The various government agencies, so far, have been reluctant to finance a sufficient detoxification program, a fact that amounts to nothing less than a public health scandal of the first order. However, given the political realities and the enormous unpopularity of drug users, little seems likely to change in the near future.

Therefore, some respected American drug experts strongly recommend a needle-free methadone maintenance program, at least for those drug users who are willing to try it.

These experts also believe that it is a mistake to think in stereotypes about IV drug users and that it is necessary to develop a differentiated view of this population. They believe that it is a mistake to "write the drug users off" as hopeless.

The various considerations entering risk reduction programs for IV drug users are briefly summarized on the following page:

AIDS/SUBSTANCE ABUSE SERVICES

<u>Goals</u>	<u>Services</u>	<u>Populations requiring special services</u>	<u>Factors influencing service development</u>
End the sharing of contaminated needles and unsafe sexual activity associated with substance use	Outpatient and inpatient detoxification	IV drug users	Continuance of current programs at issue due to lack of State funding
End the substance use which encourages needle sharing and unsafe sexual activity	Outpatient and inpatient treatment and rehabilitation	People whose sexual behavior is disinhibited by substance abuse	Substance abuse prevention services are considered AIDS prevention services
End substance use which undermines attempts to stem or reverse the progress of the disease	Recruitment to treatment programs	PWAs/ARC with concurrent substance abuse problems who are able to participate in substance abuse treatment	The potential limited life span of someone with AIDS/ARC is a disincentive to changing substance abuse patterns
Control the substance abuse sufficiently to insure highest possible quality of remaining life without compromising well-being of others	Prevention education to substance abusers not in treatment	PWAs/ARC with concurrent substance abuse problems who are not able to participate in substance abuse treatment	Care of PWA/ARC presents a new set of problems for service providers
	AIDS health care and support services specifically designed to accommodate needs of persons who are also substance abusers	Subsets of the above who have special concerns (e.g. adults with dependent children)	Compound problems of clinical disease and substance abuse Seroconversion rate in this population growing

MEASURES OF EFFECTIVENESS

Over the last few years, the United States has made an enormous and very expensive effort trying to prevent the further spread of AIDS. It has relied very heavily on information, education, training and risk reduction as the chief means of achieving this objective. At the same time, it has rejected all compulsory measures that could result in the discrimination and social isolation of the infected and ill. Generally speaking, the consensus about the appropriateness of this response still holds at this time.

It is very difficult, however, to prove beyond a reasonable doubt, that the American prevention efforts have been and will remain effective. The nature of the disease and its long incubation period make any assessment of prophylactic measures extremely difficult.

Even so, there are a number of very encouraging studies and findings which tend to confirm the current American assumptions.

The most impressive of these is perhaps the enormous decrease in the infection rate of the "classic" sexually transmitted diseases among homosexual and bisexual men. This decrease has been observed in virtually all large American cities that have mounted noticeable AIDS prevention efforts. It is not quite clear, however, whether the underlying behavior change is due to fear of infection alone or to an adoption of pleasurable, risk free, so-called safe sex techniques. In other words, it is difficult to prove, in this instance, that the risk reduction efforts as such as opposed to mere general information about the dangers of AIDS has reduced the rate of venereal infection among homosexual and bisexual men.

However, the figures show, without any doubt, that a significant change in sexual behavior had taken place in this population over a relatively short period of time. The rate of infection with rectal gonorrhea, for example, is a very powerful, if indirect, gauge of the frequency and "safety" of anal intercourse between men. If the rate has gone down, this can be due only to the avoidance of anal intercourse or to the increased use of a condom. Thus, the rate of rectal gonorrhea becomes an indication of the rate of change in sexual behavior. Since anal intercourse has been identified as a "high risk" sexual behavior for HIV transmission, the change is highly significant.

The following pages report the rectal gonorrhea rate in San Francisco over a two year period, from October, 1984, to September, 1987. As this report shows, the rate has dropped very dramatically. Similar reports have appeared in other American cities.

SAN FRANCISCO EPIDEMIOLOGIC BULLETIN

CITY AND COUNTY OF SAN FRANCISCO • DEPARTMENT OF PUBLIC HEALTH • BUREAU OF COMMUNICABLE DISEASE CONTROL

Vol. 2, No. 12

December 1986

Rectal Gonorrhoea in San Francisco, October 1984-September 1986

While the number of cases of rectal gonorrhoea (RG) reported to the Bureau of Communicable Disease Control (BCDC) each month has decreased dramatically since the advent of the AIDS epidemic, some cases continue to be reported. The monthly total decreased from 142 to 20 cases over the two-year period from 1 October 1984 to 30 September 1986 (Figure 1). Of the 1614 cases reported during this period, 1520 (94.2%) were male and 94 (5.8%) were female.

The decrease in number of male cases during this period was greater than the decrease in female cases. Logistic regression revealed that the proportion of female cases had increased over the two years ($p=0.08$ for coefficient of sex variable). The magnitude of this increase, however, was only 5.3 percentage points between the first two months and the last two months.*

The number of male cases over the two-year period closely followed an exponential decay with a 5.7% decrease in number of cases every month and a 50.8% decrease every year. This is a greater rate of decrease than has previously been seen. At San Francisco City Clinic, the municipal sexually transmitted disease clinic, the average monthly total for RG cases dropped from 334 per month in 1982 to 175.8 per month in 1983, a 47% decrease, and dropped to 114.6 per month in 1984, a 34% decrease from 1983.

Mean age for male cases was 29.9 years old. Cases at the end of the two-year period tended to be older than those at the beginning; linear regression indicated an increase of 0.07 years of age (equivalent to 0.83 months of age) per month ($p=0.02$).

Each race experienced a decrease in number of male cases (Figure 2). Where race was indicated, 64.0% of male cases were white, 19.1% were black, 3.2% were East Asian, and 13.8% were listed as "other". Five and one-half percent (83) of male cases did not indicate race. No significant deviations from these overall proportions were seen over the two-year period, except for a one-time increase in number of "other" cases and a drop in number of white cases during June and July of 1986.

Of all male cases, 85.9% were diagnosed and reported by City Clinic; this proportion did not change significantly over the two years.

The Castro/17th Street/Stanyan district (defined by the 1984 report of the Association of Bay Area Governments [1], as are all districts discussed below) was the most frequent residence reported by male RG cases (25.1%), followed by Western Addition (18.9%), Civic Center (17.7%), the Mission district (8.0%), Bernal Heights/South Central (5.5%), and South-of-Market (4.6%). Together, these neighborhoods accounted for 79.8% of male cases. The proportion of cases from the Castro/17th Street/Stanyan district increased from 20.8% to 26.7% over the two-year period, though it had dropped to 11.5% during July 1985. The Western Addition had the highest crude rate for male RG at 271.64 cases per 100,000 population per month, followed by Civic Center (247.84), South-of-Market (232.17), and Castro/17th Street/Stanyan (174.74).

A total of 59 male RG cases were reported in August and September, 1986. Of these, 47 (79.7%) had not been reported as a case within the previous 22 months (i.e., only one infection

in the two-year period); 9 (15.3%) had been reported once before, and 3 (5.1%) had been reported twice before. The mean number of reports within the entire two-year period was 1.254 reports per case. Of the 12 repeat cases, 10 had their first visit on or before May 1986; the remaining 2 cases were first seen in August, 1986.

* Two-month totals were used in all statistical tests due to the small number of cases at the end of the two years.

Comment: The male RG population is of interest because it is one of the populations at highest risk for AIDS. Educational efforts aimed at preventing AIDS through the elimination of high-risk sexual practices would be expected to first show an impact on RG, as the incubation period of gonorrhea is much shorter than that of AIDS.

As the decrease in number of cases each month becomes smaller, we should determine whether we are approaching a "hard core" of cases who are not amenable to education on safe sexual practices. The results presented here do not support this hypothesis. The number of cases has decreased by a constant percentage, 11% every two

months and 50% every year; the number of cases does not appear to be leveling off.

Further, while the number of cases fell from 235 to 61, the demographics of the cases changed very little. The increase in mean age of male cases could indicate a single birth cohort of cases aging with time (i.e., a change of one month of age per month). No trends in racial proportions were seen over time.

Lastly, and most importantly, nearly 80% of cases diagnosed during the last two months had no previous RG diagnosis in the previous 22 months, and none had more than 2 previous diagnoses. We are still seeing mostly "new" cases of RG, and the number of cases continues to drop. There is no indication here that we have finished educating our populace about safe sexual practices.

Reference:

1. The Association of Bay Area Governments. The City and County of San Francisco Social Area Analysis. July, 1984.

This issue completes the second volume of the San Francisco Epidemiologic Bulletin. Consistent with the objectives of the San Francisco Department of Public Health, the Bureau of Communicable Disease Control publishes the Bulletin to update the medical community on the epidemiology of certain diseases. The epidemiologic perspective not only aids in the planning of public health interventions but also enables clinicians to view patients within the community context. In past issues of the Bulletin, we have tried to present a broad range of topics of interest to the medical community. We would like to take this opportunity to thank our readers for their input and support. The Bureau of Communicable Disease Control welcomes comments regarding previous issues and suggestions for future topics.

Dean F. Echenberg, M.D., Ph.D.
Director, Bureau of Communicable
Disease Control

Elizabeth Stoller, M.P.H.
Editor, San Francisco Epidemiologic
Bulletin

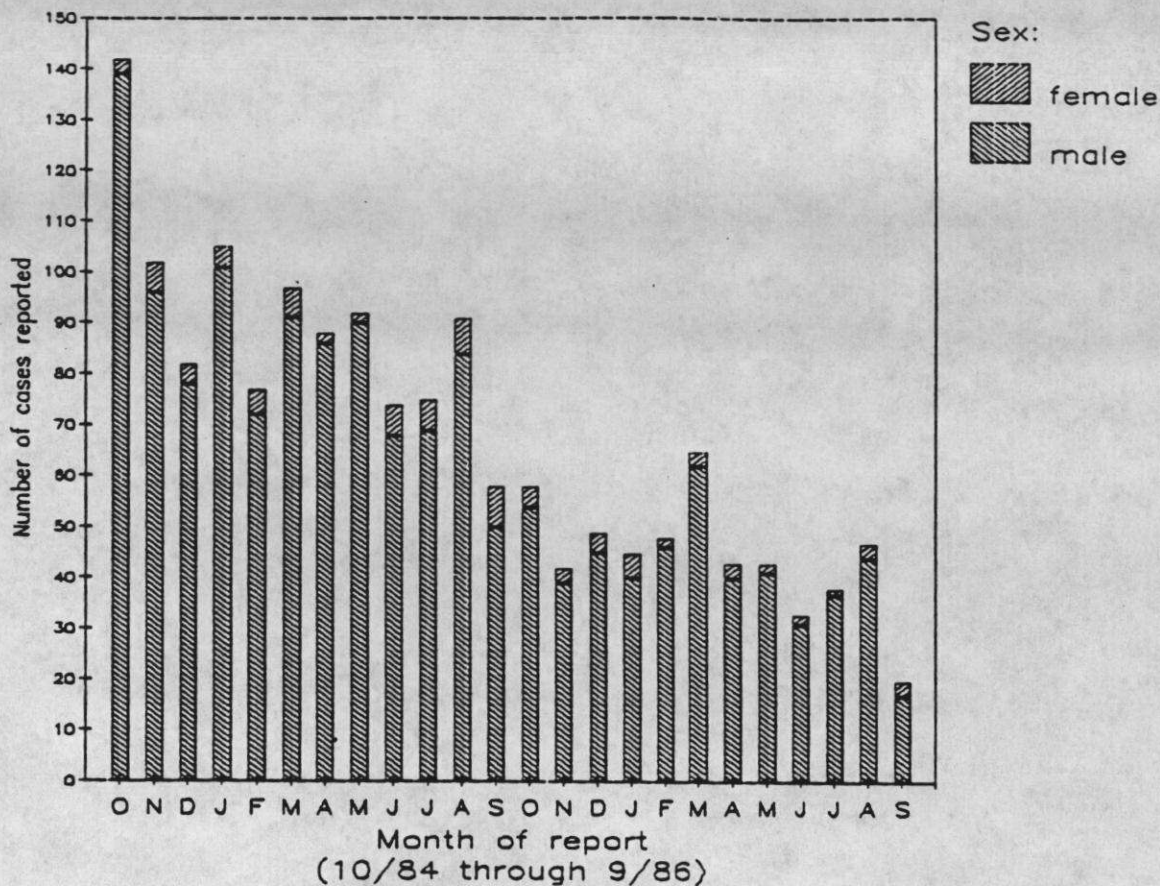


Figure 1. Male and female rectal gonorrhoea cases by month of report, San Francisco, October 1984 through September 1986

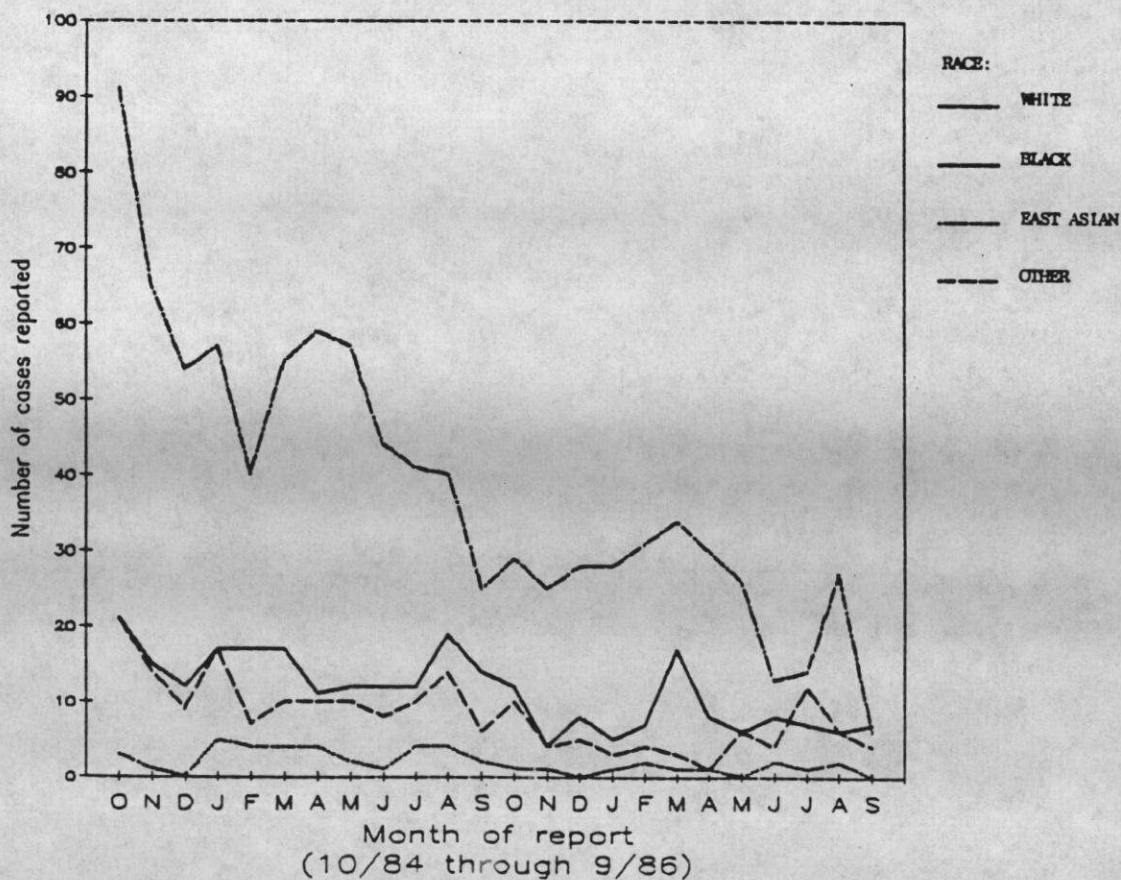


Figure 2. Rectal gonorrhoea cases by race and month of report, San Francisco, October 1984 through September 1986

Another method of measuring behavior change has been a periodic survey of a random sample taken from a high risk population. This kind of survey has been taken three times in San Francisco of the gay and bisexual population (1984, 1985 and 1986).

These surveys consisted of telephone interviews with hundreds of self-defined gay or bisexual males in the city and they showed a decreasing risk in their sexual behavior.

In 1984, only 55% reported that AIDS had had a major impact on their sexual behavior or lifestyle. By 1986, the number had risen to roughly 85%.

In 1986, nearly one in every five men reported being abstinent, double the number in 1984.

Roughly half of the respondents in 1986 were in primary relationships with other men, the majority of which were monogamous.

Moreover, in 1986, 98% of the men reported not having engaged in unsafe anal sex with secondary partners. (This is another confirmation of the finding by the San Francisco Department of Public Health on the decline of rectal gonorrhea infection.)

In 1986, only 10% of the respondents were engaging in any kind of sex act designated as unsafe with secondary partners.

Finally, gay and bisexual men reported considerable peer pressure to engage only in safe sex. In fact, peer support for safe sex in general was reported by two thirds of the respondents, up from less than one third in 1984.

These and other findings over the years were reported by two cooperating San Francisco public opinion research firms: The Research and Decisions Corporation and Communication Technologies. Funding for these studies was provided by the San Francisco Department of Public Health. All of these studies can be obtained from the San Francisco AIDS Foundation.

The above-mentioned research firms are now also beginning to move into new areas such as surveys among heterosexual adults with multiple partners and among racial minorities, groups that have long been neglected in the AIDS prevention efforts.

AIDS prevention among the black, Hispanic and Asian minorities is an especially difficult problem, and it is so new that the authorities still have to proceed largely by trial and error. Preliminary discussions with minority leaders have shown, however, that the approach chosen so far has to be somewhat modified in order to be effective in these new target populations. Since the respective experiences do not apply to the situation in the Federal Republic of Germany, they are not discussed in any greater detail here. German programs directed at Turkish, Northern African, and Southern European "guest" populations will have to start "from scratch". However, the need for such programs seems obvious not only in Germany but in several other European countries.

A very interesting study of 800 gay men has been conducted by the Gay Men's Health Crisis in New York City. The study has not yet been published, however, some preliminary findings indicate the following:

The GMHC has been conducting AIDS prevention programs for gay men, combining several elements, especially the basic medical overview and erotic educational "safe sex material". These programs were accompanied by a study measuring their effectiveness. It was found that the basic medical overview was very powerful in persuading the participants to reduce risky

sexual behaviors. The erotic "safe sex" component, on the other hand, was most effective in encouraging participants to increase risk-free sexual activities. The study also found that men who, as a group, participated in a full weekend of risk reduction programs were more highly motivated to adopt safe sex activities than those who received the information individually or at home. In short, there seems to be evidence that sexually explicit attempts to eroticize safe sex behavior, when supported by a group experience and peer pressure, can be a very effective tool of AIDS prevention. Curiously enough, in the course of the study, even the number of those men who chose abstinence increased from 20% to 30%.

The San Francisco Department of Public Health, in a recent study conducted by Dr. George Lemp, has come to the conclusion that the majority of today's AIDS infections were acquired before the disease was even heard of. The study also found that the infection rate has plummeted since gay and bisexual men began practicing safe sex. The study was based on the periodic testing of 359 men who volunteered for a hepatitis vaccine study in the late 1970s. The study now shows that in 1982, 12.4% of the healthy men in this group became infected with the HI virus. Only one year later this percentage had dropped to 1.6%. The spread of the virus has continued to slow with only 1% of those studied becoming infected in 1986.

Another recent study, by Dr. Warren Winkelstein and others at the University of California at Berkeley, has shown that between 1984 and 1986 the proportions of homosexual and bisexual men reporting ten or more sexual partners declined by 60%. Other high risk behaviors also declined by 60%. This, in turn, resulted in a substantial decline in the HIV seroconversion rate. (Letter, JAMA 1987, page 1470-1471.)

These figures have to be seen in an otherwise somber context, however. It is estimated that by now about half of San Francisco's gay population is already infected. This is the conclusion of another study by Dr. Winkelstein and others. At the same time he emphasizes that the rate of HIV seroconversion has now declined to a very low level, and that by now the epidemic spread of the infection has been substantially reduced due to changes in sexual behavior. (Paper presented at the 2nd International Conference on AIDS, June 23-25, 1986, in Paris under the title Reduction in Human Immunodeficiency Virus Transmission in San Francisco, 1982-1985.)

In sum, there are very strong indications that the American AIDS prevention efforts have succeeded to a considerable extent where they have been aggressively pursued and generously funded. That this success could not immediately translate into a decline of the still rising number of AIDS cases is largely due to the long incubation period of this disease. Most of today's AIDS cases in cities such as San Francisco were infected before the prevention efforts had gained momentum or had even been in place.

X. SUMMARY AND RECOMMENDATIONS

The AIDS prevention efforts in the United States have evolved gradually from a combination of local initiatives, especially those of the gay communities in New York, San Francisco, Los Angeles and other large American cities and of some federal programs especially those undertaken by the CDC. The various states such as California, New York, Illinois, etc. have begun to participate in these efforts only hesitantly and belatedly. In the opinion of most public health authorities interviewed by the author, there also continues to be a need for much stronger leadership on the national level.

The United States has been very fortunate in the choice of its Surgeon General, Dr. C. Everett Koop, who, with impeccable conservative credentials, has been in the forefront of the AIDS prevention effort by urging a massive public education campaign and in rejecting all compulsory measures with their possibly resulting discrimination as detrimental to American public health.

Dr. Koop is now widely admired, even among his former liberal adversaries and doubters, but many of his admirers feel very strongly that he has been let down by President Reagan and his cabinet. Congressional pressure is building for a National AIDS Commission which would not only coordinate but also multiply the existing efforts.

There is now a constantly growing danger of AIDS becoming an issue in partisan and electoral politics, a development that ultimately could spell disaster for the present excellent prevention programs. This development can only be forestalled by the early appointment of a National Commission which would be charged, among other things, with preserving the national consensus. There is no doubt, however, that national leadership is also required in increasing the budget for the fight against AIDS. Such leadership, in turn, could motivate the states and municipalities to increase their own share.

The American emphasis on local initiatives and the involvement of the private sector may give hope for the continued expansion and effectiveness of many present programs. Still, even here, national leadership, by setting an example, can make an enormous difference.

In short, there is no doubt that because of the long incubation period of AIDS and the continued underfunding of even excellent prevention programs, the AIDS crisis will reach truly frightening proportions in the United States before any substantial improvement will be observable. Frightening as the epidemic itself is, the socio-political "side effects" are bound to be just as bad or perhaps worse.

The Federal Republic of Germany, as well as other European countries, can, in the author's opinion, learn a great deal from the example of the United States, where the epidemiological and socio-political developments are ahead by two or three years. In particular, he makes the following recommendations:

- Establish a permanent transatlantic information exchange, emphasizing the social, legal, economic and political issues relating to AIDS. This could be done in the form of an information center somewhere in West Germany with a satellite center somewhere in the United States, preferably in San Francisco.
- Establish a German National AIDS Commission patterned after the one now being demanded in the United States Congress. Such a commission would be charged with reporting to the government and to the Bundestag at regular intervals and to constantly play through various socio-political scenarios relating to the AIDS epidemic and to the ways of fighting it.

■ Establish a German National AIDS Foundation patterned along the lines of the San Francisco AIDS Foundation. This should be a largely autonomous professionally run organization using both public and private monies and coordinating the various existing German self-help groups. In the long run, it is more efficient to delegate the task of AIDS prevention to such a foundation than to manage it directly by government. Only a foundation of this kind can assume a middle position between government on the one hand and the various prevention target groups on the other. As the example of San Francisco shows, such a foundation can be much more innovative much faster than any government agency. It can also enter controversial areas with its programs, something government agencies are likely to avoid.

However, as the American example shows, the medical and socio-political threat posed by AIDS is so enormous that immediate and drastic measures are required. The United States has now begun to implement such measures, although they are coming rather late. Europe, and the Federal Republic of Germany in particular, would do well not to wait and to take immediate advantage of a time lag which is still working in their favor.