MEMORANDUM

DATE: December 1, 1988

TO: Chuck, Ernesto, Les, Isabel, Ruth

FROM: Lyn Paleo

SUBJ: State Leadership Committee

The State Leadership Committee is the new incarnation of the old Bruce Decker AIDS Advisory Task Force to the Governor and the State Department of Health Services.

Tim is on the Education Sub-committee which produced the attached document. He asked that we review and make comments on it. Comments are due to me by Tuesday, December 6 at Noon, so that I can give them to Tim.

I hope you will take a critical look at it, for it may guide the State's work for some time.
Human Immunodeficiency Virus-1 (HIV-1) is one of the most virulent infectious agents known. Large numbers of Californians could potentially be infected with HIV-1 because it is sexually transmitted and other sexually transmitted diseases have been widespread in California. In addition, equipment (needle/syringe) sharing among intravenous drug users (IVDU's) increases the risk that the HIV-1 epidemic will spread even more into the community and that subsequently, infected mothers will transmit the infection to newborn babies.

Although California has been on the forefront of HIV-1 prevention, adequate resources needed to combat this very serious epidemic have still not been committed. The federal government has been especially tardy in providing necessary resources. Minority communities with pre-existing diminished resources are particularly hard pressed to counteract the HIV-1 epidemic.

RECOMMENDATION: Because HIV-1 is both deadly and transmissible, it must be accorded the highest public health priority.

HIV-1 is only transmitted between adults who practice behaviors which put them at risk for infection (i.e., sexual intercourse and intravenous drug use) and not through more casual contact. Prevention programs directed towards reducing and/or
elminating these behaviors can interrupt HIV-1 transmission. Government has a duty to protect the public's health by offering prevention interventions which encourage citizens to make voluntary choices to change the behaviors which put themselves and others at risk for the infection by HIV-1. Individuals who are infected must be responsible for not exposing others others. However, public health officials cannot control or monitor every personal choice and action of HIV-1 infected persons. The responsibility of public health is to educate HIV-1 infected individuals about the risk to their sexual partners, to persons with whom they are sharing needles and/or syringes, and to recipients of their blood.

RECOMMENDATION: State and local governments must: 1) educate those at-risk of infection in the most effective way known so that they understand their risk and ways to minimize that risk, 2) educate infected persons on their responsibility to protect others and on means by which to do that, and 3) educate and counsel infected women in the child bearing age on all of the options available to them.

TARGET AUDIENCES

The audience for HIV-1 prevention messages can be divided into three categories of risk of HIV-1 infection (See figure ). The content of the message and/or the intensity of delivery must be different for each group.
For the largest group, those at no or minimal risk of infection, the major thrust of the message must convey ways that HIV-1 is and is NOT transmitted. These persons must be educated through the mass media, through secular and religious educational institutions, and in the worksite so that undue fears of infection do not lead to public hysteria and calls for unwarranted and ineffectual containment programs. In addition, many of these people are parents and, for the education of their children, need to be knowledgeable about HIV-1.

The second group, those whose behavior (sexual activity and/or intravenous drug use) places them at risk for HIV-1 infection, requires more intensive intervention (including, where appropriate, serologic testing). Persons in these groups can be enrolled into HIV-1 prevention programs by various processes (see below).

The third group, those in transition from no-risk to at-risk categories, deserve special mention. Many of these persons are young people who are becoming sexually active and often experiment with drugs. Special programs are needed to educate students about HIV-1 and teach them how to prevent infection (see Public and Private School/University Programs).

GENERAL GUIDELINES AND RECOMMENDATIONS

Education for the prevention of HIV-1 transmission requires a general message.
Delivery of this message must be modified for the specific group to which it is directed. It needs to be tailored to be effectively communicated to different ethnic, racial, cultural communities.

RECOMMENDATION: The following message should be delivered and guidelines for promoting that message should be followed.

THE MESSAGE

The HIV-1 virus is extremely deadly. There are infected persons in every California community. Everyone having sex or using IV drugs should be concerned. You must develop your own plan NOW, for staying uninfected.

If you are not infected with the HIV-1 virus, you can keep from getting it if you do a few basic things to protect yourself, your loved ones and your family. Learn how, because no one is going to do it for you.

The HIV-1 virus spreads through sexual intercourse and through the sharing of drug injection equipment. It is also spread from an infected mother to her baby during or near the time of birth.
SEX

You don't have to have sexual intercourse if you don't want to. -- That's OK.

Unless you are absolutely certain that neither you nor your partner have been exposed to HIV-1, you should:

Always use a condom during oral, vaginal and anal intercourse. If you cannot or do not wish to use a condom, engage in other activities. (Oral sex may transmit infection). Nonoxynol-9 containing spermicide (jelly/foam/sponge) should also be used. Do not use oil-based lubricants (e.g., vaseline, baby oil, etc.) as they dissolve rubber condoms.

INTRAVENOUS DRUG USE

Do not use IV drugs.

If you must use IV drugs, do not share your works.

If you must share your works, clean your works with bleach every time.

Be certain to follow the sex guidelines (above).
MOTHER-TO-INFANT

If you are considering pregnancy or are pregnant and you possibly have been exposed to HIV-1, get tested. If you test positive, there is a high (about 50%) chance that your baby will be infected. Get advice and determine your options.

TESTING

If you have been at-risk HIV-1 infection, you should have your blood tested for signs of infection. Getting tested early is important. If you are infected, testing will help you get early treatment and it will help you to protect others.

If you know or think you may have been infected with the HIV-1 virus, protect others. Don’t donate blood, semen, breast milk or organs. Do not expose others through sex or needle/syringe sharing.

DELIVERING THE AIDS PREVENTION MESSAGE
There is no evidence that HIV-1 prevention messages which contain information on sexual intercourse or intravenous drug use increase these activities. Indeed, all evidence indicates that the contrary is true. Thus, prevention programs must move forward with their programs despite the claim that such programs "advocate" these activities.

RECOMMENDATION: In regards to the explicitness of AIDS prevention materials:

1. Candor, frankness and explicit representations are essential for effective communications of AIDS prevention messages.

2. It must be assumed, because of the nature of AIDS virus transmission, that some AIDS prevention materials will offend some people.

3. It is the opinion of this committee that the social and economic benefits of preventing AIDS virus transmission clearly outweigh the offense to some of explicit AIDS prevention materials.

Therefore, it is recommended that those who are producing AIDS education materials use language, pictorials, or demonstrations which their local experts feel are necessary to maximize behavior change. It is the intent of this
recommending that education materials be designed to maximize their educational effect. However, material designers should be sensitive to others and, while trying to improve their products, should also try to minimize any unnecessarily explicit depictions of sexual or drug-using practices.


MAXIMIZING BEHAVIOR CHANGE

Although there is no vaccine against HIV-1, and no cure for AIDS, not one more person in the State of California or elsewhere need become infected with HIV-1. People get infected through their actions -- they have sex or share IV needles with HIV-1 infected people. The most effective prevention programs must be directed toward eliminating or reducing behaviors which put people at risk for HIV-1 transmission. Many people find it difficult to change sexual and addictive behaviors. Dramatic AIDS-related behavior changes have been documented in the gay and intravenous drug using communities in some parts of California. In fact, the degree and kinds of behavioral changes that have occurred exceed anything documented to date in the public health field.
RECOMMENDATION: Programs which aim to help people keep their AIDS prevention resolutions need to include approaches which:

1. influence people’s perception and understanding that they are at risk of becoming infected if they continue at-risk behaviors;

2. help people to remove the barriers to practicing safer sex or safer IV use. (These barriers could be physical, economic, psychological, etc.)

3. encourage people to identify benefits from practicing risk reduction behaviors.

4. help people to develop new skills (e.g., putting on condoms) or improving existing skills (e.g., communication with sexual partners)

5. make it possible for people to believe they are capable of making and maintaining the necessary behavior changes.

6. offer opportunities for social support and reinforcement for risk-reducing behaviors.

7. address fear and denial to relieve anxiety.
8. Target risk reduction messages to people so that the messages are perceived as credible, are culturally sensitive, and match people's educational background and lifestyle.

Minorities require AIDS educational materials and programs that are culture and language specific. If AIDS education materials are to be effective, they must be conceptualized and developed by and for a specific racial and ethnic group. Bilingual/bicultural services, must be provided at all levels to those who have been infected with HIV-1.

COMMUNITY BASED INTERVENTIONS

Successes in AIDS related behavior change have been attributed to community-based approaches which both provide individuals with information and skills for behavior change while at the same time create a social environment that supports behaviors that prevent the spread of HIV-1. People are more likely to both initiate and maintain healthful behaviors when harmful behaviors become less socially acceptable and others are sanctioned to take their place. AIDS prevention is a social process; community organizing techniques and small group discussion and decision techniques have been found to accelerate the rate of change.
RECOMMENDATION: Programs should use a community-based approach which includes the following characteristics:

1. strong leadership from within the community

2. genuine collaboration in the planning of the prevention effort with an emphasis on community participation, intergovernmental coordination and building of private/public partnerships

3. market research techniques to identify appropriate messages and communication channels for reaching the target audience

4. programs to inform and motivate target audiences;

5. capacity for centralized information and referral services

6. efforts which are catalysts for social and cultural change

7. reliance on multiple channels of communication including print, broadcast, and face-to-face communication

8. broad-scale, grass roots participation
INVOLVEMENT OF RELIGIOUS COMMUNITIES

One of the most significant facets in our pluralistic society is the presence of religious communities. These need to play a major role in AIDS education, prevention and the rendering of supportive services to people who are HIV-1 infected and their loved ones.

Acknowledging the specific nature of every religious community, there is much to be gained when coalitions of denominations meet regularly to share information, to exchange ideas about education and prevention strategies and to be certain that pastoral care is rendered to everyone who is HIV-1 infected.

RECOMMENDATION: Relying upon its distinctive moral orientation, every religious denomination should provide information about AIDS to its adherents in order to educate children and adults within the context of ethical behavior and to render assistance to those who are ill. This is an extension of each denomination's prophetic mandate.
PUBLIC AND PRIVATE SCHOOL/UNIVERSITY PROGRAMS

RECOMMENDATION: All students must receive current, age-appropriate, and accurate information about the HIV-1 epidemic so they can make informed decisions about their behavior and avoid those actions that put them at risk for HIV infection.

All schools have two essential obligations in the HIV-1 epidemic. The first is to provide accurate, age-appropriate information for their students so the students can 1) avoid becoming infected; and 2) act in a safe and supportive manner toward infected persons.

The second obligation is to adopt and implement nondiscriminatory policies for dealing with HIV-1 infected employees and students in the school setting. Administrative policies and decision-making in schools can be an opportunity to model application of scientific information about transmission of HIV-1. On the other hand, policies that contradict information presented in the classrooms can teach a negative lesson about the importance of scientific knowledge.

Education at school about AIDS is most appropriate when carried out within a more comprehensive health education program that establishes the relationship between personal decision-making, behavior, and health. However, education about AIDS and HIV-1 infection must be provided as rapidly as possible even if
temporarily taught as a separate subject. School administrations must provide training for teachers providing instruction about HIV-1 infection and insure that the instruction is 1) based on current and accurate information, and 2) emphasizes voluntary behavior choices that reduce personal risk of HIV-1 infection and protect the health of others.

Using national (Centers for Disease Control), state (State Department of Education), and in some cases, county guidelines, each school governing board needs to identify, develop and implement curriculum and instructional programs that are tailored to its unique cultural community, and to student needs. Local curriculum can be developed with input from parents, students, teachers, representatives of religious groups, health care providers to persons with HIV-1 infection, and health care providers to persons with other sexually transmitted diseases and/or chemical dependency. Ideally, school programs will be planned to include youth-serving agencies, particularly those that serve out-of-school youth in the community and school age persons who practice behaviors increasing their risk of exposure to HIV-1.

For schools with grades Kindergarten through 12, existing California Education Code mandates instruction about sexually transmitted diseases at appropriate grade levels (Section 51202) and requires parent notification prior to that instruction (Section 51820). Parents of minors must be given the opportunity to review instructional materials and to exclude their student(s) from classroom
instruction about sexually transmitted diseases (including AIDS). While parents may review instructional materials in order to determine if their children will participate in the instruction, this is also an opportunity to provide information to the parents in the community. Elementary and secondary schools are also required to provide programs to prevent drug abuse. AIDS education should be a component of all drug prevention programs in schools.

While health instruction is mandated, specific time for instruction, standardized testing, and specific health courses are not required. In order to hold schools accountable for students' learning and for having AIDS related policies, two existing evaluation processes should be augmented. Age-appropriate AIDS-related items should be added to standardized tests in the California Assessment Program. Further AIDS-related health criteria should be added to the Quality Review Process, the existing system for evaluating schools which currently lacks any health considerations. The review process should also determine the presence or absence of policies regarding nondiscrimination toward HIV-1 infected persons in schools and effective procedures to prevent the spread of all infectious diseases in schools.

Until sequential planned AIDS education or comprehensive health education is in place in K-12 school systems, all higher education students should receive instruction regarding the prevention of HIV-1 infection and about acting in a non-discriminatory and supportive manner toward HIV-1 infected persons. For
colleges and universities, Senate Committee Resolution 79 (Chaptered 119) urges college campuses to develop policy guidelines and to provide education about AIDS. This resolution was unanimously approved by the Senate and signed by the Governor in September 1988.

DISTINCT POPULATIONS

While the HIV-1 epidemic affects all segments of society, it is important to recognize that each distinct segment has its own unique educational needs. It is behavior, not membership in any particular group or population, that places a person at risk for HIV-1 infection. However, the educational response to the epidemic needs to acknowledge the eclectic nature of our society and effectively match the proper educational approach to a receptive target audience (e.g., homosexual men, Blacks, Hispanics, students, runaway and homeless youths.) It must also be recognized that concentrations in certain geographical areas of persons who practice high-risk behaviors will require the development of programs which are suitable, specific, and acceptable to those communities. In addition, specialized programs must be developed for those groups for whom behavior change is especially difficult (e.g., youths, persons of lower educational status.)

Despite early evidence that HIV-1 was infecting individuals indiscriminately, resources for AIDS information and education on prevention have not approached
the levels needed in racial and ethnic minority communities.

The future of HIV-1 infection in the United States and indeed in California will have a major impact on minority communities as the second wave of the AIDS epidemic. All future HIV-1 education and prevention strategies must be prepared to provide culturally and linguistically appropriate AIDS education programs.

PROGRAMS TARGETED TO THOSE AT-RISK OF INFECTION

RECOMMENDATION: Prevention programs need to be developed and aimed specifically at those persons whose behaviors place them at highest risk of being infected with HIV-1 and subsequently developing disease. Priorities must be set in order to maximize available resources. Programs should include the following elements:

1. Persons already infected.

   Specific government and private programs must be established to provide long-term clinical and behavioral care to infected persons. Ideally, all HIV-1 infected persons should be tested and followed to maximize longevity and minimize the risk of transmission to others. Since it is beneficial to the individual and the society for infected persons to know that they are infected, easily accessible testing facilities should be available.
2. Testing facilities.

Cost free, anonymous (without name), and confidential (with name) testing facilities should be available through each health department. In addition, testing should be available through physicians' offices and community clinics. All testing must maintain the highest of standards (laboratory, counseling and confidentiality). In all but the rarest of circumstances, HIV-1 testing should be done on a voluntary basis.


Testing on a routine basis (voluntary but recommended for everyone) along with appropriate counseling, is also recommended for any health facility (hospital, pre-natal clinic, drug treatment program, etc.) where the prevalence of infection has been determined to be high enough to justify testing. (See HIV-1 Testing Subcommittee statement for additions including confidentiality and non-discrimination.)

4. Health Facilities.

Regarding those at high-risk, specific counseling and testing programs should be targeted towards persons at increased-risk of infection. Some of these persons rely on the various health facilities and these can be used as points of access for such patients. All persons who come to sexually transmitted disease clinics, drug services, jails, prenatal and
family planning services need should be provided with counseling and options for testing.

5. Outreach.

Many at-risk persons do not attend health care facilities, so specific outreach programs will be necessary to enroll them into prevention systems. Specific outreach programs are essential to reach persons who practice high risk behaviors but do not come to other health facilities. These include IV drug users, prostitutes, street youth, and gay men.

INTRAVENTOUS DRUG USERS

The sharing of intravenous injection equipment among intravenous drug users is an especially important factor in the spread of the HIV-1 epidemic. The sharing of injection equipment by many people serves as an amplifier of transmission among IVDU's; in the same way that having multiple sex partners spreads the infection among homosexual men or prostitutes; it allows this slow-to-transmit virus to spread rapidly.

Furthermore, the combination of intravenous drug use and prostitution supplements this amplification and maximizes the HIV's invasion into California, especially in urban poverty centers. Thus, the urgency of attacking this issue is of
paramount importance if the spread of HIV-1 into the general population is to be prevented.

Experts in the field of IVDU-associated HIV-1 transmission conclude that no single approach will successfully decrease transmission. In fact, there is compelling evidence from research, that a multi-pronged, comprehensive approach using public health education measures of the type outlined here significantly decreases transmission associated behaviors. At the same time, there has been no evidence that such interventions increase IV drug use. Instead, dramatic, positive behavior change has been documented by researchers in areas having strong programs.

Ethnic minorities are disproportionately represented in both AIDS case data and seroprevalence studies among IVUD's in California. Education efforts should be targeted in ways that will be culturally and linguistically appropriate and effective in reaching and educating members of ethnic minority communities.

RECOMMENDATION: The following components are essential and should be included in a comprehensive multi-pronged program:

1. Counseling and treatment for heroin addiction (detoxification and methadone maintenance in the most convenient, lowest-cost, and least repressive environment).

2. Counseling and treatment for stimulant (amphetamine and cocaine
addiction).

3. Voluntary and confidential serologic testing, counseling, and referral services for HIV-1 positive and potentially HIV-1 positive persons and their sexual partners.

4. Street outreach programs involving community education, counseling and transmission/risk reduction education (e.g., bleach/condom distribution and referrals to treatment programs and other social services as appropriate). Outreach should include prostitutes and homeless persons.

5. Needle exchange evaluation projects that rigorously test the efficacy and public health safety of this approach.

6. Educational counseling, voluntary and confidential testing and referral programs, in jails and prisons.

7. Social services (essential food, housing and social support) for HIV-1 infected persons unable to secure these basic needs without assistance.

8. Evaluation of these developing programs is essential. Continued monitoring of at-risk behavior, prevalence and incidence of HIV-1
infection, number of IVDUs stopping or reducing equipment sharing, number and extent of IVDUs disinfecting equipment, and number of persons starting IV drug use will be essential criteria for program planning and evaluation.  

9. Legalize drugs

SEX INDUSTRIES.

Persons working in various sex industries (e.g. prostitution, pornography) are obviously at risk for HIV-1 exposure, especially if they are engaging intravenous drug use and sharing equipment.

RECOMMENDATION: Special outreach programs are needed to help these persons working in sex industries to change occupation if they so desire and/or learn to protect themselves and others in the practice of their occupation. Outreach programs need to be brought to those places where sex related occupations are practiced (e.g., pornographic movie houses, "massage" parlours, houses of prostitution, the street.)

SURVEILLANCE AND ASSESSMENT
(MICHELE GINSBURG TO ADD STATEMENT)

Prevalence of HIV-1 infection varies from group to group. Accurate, current information regarding infection rates is necessary to guide education and testing