

New Study Plans to Explore Risks

By Nisa Donnelly

There is still little information about sexual transmission and AIDS. If women and children are the overlooked victims of this disease, however, lesbians are virtually invisible.

A new study to begin this month, will look at 400 California lesbians and in some cases their children and sexual partners, in an attempt to learn more about Acquired Immune Deficiency Syndrome. To date, few studies have targeted women, and none has looked specifically at lesbians or their sexual partners.

Although the new study will examine lesbians who have used artificial insemination since 1980, a comparable study is being done in Boston.

Cheri Pies, coordinator of the California project, which is a joint project of the School of Public Health, U.C. Berkeley, and AWARE (Association for Women's AIDS Research and Education) sees the study as a valuable tool for uncovering new information about lesbians and AIDS.

"We hope if we find lesbians who have been exposed to the AIDS virus that we'll be able to look at their sexual partners and children. Then we'll possibly be better able to understand how this virus is transmitted among women," Pies said.

The few studies that have been done on women and AIDS have primarily been targeted at either heterosexual women or women who have fallen into other risk groups, primarily intravenous drug users. Most studies have not looked at the sexual partners of women.

Lesbian Insemination Project participants are not required to give their names or any information that could be traced to them. Participation requires about 30 minutes at one of the test sites in the East Bay

or San Francisco. Included are a self-administered questionnaire and an anonymous interview that consists of questions about the participant's insemination history, health history, and sexual practices.

A blood sample is then taken for the AIDS antibody test. The antibody test shows only if a person has been exposed to the AIDS virus, not if the person has or will develop AIDS. About 25 percent of those persons who test antibody-positive, develop AIDS; another 25 percent develop AIDS-related symptoms; the remainder develop no symptoms. However, persons who have antibodies to AIDS are considered to be contagious. Participants who request it may receive test results.

"I don't want to be an alarmist," Pies said, "but I feel if someone has been exposed to the virus and is antibody-positive, they are probably contagious." For this reason, Pies is anxious for women who have been inseminated to participate in the study. "I don't think we'll find many women who are antibody-positive, but we don't know.

"There are no documented cases where a woman who has been inseminated contracted AIDS and had a child with AIDS," Pies said. Yet, four women in Australia, who received semen from a man who later showed antibodies to the AIDS virus, now also have the antibody. None of those inseminations resulted in pregnancy and none of the women has developed AIDS. Also, one of the women's husbands has developed antibodies to the virus. Later pregnancies by three of the women resulted in children who also show no antibodies to the virus.

In California, which has the second largest number of AIDS cases in the country, State Health Director Dr. Kenneth W. Kizer has ordered all potential semen donors be tested for the antibody and some sperm banks have stopped accept-

ing semen from homosexual donors. However, many lesbians circumvent the traditional sperm bank methods, choosing to select their own donors. And many of those donors are gay or bisexual men.

Pies advocates lesbians choosing donors carefully. "Not all gay men are at high risk," she said, "but women must be careful about screening no matter what kind of donor is used. They must ask questions to protect themselves and their children, whether it's a private insemination, through a doctor, or a sperm bank." Before accepting any man as a semen donor, she believes, women must ask how many sex partners he has had, what kind of sexual practices he has engaged in, his current sexual practices, his general physical health, and the results of any HTLV-III (Human T-cell Lymphotropic Virus) testing.

"We don't know if insemination in and of itself will expose a lesbian to the AIDS virus," she said. "If insemination is the only mode of risk, it lowers the chance. But we don't want to take the chance at all."

Repeated exposure to the virus is believed to increase the chance of contracting the disease. Because lesbians would generally have had little or no sexual contact with men in risk groups, the presence of the antibody could more reliably be linked to the insemination. With lesbians, the date of insemination and possible exposure to the AIDS virus can be more easily established than for heterosexual women who could not as easily determine the exact date of contact with semen that might carry the virus. Pies believes this aspect of the study will provide valuable information about exposure, insemination, and sexual transmission among women.

Laurie Hauer is a research nurse with the AWARE Project who is active in AIDS research at San Fran-

cisco General Hospital. She is concerned about the lack of information about women, sexual transmission, and AIDS. She feels it is important for researchers to look at the sexual partners of lesbians who have AIDS (or who are antibody-positive) in order to better understand how transmission takes place.

"We want to better understand if the virus exists and can be transmitted through vaginal and cervical secretions. We want to better understand if women's sex practices are safe or unsafe." Like Pies and others attached to research surrounding lesbians and AIDS, Hauer believes the risk for lesbians is "very tiny."

In the United States, 892 women have been diagnosed with AIDS since 1979. To date, 12,751 men have been diagnosed as having AIDS. It is virtually impossible to calculate how many lesbians have AIDS because of the method of keeping statistics, however, researchers believe the number is very low—possibly 5 percent or less. No one has been documented having contracted AIDS by lesbian sexual contact. In California, where there are currently 48 women with AIDS, two are lesbians. One contracted the disease through a blood transfusion, the other through unknown sources.

Nancy Shaw of the San Francisco AIDS Foundation believes the risk of contracting AIDS from another woman who may be carrying the virus seems quite low because of the nature of lesbian sexual practices. "But we don't yet have the evidence to state categorically what the risk is. The research just isn't there."

Women who work with AIDS through AWARE and the AIDS Foundation have established a list of safe sex guidelines targeted toward lesbians who are involved with a partner who may have been

exposed to the virus or who is in a high-risk group. Those at high risk include intravenous drug-users who share needles, women who have had non-lesbian sexual contact with a person in a high-risk group such as gay or bisexual men, women whose history of sexual practices may be unknown, or women who were inseminated with semen from men whose history is not known or who have AIDS or AIDS antibodies. The guidelines are designed, Shaw asserts, for sexually active women who are at high risk for getting or transmitting the virus.

Safe Sex Guidelines for Lesbians at High Risk

- Do not allow urine in your mouth, vagina, or rectum;
- Avoid oral-genital contact, especially during menstruation (menstrual blood is basically the same as other blood which is a known carrier of the AIDS virus). Epidemiologists suggest the virus can be transmitted through vaginal secretions, but at the same time oral injection provides something of a filter, Shaw said. Also researchers are not yet sure how well the virus lives in vaginal or cervical secretions;
- Engage in hand-genital and hand-anal contact only when neither partner has cuts, scratches, or sores;
- Avoid having the tongue on or in the anus or rectum;
- Sex toys that are inserted into the vagina or rectum or that come into contact with bodily secretions should be washed thoroughly (one part bleach to 10 parts water) before being shared.

For additional information on safe sex for women, contact the San Francisco AIDS Foundation: (415) 863-AIDS. For more information or to participate in the Lesbian Insemination Project, contact Project AWARE: (415) 476-4091. □

CENTERS FOR DISEASE CONTROL

December 6, 1985 / Vol. 34 / No. 48

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

- 721 Recommendations for Assisting in the Prevention of Perinatal Transmission of HTLV-III/LAV and AIDS
- 732 *Mucuna pruriens*-Associated Pruritus — New Jersey
- 734 Influenza Outbreaks — Alaska

U.S. DEPT. OF HEALTH AND HUMAN SERVICES
BUREAU OF COMMUNICATIONS
DISEASE CONTROLCurrent Trends

DEC 16 1985

**Recommendations for Assisting in the Prevention
of Perinatal Transmission of Human T-Lymphotropic Virus
Type III/Lymphadenopathy-Associated Virus
and Acquired Immunodeficiency Syndrome**

The information and recommendations in this document are intended to assist health-care providers and state and local health departments in developing procedures to prevent perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS).

This document contains recommendations for providing counselling and, when indicated, testing for antibody to HTLV-III/LAV for women who are at increased risk of acquiring the virus and who are either pregnant or may become pregnant. It is important that these women know they are at risk, as well as know and understand their HTLV-III/LAV-antibody status, so they can make informed decisions to help prevent perinatally acquired HTLV-III/LAV.

Through counselling, uninfected women can learn how to avoid becoming infected, and infected women can choose to delay pregnancy until more is known about perinatal transmission of the virus. If already pregnant, infected women can be provided information for managing the pregnancy and caring for the child.

Currently available data indicate that most pediatric HTLV-III/LAV infections and AIDS are acquired perinatally from infected women, but additional studies are needed to better quantify the risk of transmission from an infected pregnant woman to the fetus or newborn.

The recommendations below pertain to women. However, men who are HTLV-III/LAV-antibody positive should also be counselled regarding the risks of sexual and perinatal transmission, so they can refer for counselling and testing their sex partners who may be pregnant or considering pregnancy.

BACKGROUND

Pediatric AIDS Cases due to Perinatal Transmission. As of December 1, 1985, 217 (1%) of the 15,172 AIDS cases reported to CDC occurred among children under 13 years of age. Sixty percent of these children are known to have died. These 217 cases represent only the more severe manifestations of HTLV-III/LAV infection. Less severe manifestations, often described as AIDS-related complex (ARC), are not reported to CDC, so the number of children with clinically significant illness attributable to HTLV-III/LAV infection is greater than the reported cases of pediatric AIDS. In addition, a number of infected children are probably asymptomatic.

HTLV-III/LAV — Continued

Of the 217 reported pediatric AIDS patients, 165 (76%) have as their only known risk factor a mother belonging to a group with increased prevalence of HTLV-III/LAV infection. An additional 18% of the pediatric cases are attributable to transfusions of blood or blood products, while risk factor information is missing or incomplete on the remaining 6%. Of the 217 children with AIDS, 48% had mothers who were intravenous (IV) drug abusers; 17% had mothers who were born in Haiti; and 10% had mothers who were sex partners of either IV drug abusers or bisexual men.

Of the patients with perinatally acquired AIDS, 45% resided in New York City, while Florida and New Jersey accounted for an additional 32%.

Mechanisms of Perinatal Transmission. It is believed that HTLV-III/LAV is transmitted from infected women to their fetuses or offspring during pregnancy, during labor and delivery, or perhaps shortly after birth. Transmission of the virus during pregnancy or labor and delivery is demonstrated by two reported AIDS cases occurring in children who had no contact with their infected mothers after birth. One was delivered by Cesarean section (1,2).

Transmission of the virus after birth has been implicated in one case of HTLV-III/LAV infection in a child born to a mother reported to have acquired the infection from a postpartum blood transfusion. Since she breastfed the child for 6 weeks, the authors suggested breastfeeding as the possible mode of transmission (3). Recently, HTLV-III/LAV has been isolated from the breast milk of infected women (4).

Risk of Perinatal Transmission from Infected Mothers. The rate of perinatal transmission of HTLV-III/LAV from infected pregnant women is unknown; however, available data suggest a high rate. In one study of 20 infants born to infected mothers who had already delivered one infant with AIDS, 13 (65%) had serologic and/or clinical evidence of infection with HTLV-III/LAV several months after birth (5,6). Since these women were selected on the basis of having previously transmitted HTLV-III/LAV perinatally, this study may overestimate the average risk of transmission for all infected pregnant women.

Perinatal transmission from an infected mother to her newborn is not inevitable. Of three children born to women who became infected with HTLV-III/LAV by artificial insemination from an infected donor, all were in good health and negative for antibody to the virus more than 1 year after birth (7). Another child, born to a woman who was already pregnant at the time of AIDS diagnosis and was demonstrated to be viremic, was seronegative, culture negative, and healthy at birth and at 4 months of age (8). In a retrospective study evaluating nine children under 5 years of age whose mothers were later diagnosed with AIDS, two (22%) had antibody to HTLV-III/LAV (9). The infection status of these women during pregnancy was unknown.

In these studies, the rate of transmission ranged from 0% (0/3) to 65% (13/20). Additional studies are needed to better define the rate of transmission and variables associated with it.

Risk of Illness among Infected Pregnant Women. Pregnancy is associated with suppression of cell-mediated immunity and increased susceptibility to some infections (10). The T-helper to T-suppressor ratio is decreased during normal pregnancy, being lowest in the third trimester, and returns to normal approximately 3 months postpartum (10). It is not known whether pregnancy increases an infected woman's risk of developing AIDS or ARC, but one study suggests it does (6). Fifteen infected women who were well at time of delivery were followed an average of 30 months after the births of their children. Five (33%) subsequently developed AIDS; seven (47%) developed AIDS-related conditions; and only three (20%) remained asymptomatic. These results may not apply to all infected pregnant women, but they do suggest an increased likelihood of developing disease when an HTLV-III/LAV infection occurs in association with pregnancy.

HTLV-III/LAV — Continued

Of the 217 reported pediatric AIDS patients, 165 (76%) have as their only known risk factor a mother belonging to a group with increased prevalence of HTLV-III/LAV infection. An additional 18% of the pediatric cases are attributable to transfusions of blood or blood products, while risk factor information is missing or incomplete on the remaining 6%. Of the 217 children with AIDS, 48% had mothers who were intravenous (IV) drug abusers; 17% had mothers who were born in Haiti; and 10% had mothers who were sex partners of either IV drug abusers or bisexual men.

Of the patients with perinatally acquired AIDS, 45% resided in New York City, while Florida and New Jersey accounted for an additional 32%.

Mechanisms of Perinatal Transmission. It is believed that HTLV-III/LAV is transmitted from infected women to their fetuses or offspring during pregnancy, during labor and delivery, or perhaps shortly after birth. Transmission of the virus during pregnancy or labor and delivery is demonstrated by two reported AIDS cases occurring in children who had no contact with their infected mothers after birth. One was delivered by Cesarean section (1,2).

Transmission of the virus after birth has been implicated in one case of HTLV-III/LAV infection in a child born to a mother reported to have acquired the infection from a postpartum blood transfusion. Since she breastfed the child for 6 weeks, the authors suggested breastfeeding as the possible mode of transmission (3). Recently, HTLV-III/LAV has been isolated from the breast milk of infected women (4).

Risk of Perinatal Transmission from Infected Mothers. The rate of perinatal transmission of HTLV-III/LAV from infected pregnant women is unknown; however, available data suggest a high rate. In one study of 20 infants born to infected mothers who had already delivered one infant with AIDS, 13 (65%) had serologic and/or clinical evidence of infection with HTLV-III/LAV several months after birth (5,6). Since these women were selected on the basis of having previously transmitted HTLV-III/LAV perinatally, this study may overestimate the average risk of transmission for all infected pregnant women.

Perinatal transmission from an infected mother to her newborn is not inevitable. Of three children born to women who became infected with HTLV-III/LAV by artificial insemination from an infected donor, all were in good health and negative for antibody to the virus more than 1 year after birth (7). Another child, born to a woman who was already pregnant at the time of AIDS diagnosis and was demonstrated to be viremic, was seronegative, culture negative, and healthy at birth and at 4 months of age (8). In a retrospective study evaluating nine children under 5 years of age whose mothers were later diagnosed with AIDS, two (22%) had antibody to HTLV-III/LAV (9). The infection status of these women during pregnancy was unknown.

In these studies, the rate of transmission ranged from 0% (0/3) to 65% (13/20). Additional studies are needed to better define the rate of transmission and variables associated with it.

Risk of Illness among Infected Pregnant Women. Pregnancy is associated with suppression of cell-mediated immunity and increased susceptibility to some infections (10). The T-helper to T-suppressor ratio is decreased during normal pregnancy, being lowest in the third trimester, and returns to normal approximately 3 months postpartum (10). It is not known whether pregnancy increases an infected woman's risk of developing AIDS or ARC, but one study suggests it does (6). Fifteen infected women who were well at time of delivery were followed an average of 30 months after the births of their children. Five (33%) subsequently developed AIDS; seven (47%) developed AIDS-related conditions; and only three (20%) remained asymptomatic. These results may not apply to all infected pregnant women, but they do suggest an increased likelihood of developing disease when an HTLV-III/LAV infection occurs in association with pregnancy.

HTLV-III/LAV - Continued

denied belonging to high-risk groups, 0.01% had repeatedly reactive enzyme-linked immunosorbent assays (ELISAs) followed by reactive Western blot tests (15).

Commercially available tests to detect antibody to HTLV-III/LAV are ELISAs using antigens derived from whole disrupted HTLV-III/LAV. When the ELISA is reactive on initial testing, it is standard procedure to repeat the test on the same specimen. Repeatedly reactive tests are highly sensitive and specific for antibody to HTLV-III/LAV. However, when the ELISA is used to screen populations in which the prevalence of infection is very low (such as blood donors or women not in high-risk groups), the proportion of repeatedly reactive results that are falsely positive will be higher. For that reason, an additional test, such as a Western blot, is recommended following repeatedly reactive ELISA results, especially in low-prevalence populations. In populations with high prevalence of infection (e.g. homosexual men or IV drug abusers), most repeatedly reactive ELISAs are reactive by Western blot or another test. For example, among 109 IV drug abusers whose sera were repeatedly reactive by ELISA, over 85% were reactive by Western blot (22). In contrast, in a low-prevalence population of 69 female blood donors whose sera were repeatedly reactive by ELISA, only 5% were reactive by Western blot (15).

Due to the seriousness of the implications of HTLV-III/LAV-antibody reactivity, it is recommended that repeatedly reactive ELISAs be followed by an additional test, such as the Western blot. Women with sera repeatedly reactive by ELISA and reactive by Western blot should have a thorough medical evaluation. HTLV-III/LAV has been isolated from a single specimen in 67%-95% of persons with specific antibody (23,24). Because infection has been demonstrated in asymptomatic persons, the presence of specific antibody should be considered presumptive evidence of current infection and infectiousness.

RECOMMENDATIONS

Women Who Should be Offered Counselling and Testing. Counselling services and testing for antibody to HTLV-III/LAV should be offered to pregnant women and women who may become pregnant in the following groups: (1) those who have evidence of HTLV-III/LAV infection; (2) those who have used drugs intravenously for nonmedical purposes; (3) those who were born in countries where heterosexual transmission is thought to play a major role (11,12); (4) those who have engaged in prostitution; (5) those who are or have been sex partners of: IV drug abusers, bisexual men, men with hemophilia, men who were born in countries where heterosexual transmission is thought to play a major role (11,12), or men who otherwise have evidence of HTLV-III/LAV infection. If data become available to show that HTLV-III/LAV-antibody prevalence is increased in other groups or settings, counselling and testing programs should be extended to include them. Routine counselling and testing of women who are not included in the above-mentioned groups is not recommended due to low prevalence of infection and concern about interpretation of test results in a low-prevalence population. However if a woman requests it, the service should be provided in accordance with these recommendations.

Settings for Offering Counselling and Testing. Counselling and testing for antibody to HTLV-III/LAV to prevent perinatal transmission is recommended in the setting of any medical service in which women at increased risk are commonly encountered. These include services for treating IV drug abuse (i.e., detoxification and methadone maintenance), comprehensive hemophilia treatment centers, sexually transmitted disease clinics, and clinics that serve female prostitutes. In addition, services related to reproduction, such as family planning and infertility services, gynecologic, premarital, or preconceptual examinations, and prenatal and

HTLV-III/LAV — Continued

obstetric services should also consider offering counselling and testing if high-risk women are seen at these facilities. Testing for antibody to HTLV-III/LAV should be performed with the woman's consent after counselling is provided regarding risk factors for infection, the interpretation of test results, the risks of transmission, and the possible increased likelihood of disease among women infected with HTLV-III/LAV in association with pregnancy. The counselling and testing must be conducted in an environment in which confidentiality can be assured. In settings where confidential counselling and testing cannot be assured, information should be provided and referrals made to appropriate facilities.

Frequency of Testing. Detectable antibodies to HTLV-III/LAV may not develop until 2-4 months after exposure. This, and whether the woman is continuously exposed, should be taken into account when considering the need for, and frequency of, repeat testing. High-risk women should be offered counselling and testing before they become pregnant. During pregnancy, counselling and testing should be offered as soon as the woman is known to be pregnant. If the initial test is negative, repeat testing may be indicated near delivery to aid in the clinical management of the pregnant woman and newborn. If this final test is negative and the mother's risk of exposure no longer exists, she may safely consider breastfeeding the child, and management of the child need not include the same concerns that would be appropriate if the woman had had a positive test or if she were at high risk and had not been tested at all.

Counselling Women with Positive Results. Women with virologic or serologic evidence of HTLV-III/LAV infection should be counselled regarding their own risk of AIDS and the risk of perinatal and sexual transmission of HTLV-III/LAV. Infected women should be counselled to refer their sex partners for counselling and testing. If the partners of these women are not infected, both members of the couple should be counselled on how they may modify their sexual practices to reduce the risk of HTLV-III/LAV transmission to the uninfected partner. In addition, the couple should be told not to donate blood, organs, or sperm and should be discouraged from using IV drugs and advised against sharing needles and syringes. When seeking medical or dental care for intercurrent illness, they should inform those responsible for their care of their positive antibody status so appropriate evaluation can be undertaken. Recommendations for providing information and advice to individuals infected with HTLV-III/LAV have been published (25).

Infected women should be advised to consider delaying pregnancy until more is known about perinatal transmission of the virus. Pregnant infected women may require additional medical and social support services due to an enhanced risk of opportunistic infections and psychosocial difficulties during and after pregnancy. Obstetric-care providers should be alert to signs and symptoms of HTLV-III/LAV and related opportunistic infections in these pregnant women and to the need for specialized medical care.

HTLV-III/LAV-infected women should be advised against breastfeeding to avoid postnatal transmission to a child who may not yet be infected. The child should receive follow-up pediatric evaluations to determine whether he/she has HTLV-III/LAV infection, and to diagnose and treat promptly any diseases that may be secondary to HTLV-III/LAV infection. Recommendations for educating and providing foster care for infected children have been published (26).

Counselling Women with Negative Test Results. A negative ELISA for HTLV-III/LAV antibody in women who have no clinical or laboratory evidence of HTLV-III/LAV infection is evidence that they have probably not been infected. However, uninfected women who have sex

HTLV-III/LAV — Continued

partners with evidence of HTLV-III/LAV infection or with an increased risk of becoming infected should be informed that sexual intercourse increases their risk of infection. These women should be informed of the risks associated with pregnancy if they become infected and advised to consider delaying pregnancy until more is known about perinatal transmission of the virus or until they are no longer considered to be at risk for acquiring the virus. In addition to preventing pregnancy, the consistent and proper use of condoms can offer some protection against HTLV-III/LAV infection.

High-risk women, even if seronegative, should be told not to donate blood or organs. To decrease their risk of becoming infected, IV drug abusers should be encouraged to seek treatment for their drug abuse. Persons counselling IV drug abusers should know that IV drug abuse is often strongly ingrained and compulsive. Despite educational efforts and encouragement for treatment, some addicts will continue to abuse drugs or relapse after treatment. If drug abuse continues, they should be advised not to share needles or syringes and to use only sterile equipment.

(Continued on page 731)

TABLE I. Summary—cases of specified notifiable diseases, United States

Disease	48th Week Ending			Cumulative, 48th Week Ending		
	Nov. 30, 1985	Dec. 1, 1984	Median 1980-1984	Nov. 30, 1985	Dec. 1, 1984	Median 1980-1984
Acquired Immunodeficiency Syndrome (AIDS)	111	138	N	7,318	3,911	N
Asplenic meningitis	158	227	222	9,467	7,655	8,954
Encephalitis: Primary (arthropod-borne & unsp.)	7	22	23	1,173	1,098	1,430
Post-infectious	1	3	2	109	105	83
Gonorrhea: Civilian	10,808	18,535	16,913	775,020	777,626	882,338
Military	125	240	283	18,719	18,545	24,044
Hepatitis: Type A	457	455	476	21,040	18,907	21,145
Type B	505	550	488	24,188	23,993	20,172
Non A, Non B	58	60	N	3,721	3,520	N
Unspecified	105	103	188	5,286	4,746	7,986
Legionellosis	16	17	N	815	641	N
Leprosy	4	7	7	332	217	217
Malaria	12	10	21	935	921	985
Measles: Total*	14	15	15	2,628	2,516	2,516
Indigenous	14	12	N	2,191	2,222	N
Imported	-	3	N	437	294	N
Meningococcal infections: Total	38	55	49	2,165	2,481	2,508
Civilian	38	55	49	2,161	2,457	2,493
Military	-	-	-	4	4	14
Mumps	38	67	81	2,685	2,722	4,267
Pertussis	55	36	36	2,039	2,150	1,624
Rubella (German measles)	3	11	21	590	707	1,966
Syphilis (Primary & Secondary): Civilian	220	511	521	23,486	26,709	28,565
Military	3	3	5	122	271	351
Toxic Shock syndrome	6	5	N	324	438	N
Tuberculosis	220	489	515	18,621	16,568	23,485
Typhoid fever	2	4	4	156	276	280
Typhus fever	6	4	8	350	345	426
Typhus fever, tick-borne (EMSF)	4	9	5	675	621	1,087
Rabies, animal	88	90	90	4,856	5,009	5,531

TABLE II. Notifiable diseases of low frequency, United States

	Cum 1985		Cum 1985
Anthrax	-	Leptospirosis	33
Boutan: Foodborne (Alaska 8)	51	Plague	16
Infant (Idaho 1)	60	Polomyelitis: Total	6
Other	1	Paralytic	5
Brucellosis	125	Psittacosis (Ariz. 1)	102
Cholera	3	Rabies, human	1
Congenital rubella syndrome	-	Tetanus (Pa. 1)	67
Congenital syphilis, ages < 1 year	148	Trichinosis (Upstate N.Y. 1)	56
Ephthens	2	Typhus fever, flea-borne (endemic, murine)	25

*There were no cases of internationally imported measles reported for this week.

HTLV-III/LAV — Continued

Additional Considerations. These recommendations will be revised as additional information becomes available. It is recognized that provision of the recommended professional counselling, HTLV-III/LAV-antibody testing and associated specialized medical services will take time to implement and may stress available resources, particularly in public facilities, which are most greatly affected. Health-care providers, social-service personnel, and others involved in educating and caring for HTLV-III/LAV-infected persons should be aware of the potential for social isolation and should be sensitive to the need for confidentiality. They should be familiar with federal and state laws, regulations, and policies that protect the confidentiality of clinical data and test results. Each institution should assure that specific mechanisms are in place to protect the confidentiality of all records and to prevent the misuse of information. Anonymous testing would not be appropriate if it prevents adequate counselling and medical follow-up evaluation.

Hospital precautions for managing infected women and infants should be patterned after those for caring for patients with HTLV-III/LAV infection (27,28). Additional recommendations will follow.

DEVELOPMENT OF THESE RECOMMENDATIONS

The information and recommendations contained in this document were developed and compiled by CDC and the U.S. Public Health Service in consultation with individuals representing: the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officials, the American Public Health Association, the United States Conference of Local Health Officers, the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Planned Parenthood Federation of America, the American Venereal Disease Association, the Division of Maternal and Child Health of the Health Resources and Services Administration, the National Institute on Drug Abuse of the Alcohol, Drug Abuse, and Mental Health Administration, the National Hemophilia Foundation, the Haitian Medical Association, the American Bar Foundation, and the Kennedy Institute of Ethics at Georgetown University. The consultants also included representatives of the departments of health of the areas with the largest number of perinatally transmitted pediatric AIDS cases: New York City, Florida, and New Jersey. These recommendations may not reflect the views of all individual consultants or the organizations they represented.

References

1. Lapointe N, Michaud J, Pakovic D, Chausseau JP, Dupuy JM. Transplacental transmission of HTLV-III virus. [Letter] *N Engl J Med* 1985;312:1325-6.
2. Cowan MJ, Hellmann D, Chudwin D, Wara DW, Cheng RS, Ammann AJ. Maternal transmission of acquired immune deficiency syndrome. *Pediatrics* 1984;73:382-6.
3. Ziegler JB, Cooper DA, Johnson RO, Gold J. Postnatal transmission of AIDS-associated retrovirus from mother to infant. *Lancet* 1985;i:896-7.
4. Thiry L, Sprecher-Goldberger S, Jonckheer T, et al. Isolation of AIDS virus from cell-free breast milk of three healthy virus carriers. [Letter] *Lancet* 1985;i:891-2.
5. Scott GB, Fischl MA, Klimas N, et al. Mothers of infants with the acquired immunodeficiency syndrome: outcome of subsequent pregnancies. Atlanta, Georgia: International conference on acquired immunodeficiency syndrome, April 14-17, 1985.
6. Scott GB, Fischl MA, Klimas N, et al. Mothers of infants with the acquired immunodeficiency syndrome: evidence for both symptomatic and asymptomatic carriers. *JAMA* 1985;253:363-6.
7. Stewart GJ, Tyler JPP, Cunningham AL, et al. Transmission of human T-lymphotropic virus type III (HTLV-III) virus by artificial insemination by donor. *Lancet* 1985;ii:581-4.
8. CDC. Unpublished data.
9. Thomas PA, Lubin K, Enlow RW, Getchell J. Comparison of HTLV-III serology, T-cell levels, and general health status of children whose mothers have AIDS with children of healthy inner city

HTLV-III/LAV — Continued

- mothers in New York, Atlanta, Georgia: International conference on acquired immunodeficiency syndrome, April 14-17, 1985.
10. Weinberg ED. Pregnancy-associated depression of cell-mediated immunity. *Rev Inf Dis* 1984;6: 814-31.
 11. WHO. Acquired immune deficiency syndrome (AIDS): Report on the situation in Europe as of 31 December 1984. *Weekly Epidemiological Record* 1985;60:85-92.
 12. Castro KG, Fischl MA, Landesman SH, et al. Risk factors for AIDS among Haitians in the United States. Atlanta, Georgia: International conference on acquired immunodeficiency syndrome, April 14-17, 1985.
 13. Jason J, McDougal JS, Holman RC, et al. Human T-lymphotropic retrovirus type III/lymphadenopathy-associated virus antibody: association with hemophiliacs' immune status and blood component usage. *JAMA* 1985; 253:3409-15.
 14. Gjerset GF, McGredy G, Counts RB, et al. Lymphadenopathy-associated virus antibodies and T cells in hemophiliacs treated with cryoprecipitate or concentrate. *Blood* 1985;66:718-20.
 15. CDC. Unpublished data.
 16. Spira TJ, Des Jarlais DC, Rokos D, et al. HTLV-III/LAV antibodies in intravenous drug abusers: comparison of low and high risk areas for AIDS. Atlanta, Georgia: International conference on acquired immunodeficiency syndrome, April 14-17, 1985.
 17. Weiss SH, Ginzburg HM, Goedert JJ, et al. Risk for HTLV-III exposure and AIDS among parenteral drug abusers in New Jersey. Atlanta, Georgia: International conference on acquired immunodeficiency syndrome, April 14-17, 1985.
 18. Kreiss JK, Kitchen LW, Prince HE, Kasper CK, Essex M. Antibody to human T-lymphotropic virus type III in wives of hemophiliacs: evidence for heterosexual transmission. *Ann Intern Med* 1985; 102:623-6.
 19. Redfield RR, Markham FD, Salehuddin SZ, et al. Frequent transmission of HTLV-III among spouses of patients with AIDS-related complex and AIDS. *JAMA* 1985;253:1571-3.
 20. Harris CA, Cabradilla CD, Robert-Guroff M, et al. HTLV-III/LAV infection and AIDS in heterosexual partners of AIDS patients. Minneapolis, Minnesota: Twenty-fifth interscience conference on antimicrobial agents and chemotherapy, September 29-October 2, 1985.
 21. CDC. Heterosexual transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus. *MMWR* 1985;34:581-3.
 22. CDC. Unpublished data.
 23. Feorino PM, Jaffe HW, Palmer E, et al. Transfusion-associated acquired immunodeficiency syndrome: evidence for persistent infection in blood donors. *N Engl J Med* 1985;312:1293-6.
 24. Jaffe HW, Feorino PM, Darrow WW, et al. Persistent infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in apparently healthy homosexual men. *Ann Intern Med* 1985;102:627-30.
 25. CDC. Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome. *MMWR* 1985;34:1-5.
 26. CDC. Education and foster care of children infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus. *MMWR* 1985;34:517-21.
 27. CDC. Acquired immune deficiency syndrome (AIDS): precautions for clinical and laboratory staffs. *MMWR* 1982;31:577-80.
 28. CDC. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in the workplace. *MMWR* 1985;34:681-6, 691-5.

*Epidemiologic Notes and Reports**Mucuna pruriens-Associated Pruritus — New Jersey*

On October 6, 1985, a Paterson, New Jersey, Fire Department ambulance responded to a call reporting two people with severe pruritus. On arrival, the two emergency medical technicians (EMTs) found a Spanish-speaking couple living above a beauty salon who described

HEALTH



City and County of San Francisco

Department of Public Health

Jan. 3, 1986
CONTACT: Paul Barnes
PHONE: 558-5123

FOR IMMEDIATE RELEASE

The San Francisco Department of Public Health is recommending that all women who are at high risk of contracting AIDS be tested for the antibody to the virus and counseled on the problems of AIDS and pregnancy.

The recommendation comes in a report by a task force established by the department to develop guidelines to control the transfer of the AIDS virus from mother to child, and for the medical care of infected mothers, infants and pre-school children.

The guidelines may be the first of their kind established by any city and will go to the Health Commission for ratification on Jan. 7. The commission meeting begins at 2 p.m. in room 282 of City Hall.

The Centers for Disease Control in Atlanta has issued similar guidelines nationally but Dr. Moses Grossman, Chief of Pediatrics at San Francisco General Hospital and chairman of the task force, said these guidelines go further than CDC recommendations by calling for specific action and by dealing with the care of foster children who are antibody positive.

Nationwide, 217 cases of pediatric AIDS have been reported to CDC as of Dec. 1, 1985. In San Francisco, only three cases of pediatric AIDS have been recorded as of July 1, 1981, but as many as 60 women who are IV drug users give birth at SFGH each year.

Those women are considered to be at high risk of contracting AIDS and Dr. Grossman estimated that up to 10 percent of those women could be carrying the AIDS antibody.

Other high risk women who may give birth include women who are sexual partners of men with AIDS or at risk of AIDS.

"If the mother is infected we assume the child is at high risk of being infected," Dr. Grossman said.

For that reason, the guidelines recommend testing of high risk women to prevent the increase in AIDS-related births.

Although the number of infant AIDS cases is small, Dr. Grossman said the guidelines are being developed so they will be in place if that number increases.

The pre-pregnancy testing of high-risk women should be done voluntarily, according to the guidelines, through private physicians, family planning clinics, drug treatment programs, sexually transmitted disease clinics and other agencies that deal with IV drug users and women who are at risk.

High-risk women should also be tested when they present themselves for prenatal care. The guidelines recommend that women who test positive in early gestation periods should be counseled on the risk of transmitting AIDS to their fetus and be offered therapeutic abortion.

High-risk women who test negative early in pregnancy should be tested again before giving birth, according to the guidelines.

Children who are born of women who use IV drugs at times become wards of the state and are placed in foster care. The task force guidelines recommend that, when the mother is antibody positive, her consent be obtained for releasing that information to certain medical and social workers who may place and care for the child.

If consent is not received, the guidelines state a court-ordered test on the child should be sought.

The condition of the antibody-positive infant should be known to medical and social workers to avoid such things as inoculations with live virus vaccines, which could endanger the life of an infant with AIDS.

The guidelines discuss the care of infants with AIDS and also discuss precautions that medical workers who treat infected women should use. The guidelines recommend, for example, that those workers wear protective gear during delivery.

A widespread health education campaign should be launched to address the risk of AIDS infection among heterosexuals and especially women of child-bearing age, according to the task force report.

The report stated that these guidelines are interim and should be reviewed as more information becomes available on perinatal transmission of AIDS.

The task force included representatives of the Department of Public Health; the departments of Obstetrics, Gynecology, Reproductive Sciences, Medicine, Pediatrics and AIDS Activities from San Francisco General Hospital-University of California, San Francisco; the San Francisco County Medical Society; The American Academy of Pediatrics; the San Francisco Gynecologic Society; the Department of Social Services; the City Attorney's Office and the Juvenile Court of the City and County of San Francisco.

RESOLUTION ACCEPTING THE REPORT ON THE CONTROL OF PERINATALLY TRANSMITTED HTLV-III/LAV ASSOCIATED VIRUS INFECTION AND CARE OF INFECTED MOTHERS, INFANTS AND PRE-SCHOOL AGED CHILDREN AND ADOPTING THE RECOMMENDATIONS AS OFFICIAL GUIDELINES FOR THE DEPARTMENT OF PUBLIC HEALTH.

Whereas, the Department of Public Health has issued a report which contains information and recommendations on perinatal HTLV-III/LAV infection and pediatric AIDS which were developed and compiled by a task force of the Department of Public Health; and

Whereas, the task force included representatives of the departments of obstetrics and gynecology, medicine and pediatrics, and the AIDS Activities Unit, San Francisco General Hospital, University of California, the San Francisco Medical Society; the American Academy of Pediatrics; the San Francisco Gynecologic Society, and the Department of Social Services, the City Attorney's Office, and the Juvenile Court of San Francisco; and

Whereas, the report contains recommendations on risk reduction education, laboratory testing procedures; pre-conception recommendations; identification of infected women; care of infected women and intravenous drug using mothers; and also contains recommendations on the identification of exposed infants and the care of exposed and infected infants and children which will protect and promote public health; and

Whereas, the members of the Health Commission support the recommendations made in the report; now therefore be it

Resolved; That the Health Commission accepts the report on policies regarding the control of the perinatally transmitted HTLV-III/LAV infection and the care of infected mothers, infants and pre-school aged children, and adopts the recommendations contained therein as guidelines for the Department of Public Health.

Ch. 4

Item 7

Item 7

Control of Perinatally Transmitted
Human T-Lymphotropic Virus-Type III/Lymphadenopathy-Associated
Virus Infection and Care of Infected Mothers, Infants, and
Pre-School-Aged Children

City and County of San Francisco
Department of Public Health
Perinatal and Pediatric AIDS Advisory Committee

January 2, 1986

The information and recommendations contained in this document were developed and compiled by a special task force of the Department of Public Health (DPH), City and County of San Francisco, which included representatives of the Departments of Obstetrics, Gynecology, and Reproductive Sciences, of Medicine, and of Pediatrics, and the AIDS Activities Unit, San Francisco General Hospital, University of California, San Francisco; the San Francisco County Medical Society; the American Academy of Pediatrics; the San Francisco Gynecologic Society; and the Department of Social Services (DSS), the City Attorney's Office, and the Juvenile Court of the City and County of San Francisco.

These recommendations apply to all infants, pre-school-aged children, and women of child-bearing age known to be infected or at high risk of being infected with human T-lymphotropic virus-type III/lymphadenopathy-associated virus (HTLV-III/LAV). This includes persons with Centers for Disease Control (CDC)-defined AIDS, persons with lesser clinical manifestations of HTLV-III/LAV infection such as AIDS-related complex (ARC), and persons with asymptomatic HTLV-III/LAV infection.

BACKGROUND

Perinatal HTLV-III/LAV Infection and Pediatric AIDS

The transmission of HTLV-III/LAV from infected mothers to infants, either in utero or perinatally, has been well established (1-10). Infection in these infants can be asymptomatic or cause a variety of clinical syndromes including AIDS (11). It is not, however, known what proportion of infants exposed in utero or perinatally will become infected and what proportion of infected infants will develop clinical disease. As of December 1, 1985, 217 cases of pediatric AIDS had been reported to CDC (12). Forty-eight percent of these children were born to intravenous-drug-using mothers, 17 percent to Haitians, and 10 percent to mothers who either had AIDS or were sexual partners of men with AIDS or at risk for AIDS. An additional 39 (18 percent) children were infected through transfusions of infected blood or blood products, and 13 (6 percent) had unknown sources of infection. Thus, 165 (76 percent) of the cases had been exposed to HTLV-III/LAV in utero or perinatally.

Perinatally infected infants who go on to develop AIDS first develop symptoms at a median age of four months, and approximately one-half of these infants will be diagnosed as having AIDS by their first birthday (11). Typical prodromal symptoms include failure to thrive, recurrent or persistent thrush, chronic interstitial pneumonitis, hepatosplenomegaly, chronic or recurrent diarrhea, lymphadenopathy, and severe recurrent bacterial infections such as sepsis and meningitis. When frank clinical

AIDS develops in these patients, the most common diagnosis is Pneumocystis carinii pneumonia (62 percent) and the second most common are other opportunistic infections without Kaposi's sarcoma or Pneumocystis carinii pneumonia (33 percent) (11).

HTLV-III/LAV Transmission in Households

None of the identified cases of HTLV-III/LAV infection in the United States are known to have been transmitted in school, day-care, or foster-care settings or through casual person-to-person contact (13). Other than sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers, none of the family members of the over 13,000 AIDS patients reported to CDC have developed AIDS. Five studies of family members of patients with HTLV-III/LAV infection have failed to demonstrate HTLV-III/LAV transmission to adults who are not sexual contacts of the infected patients or to children who are not already infected perinatally (14-18). However, if casual person-to-person transmission of HTLV-III/LAV infection does exist, it should theoretically be greatest among young children. This theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes to blood and possibly other body fluids of an infected person. We emphasize that there is no evidence of this type of transmission occurring in any setting at this time.

CDC guidelines

On August 30, 1985, CDC published guidelines for the education and foster care of children infected with HTLV-III/LAV (13). The basic guidelines which apply to control of perinatally transmitted HTLV-III/LAV infection and care of infected mothers, infants, and pre-school-aged children are numbers 3, 4, 7, 8 and 10. These guidelines are attached as Attachment I. On December 6, 1985, CDC published guidelines for the prevention of perinatal transmission of HTLV-III/LAV (19). These recommendations are attached as Attachment II.

GENERAL RECOMMENDATIONS

Education

1. Risk-Reduction Education. All sexually active homosexual, bisexual, and heterosexual adults with multiple sexual partners since 1979 should be aware that they are at risk of HTLV-III/LAV infection, and sexually active women with multiple sexual partners since 1979 should understand that, if they have been infected, they are at risk of transmitting HTLV-III/LAV perinatally. To this end, widespread health education campaigns should address the risk of infection and the ways to prevent sexual transmission

among heterosexuals and, more specifically, to women of child-bearing age. Additionally, women in recognized risk groups (see Table 1) should be the target of more intensified educational campaigns and, if indicated, special rehabilitation programs to decrease their ongoing risk of parenterally or sexually acquiring HTLV-III/LAV infection, such as referral for substance abuse treatment.

2. Provider Education. In order to provide a high standard of care for HTLV-III/LAV-infected women, infants, and pre-school-aged children, obstetricians, pediatricians, and other providers will need to be educated about the virus, its modes of transmission, its prevention, and the special issues of confidentiality surrounding the infection. Focus should be placed on those providers serving patients at highest risk of infection.

Laboratory

We recommend that more than one method of anti-HTLV-III antibody determination be used for testing pregnant women, women in risk groups, and children of women in risk groups for HTLV-III/LAV infection. Such methods include enzyme-linked immunosorbent assay (ELISA), indirect fluorescent antibody, and Western blot. Because of the complexity of prenatal testing, especially that involving intravenous-drug-using women, laboratory testing should be done in a single reliable and experienced facility. Submission of specimens identified only by code number to this laboratory will greatly decrease the chances of inadvertent disclosure.

Pre-Conception Recommendations

Whenever possible, women infected with HTLV-III/LAV should be identified and educated about the risks of perinatal transmission. Infected women should be advised to postpone pregnancy until more is known about the specific risks of perinatal transmission. Detailed contraceptive counseling should be offered to these women. Infected women should also be counseled to avoid unsafe sexual practices. Regardless of other contraceptive methods used, they should use barrier methods of contraception (e.g., condom or condom plus a diaphragm with a nonoxonyl-9-containing spermicide) during intercourse in order to diminish the chances of transmitting HTLV-III/LAV to their sexual partners.

We recommend that women at high risk for HTLV-III/LAV infection (Table 1) be tested for anti-HTLV-III antibody before conceiving. Testing can be offered through private physicians, alternative test sites, or through clinics, especially those used by women in risk groups, such as family planning clinics, drug treatment programs, sexually transmitted disease clinics. Testing of these women, although strongly recommended, should be voluntary. We do not recommend that women who are not in high-incidence groups be tested at this time. However, because of possible sexual contact

with men in risk groups, it may be prudent for women with multiple sexual partners in areas with a high incidence of AIDS to consider themselves at risk and obtain pre-conception testing.

MATERNAL RECOMMENDATIONS

Identification of Infected Women

Routine histories taken at clinical facilities serving women potentially at high risk for HTLV-III/LAV infection should include questions designed to elucidate their risk of infection. Such clinics include physicians' offices, family planning clinics, sexually transmitted disease clinics, drug treatment clinics, WIC clinics, and prenatal clinics. Written and/or audiovisual material regarding HTLV-III/LAV infection should be available at all sites where these women are seen.

We recommend that women in risk groups be tested for HTLV-III/LAV infection at the time they present for prenatal care. We do not recommend routine testing of all pregnant women. High risk women who are seronegative in the first or second trimester should be retested in the late third trimester to rule-out intercurrent HTLV-III/LAV infection. Whenever possible, the test should be ordered by the woman's obstetric care provider rather than through research studies, alternative test sites, etc. Such testing should be done only after informed consent has been obtained. A release of information form authorizing the newborn's medical provider access to the mother's test result should also be obtained at this time. Sample consent and release of information forms are included in Appendices I and II. Because of the unique potential for exposure of health care workers to large amounts of blood and amniotic fluid during the course of labor and delivery, we recommend that test results be made known to labor and delivery personnel (with the woman's consent) on a strictly controlled basis. Ideally, this information should be transmitted directly to labor and delivery personnel and through a mechanism other than the permanent medical record.

Care of Infected Women

These recommendations apply specifically to women who are known to be infected. Guidelines for women at high risk of infection who have not been tested for HTLV-III/LAV infection are found under "Special Considerations" on Page 6.

1. Prenatal Care. We recommend that seropositive women be counseled regarding the risk of perinatal HTLV-III/LAV transmission and be offered therapeutic abortion if early enough in gestation. These women should also be specifically counseled to postpone subsequent pregnancies until more is known about perinatal transmission of the virus. Infected women should be

medically evaluated to rule-out any incipient opportunistic infections or malignancies. Specifically, the possibility of infection with Mycobacterium tuberculosis should be evaluated by chest x-ray and PPD, and chronic infection with hepatitis B virus, cytomegalovirus, and Herpes simplex virus should be excluded. Teratogenic drugs, including trimethoprim and most antivirals, should be avoided except in the face of life-threatening maternal illness.

2. Intrapartum Care. We recommend that hospitals review their procedures for infection control during the intrapartum period and that hospital personnel exercise caution when dealing with any potentially infectious body fluid. For HTLV-III/LAV these fluids include blood of either maternal or fetal origin, amniotic fluid, and the placenta and membranes. Grossly contaminated linens and disposables, as well as blood and amniotic fluid specimens, should be handled according to the hospital infection control procedures. The choice of location for delivery (delivery room versus labor room) may be dictated by circumstance, but consideration should be given to a labor room delivery to minimize the need for disinfection of two locations. All personnel expected to have direct contact with the mother or newborn during delivery should wear gloves and gowns. Those exposed to the potential of a splash of infectious materials should strongly consider wearing a mask and protective eyewear during the delivery itself. Disposal of all materials should follow hospital infection control procedures. The labor room, delivery room, and all instruments should be disinfected with a 1:10 sodium hypochlorite solution. The placenta of a seropositive or high risk woman of unknown status should not be released for commercial use. It should be labeled with "H/A Precautions" or the equivalent prior to routing for pathologic examination or disposal.

3. Postpartum Care. In the postpartum period, regular hospital infection control procedures for HTLV-III/LAV infection should be followed. Isolation of asymptomatic seropositive women is not recommended. Mothers should be given full access to their infants unless they have untreated pulmonary tuberculosis. Until more is known about the potential transmission of virus in breast milk, infants of mothers known to be infected not be breast fed. Because the potential for exposure to large amounts of infectious material decreases markedly after delivery, information regarding the woman's antibody status should not be transmitted beyond the labor and delivery area.

Special Considerations

1. Women at High Risk of Infection who are not Screened. We recommend that women at high-risk of HTLV-III/LAV infection who have not been tested during pregnancy be presumed to be positive for purposes of prenatal and intrapartum care. However, as the

benefits of breast feeding in all likelihood outweigh the potential risks of postnatal transmission of the virus, we do not recommend that breast feeding be restricted unless the mother is known to be infected.

2. Intravenous-Drug-Using Mothers. In order to prevent further parenteral transmission of HTLV-III/LAV through needle sharing and further perinatal transmission, we recommend that women in this risk group be specially targeted for substance abuse treatment.

INFANT AND PRE-SCHOOL-AGED CHILD RECOMMENDATIONS

Identification of Exposed Infants

We recommend that identification of HTLV-III/LAV-exposed infants begin in utero. If women in high incidence groups are not tested during pregnancy, we recommend that for medical reasons their infants be tested as early as possible (e.g., cord blood) and definitely before two months of age.

Identification of Infected Infants

1. Infants of Seropositive Mothers. Infants born to mothers who are known to have been infected during pregnancy should be retested for anti-HTLV-III antibody at approximately one year of age when maternal antibody has disappeared. Infants presenting before one year of age with symptoms suggestive of HTLV-III/LAV infection should be retested at that time. If an IgM-specific anti-HTLV-III antibody test or other method of early diagnosis becomes available, these infants should be tested for HTLV-III/LAV infection at birth.

2. Infant and Pre-School-Aged Children of High-Risk Mothers with Unknown Serologic Status. Infants born to mothers at high-risk of HTLV-III/LAV infection whose prenatal anti-HTLV-III antibody status is unknown should be tested before two months of age for exposure to HTLV-III/LAV and retested at one year of age or earlier if clinically indicated. Older children who were born on or after January 1, 1979, and whose mothers were at risk of HTLV-III/LAV infection should be tested only (a) if they have not completed a primary series of oral polio vaccine and have not received a measles-mumps-rubella vaccination or (b) if clinically indicated. Because of potential complications of live virus vaccines, we recommend that older high-risk children be tested for HTLV-III/LAV exposure or infection prior to receiving live virus vaccines. In the event that the mother refuses testing, the infant or child should be assumed to be infected and not receive live virus vaccines.

3. Infants and Pre-School-Aged Children at Risk for Parenterally Acquired Infection. Infants and children at risk for

parenterally-acquired HTLV-III/LAV infection should be tested only (a) if they received blood or blood products from a donor identified as HTLV-III/LAV-infected; (b) if they were transfused with non-heat-treated Factor VIII and will receive live virus vaccines; or (c) if clinically indicated.

4. Infants and Pre-School-Aged children of Non-High-Risk Mothers. Infants and children born to mothers not at high-risk of HTLV-III/LAV infection and not at risk for parenterally acquired HTLV-III/LAV infection should not be tested.

Care of Exposed and Infected Infants and Children

1. Nursery and In-Hospital Care (see also "Postpartum Care"). Regular hospital infection control procedures for HTLV-III/LAV infection and regular hospital procedures for inpatient care of immunosuppressed patients should be followed in the nursery and during subsequent inpatient admissions. In order to prevent potential sources of infection, circumcision of male infants should be strongly discouraged and only done with informed consent. Umbilical stumps should be meticulously cleaned daily until they are evulsed.

2. Routine Home Care. We recommend that CDC guideline 4 be followed.

3. Medical Care. Exposed infants who remain anti-HTLV-III positive beyond age 1 year or who have documented positive HTLV-III viral cultures at any age should be considered at risk for the development of AIDS or ARC and, therefore, potentially immunodeficient. Infants and children either at risk for the development of AIDS or ARC or who have clinical AIDS or ARC should be assumed to have a secondary combined immunodeficiency, be followed closely for problems with growth and development, and be given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella and measles.

These infants and children should not receive live virus vaccines or BCG until more is known about vaccination of HTLV-III/LAV-infected persons. We recommend inactivated vaccines, including inactivated polio, Haemophilus influenzae type b, pertussis, influenza, and meningococcal vaccines and diphtheria and tetanus toxoids, are not contraindicated and should be given as regularly scheduled. Inactivated polio vaccine should be substituted for oral polio vaccine and be given in conjunction with diphtheria and tetanus toxoids and pertussis vaccine at 2, 4, 6, and 18 months and 4-6 years of age. Mumps, measles, rubella vaccine should not be administered to these children at the present time.

Infants or children with clinical AIDS or ARC should be evaluated and cared for as if they have combined immunodeficiency disease.

Because these children potentially have a significant cellular immunodeficiency, all blood products should be irradiated to avoid Graft versus Host disease. Until more is known about the natural history of disease in infants who remain anti-HTLV-III positive beyond age 1 year, the immune status of these children should be sequentially evaluated with the consultation of pediatric immunologist, is recommended. The increased risk of Pneumocystis carinii pneumonia in these children may be modified by the use of prophylactic trimethoprim-sulfamethoxazole. As these children do not make normal specific antibodies to new antigens, their increased risk of infection with bacterial agents may be altered by monthly administration of immune serum globulin, either intramuscularly or intravenously.

Special Considerations

1. Foster Care. If a child whose mother has been tested for HTLV-III/LAV infection comes to foster care, we recommend that the DSS caseworker assigned to the case request that the mother's obstetrical provider release the results of her test to a perinatal coordinator in the DPH with the mother's consent. A sample release of information form is included in Appendix II. Based on the results of these tests the perinatal coordinator will specify if the infant will need medical foster care placement or routine foster care placement. Medical placement will be required for infants of mothers with a positive anti-HTLV-III antibody test and will entail review of the placement decision by this committee. Routine placement will require that the child be negative. The perinatal coordinator will also inform the DSS caseworker assigned to follow the mother of the reasons for medical placement and will also be responsible, in conjunction with the DSS caseworker, for informing the foster family and the child's pediatrician for the reasons for medical placement. Additional releases of information will be required for each of these subsequent disclosures.

Children less than three years old currently in foster care and children entering foster care in the future whose mothers were not tested for HTLV-III/LAV infection prenatally should be tested for HTLV-III/LAV infection only if their mothers were intravenous drug users or sexual partners of AIDS patients. Testing in this setting is indicated on medical grounds alone and should be done with the consent of the mother. A sample consent form is included in Appendix III. If the mother refuses to consent to testing or refuses to release the results of her test, we recommend that testing of the child and release of the test results be ordered as part of dependency proceedings. Once results of the testing test are available they will be released by the child's provider to the perinatal coordinator in the case of voluntary testing or reported directly by the laboratory to the perinatal coordinator in the case of court-ordered testing. The perinatal coordinator will then indicate whether the child is in need of medical placement or

routine placement. If the child is in need of medical placement, the perinatal coordinator will follow procedures as outlined above.

Children in foster care three years old and older, born after January 1, 1979, and born to a mother at high risk of HTLV-III/LAV infection should be tested only if they have significant neurodevelopmental delay and lack control of their body secretions or display aggressive behavior, such as biting, or who have uncoversable, oozing lesions. Such testing should only occur after careful medical review by of this committee to determine if such behaviors truly increase the theoretical risk of casual HTLV-III/LAV transmission. Again, the consent of the child's mother should be obtained if possible for testing and release of information, or, if consent is not available, testing and release of information should be ordered by the court.

Under Section 199.21 of the Health and Safety Code of the State of California (AB 403), it is unlawful to disclose the results of a blood test to detect antibodies to the probable causative agent of AIDS to any third party except pursuant to a written authorization of the person who is tested. Therefore, if written releases of information are unavailable, specific waivers will need to be obtained so that prenatal testing results can be made available by the mother's obstetric care provider to the perinatal coordinator and so that the perinatal coordinator can make either prenatal or postnatal screening results available to the DSS caseworker, the child's foster family, and the child's pediatrician. Additionally, under Section 199.22, no person shall test a person's blood for evidence of antibodies to probable causative agent of AIDS without the written consent of the subject of the test. We feel that all prenatal testing should be done on a voluntary basis and that the mother should freely consent both to being tested and to release the test results in order to assure better medical care of her children. However, in the event that the mother has not been tested prenatally, refuses to be tested prenatally, or refuses to consent to release the results of her prenatal test, as it is our opinion that testing of high-risk children for HTLV-III/LAV infection is medically indicated, we recommend that if these children are to be placed in foster homes such testing be obtained and, if necessary, be specifically ordered by the court having jurisdiction over the child.

2. Adoption. We recommend that infants and children (a) whose mothers were at high risk of HTLV-III/LAV infection, (b) who were born on or after January 1, 1979, and (c) who have not been previously tested be tested for HTLV-III/LAV infection prior to placement. We recommend that the HTLV-III/LAV status of all children at high risk of infection be made available to adopting parents prior to final placement so that they can consider the possible social and psychological effects on their families.

CONCLUSIONS

We reemphasize that these are interim guidelines which will need to be reviewed as more information becomes available on perinatal transmission, the natural history of HTLV-III/LAV infection in pregnancy and childhood, and household transmission and also as vaccine and definitive antiviral therapy become available. Finally, it should be clearly stated that all evidence suggests that there is no risk for casual transmission of HTLV-III/LAV and that the primary intent of these guidelines is to assure appropriate medical care for infected pregnant women, infants, and pre-school-aged children.

TABLE 1.

Risk Groups for HTLV-III/LAV Infection, Females

Mode of Transmission	Risk Group
Sexual	Sexual contacts of AIDS patients or men in risk groups* Artificially inseminated women (donor insemination) between January 1, 1979, and June 1, 1985
Parenteral	Intravenous drug users Recipients of blood or blood products between January 1, 1979, and June 1, 1985
Either	Mothers of perinatally infected children

* Women with multiple sexual partners in areas with high incidences of AIDS should possibly consider themselves in this category.

References

1. CDC. Unexplained immunodeficiency and opportunistic infections in infants - New York, New Jersey, California, MMWR 1982; 31: 665-7.
2. Cowan MJ, Hellman D, Chudwin DI, et al. Maternal transmission of acquired immune deficiency syndrome. Pediatrics 1984; 73:382-6.
3. Joncas JH, Delage G, Chad Z, et al. Acquired (or congenital) immunodeficiency syndrome in infants born of Haitian mothers [letter]. N Engl J Med 1983; 308:842.
4. Lapointe N, Michaud J, Pekovic D, et al. Transplacental transmission of HTLV-III virus. N Engl J Med 1985; 312:1325-6.
5. Oleske J, Minnefor A, Cooper R Jr, et al. Immune deficiency syndrome in children. JAMA 1983; 249:2345-9.
6. Rubenstein A, Sicklic M, Gupta A, et al. Acquired immunodeficiency syndrome with reversed T4/TB ratios in infants born to promiscuous and drug-addicted mothers. JAMA 1983; 249:2350-6.
7. Scott GB, Buck BE, Letterman JG, et al. Acquired immunodeficiency syndrome in infants. N Engl J Med 1984; 310: 76-81.
8. Scott GB, Fischl MA, Klimas N, et al. Mothers of infants with acquired immunodeficiency syndrome (AIDS): evidence for both symptomatic and asymptomatic carriers. JAMA 1985; 253:363-6.
9. Thomas PA, Jaffe HW, Spira TJ, et al. Unexplained immunodeficiency in children. JAMA 1984; 252:639-44.
10. Ziegler JB, Cooper DA, Johnson RO, et al. Postnatal transmission of AIDS-associated retrovirus from mother to infant. Lancet 1985; 1:896-8.
11. Rogers MF. AIDS in children: a review of the clinical, epidemiologic, and public health aspects. Pediatr Infect Dis 1985; 4:230-6.
12. CDC. Unpublished data.
13. CDC. Education and foster care of children infected with human T-lymphotropic virus-type III/lymphadenopathy-associated virus. MMWR 1985; 34:517-21.
14. Fischl MA, Dickinson G, Scott G, et al. Evaluation of household contacts of adult patients with the acquired

immunodeficiency syndrome. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, Georgia, April 16, 1985.

15. Friedland GH, Saltzman BR, Rogers MF, et al. Lack of household transmission of HTLV-III infection. Epidemic Intelligence Service Conference, Atlanta, Georgia, April 3, 1985.

16. Kaplan JE, Oleske JM, Getchell JP, et al. Evidence against transmission of HTLV-III/LAV in families of children with AIDS. Pediatr Infect Dis 1985; 4:468-71.

17. Lewin EB, Zack R, Ayodele A. Communicability of AIDS in a foster care setting. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, Georgia, April 16, 1985.

18. Thomas PA, Lubin K, Enlow RW, et al. Comparison of HTLV-III serology, T-cell levels, and general health status of children whose mothers have AIDS with children of healthy inner city mothers in New York. International Conference on Acquired Immunodeficiency Syndrome (AIDS), Atlanta, Georgia, April 16, 1985.

19. CDC. Recommendations for assisting in the prevention of perinatal transmission of human T-lymphotropic virus-type III/lymphadenopathy-associated virus and acquired immunodeficiency syndrome. MMWR 1985; 34:721-6, 731-2.

APPENDIX I

MODEL

INFORMED CONSENT TO DO TEST FOR AIDS VIRUS
(HTLV-III/LAV) ANTIBODY

IMPORTANT INFORMATION REGARDING THIS TEST

The AIDS virus (HTLV-III/LAV) antibody test detects the presence of antibodies, naturally occurring substances in the blood produced by the body following infection with the AIDS virus, by using a simple blood test. This is not a test for AIDS. The test does not tell you if you have AIDS or an AIDS-related condition (ARC); it does show whether you have been infected with the virus that can cause AIDS. For further information regarding AIDS or the AIDS virus antibody test, consult your physician or call the San Francisco AIDS Foundation Hotline (415-863-AIDS).

I understand that this test result will be part of my medical record and my baby's medical record. I have been informed about the AIDS virus (HTLV-III/LAV) antibody test (see reverse). I have had a chance to ask questions which were answered to my satisfaction. I believe that I understand the benefits and risks of the test.

Date: _____ 19__

(Patient's Signature)

(Patient's Printed Name)

HTLV-III ANTIBODY TEST -- LIMITATIONS AND IMPLICATIONS

A. This test will not tell you:

- if you have AIDS or ARC (AIDS Related Condition);
- if you have developed AIDS or ARC;
- if you are immune to AIDS or ARC;
- if you are healthy.

B. A negative test result indicates that the antibody has not been found in your blood. If you test negative, there are three possible explanations:

- you have not been infected with the virus; or
- you have had contact with the virus but have not become infected; or
- you have been infected by the virus but have not yet produced antibodies.

Research indicates most people produce antibodies within 2-8 weeks after infection. Some people will not produce antibodies for six months or more. A very small number of people will never produce antibodies.

A negative result does not mean:

- that you are immune to the virus;
- that you have not been infected with the virus. You may have been infected and have not yet produced antibodies.

C. A positive test result indicates that you have probably been infected with the AIDS virus and your body has produced antibodies. Researchers have shown that most people with AIDS antibodies have active virus in their bodies. You may therefore assume you are contagious and capable of passing the virus on to others including your baby. A positive result does not mean:

- that you have AIDS or ARC;
- that you will necessarily get AIDS or ARC;
- that you are immune to AIDS.

D. Not everyone infected with the virus will develop AIDS.

1. The majority of infected people will develop antibodies to the virus yet remain healthy. They will display none of the symptoms of AIDS.

2. A smaller group of people who also have antibodies will develop some of the symptoms of AIDS. These people are diagnosed as having ARC (AIDS-Related Condition).

3. An unknown percentage of infected people will develop AIDS. A diagnosis of AIDS is made only after finding specific life-threatening infections or malignancies that do not normally occur in healthy people.

E. NOTE ABOUT CONFIDENTIALITY - People taking the test should be aware that there may be some risk associated with letting others know about their test results. While using test results as grounds for discrimination in insurance or employment is prohibited by California law, the burden of proof is on the person discriminated against. There are benefits associated with telling your physician, dentist, and sexual partners. You should ascertain first, however, what they will do with the information and who they will share it with.

APPENDIX LL

MODEL

AUTHORIZATION FOR RELEASE THE RESULTS OF A BLOOD TEST
TO DETECT ANTIBODIES TO THE AIDS-RELATED VIRUS (HTLV-III)

A. EXPLANATION:

Permission to release the results of your blood test to detect antibodies to the AIDS related virus (HTLV-III) is being asked of you to fulfill the terms of the Confidentiality of Medical Information Act, Civil Code Section 56 et seq. and Health and Safety Code Section, 199.21 (f,g,h).

Written permission must be given for each separate release of AIDS antibody test results by a person or institution who did the test. Release of your test results without your consent is punishable by fine (Health & Safety Code 199.21 (a,b,c,d,e)).

B. AUTHORIZATION:

I hereby authorize _____
(Name of person or institution)

to release to _____
(Name of the person who is to receive the results)
the results of blood tests to detect antibodies to the AIDS
virus (HTLV-III/LAV).

C. USES:

The results of the test cannot be used to deny insurance or employment. The information will be used only for the medical care and for foster-care placement* of your baby.

D. DURATION:

The authorization shall be effective immediately and shall remain in effect indefinitely or until _____ 19 ____.

E. RESTRICTIONS:

I understand that the requester may not further use or release my test results unless another authorization is obtained from me.

F. ADDITIONAL COPY:

I further understand that I have a right to receive a copy of this authorization upon my request.

Date: _____ 19_ _____
(Patient's Signature)

(Patient's Printed Name)

Original to Medical Record

Copy to Patient

Copy to person who is to receive the results.

* Optional language

APPENDIX III

MODEL

INFORMED CONSENT TO DO TEST FOR AIDS VIRUS
(HTLV-III/LAV) ANTIBODY

IMPORTANT INFORMATION REGARDING THIS TEST

The AIDS virus (HTLV III/LAV) antibody test detects the presence of antibodies, naturally substances proteins in the blood produced by the body following infection with the AIDS virus, by using a simple blood test. This is not a test for AIDS. The test does not tell you if your child has AIDS or an AIDS-related condition (ARC); it does show whether your child has been infected with the virus that can cause AIDS. For further information regarding AIDS or AIDS virus antibody test, consult your child's physician or call the San Francisco AIDS Foundation Hotline (415-863-AIDS).

I understand that this test result will be part of my child's medical record. I have been informed about the AIDS virus (HTLV-III/LAV) antibody test (see reverse). I have had a chance to ask questions which were answered to my satisfaction. I believe that I understand the benefits and risks of the test.

Date: _____ 19_____

(Parent's or Guardian's Signature)

(Patient's Printed Name)

HTLV-III ANTIBODY TEST - LIMITATIONS AND IMPLICATIONS

A. This test will not tell you:

- if your child has AIDS or ARC (AIDS Related Condition);
- if your child will developed AIDS or ARC;
- if your child is immune to AIDS or ARC;
- if your child is healthy.

B. A negative test result indicates that the antibody has not been found in your child's blood. If your child tests negative,

there are three possible explanations:

- your child has not been infected with the virus; or
- your child has been exposed to the virus but has not become infected; or
- your child has been infected by the virus but has not yet produced antibodies.

Research indicates most people produce antibodies within 2-8 weeks after infection. Some people will not produce antibodies for six months or more. A very small number of people will never produce antibodies.

C. A positive test result indicates that your child has probably been infected with the AIDS virus, and his or her body has produced antibodies. Researchers have shown that most people with AIDS antibodies have active virus in their bodies. A positive result does not mean:

- that your child has AIDS or ARC;
- that your child will necessarily get AIDS or ARC;
- that your child is immune to AIDS.

D. Not everyone infected with the virus will develop AIDS.

1. The majority of infected children will develop antibodies to the virus yet remain healthy. They will display none of the symptoms of AIDS.
2. A smaller group of children who also have antibodies will develop some of the symptoms of AIDS. These children are diagnosed as having ARC (AIDS-related Condition).
3. An unknown percentage of infected, antibody-positive children will develop AIDS. A diagnosis of AIDS is made only after finding specific life-threatening infections or malignancies that do not normally occur in healthy children.

E; NOTE ABOUT CONFIDENTIALITY - Parents of children taking the test should be aware that there may be some risk associated with letting others know about their child's test results. While using test results as grounds for discrimination in insurance or employment is prohibited by California law, the burden of proof is on the person discriminated against.

***"Respect Yourself, Protect Yourself
Because You're Worth It"***

"Respect Yourself, Protect Yourself, You're Worth It," is the theme chosen for our AIDS Education Project. This program is designed for young women to take a look at themselves and change their at risk behaviors. Our aim is to educate young women so they can make wise and knowledgeable choices about sex, drugs, and alcohol so that they can protect themselves from AIDS.

We as women can no longer ignore the health issues which affect us from becoming all that we can be, particularly in New Jersey, where AIDS is the number one killer of Black and Hispanic women. "Respect Yourself, Protect Yourself" acknowledges that there are choices that young women must make daily. These choices need to be based on respecting and protecting oneself as opposed to following the crowd and meeting the needs of others. Thus, in doing so, they will learn that self worth is important to their well being. This is very important because the risky behaviors in which one engages can affect one's health. Becoming aware of ways to prevent AIDS will enhance a young woman's ability to make responsible choices. Therefore, we believe that if young women adopt this theme, they will make responsible choices in hopes of preventing AIDS, teen pregnancy, and other sexually transmitted diseases.

***For more information - contact Ms. Renee Ingram
School Based Youth Services Program (Room C-107)***

TOWN - COMMUNITY MEETING
WHY?



* DISCUSS THE DEC. 90 **WOMEN AND HIV**
CONFERENCE IN WASHINGTON DC
* AND CREATE AN **ACTION PLAN** FOR
WOMEN'S ISSUES IN 1991.



WHEN?

Wed., Jan 16, 7:30-9:30 pm

WHERE?

The Women's Building 3543 18th
Street, San Francisco



(between Valencia and Guerrero Sts.)



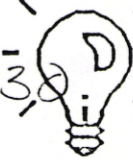
± Please notify interested clients!



± Come prepared with ideas and plans
For info: Lisa 558-9051 or Anne 626-7639



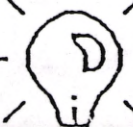
Future events include "Living with HIV,
Focus on Women's Issues", Wed. Feb 27,
1991 sponsored by UCSF AIDS Health



Project and various agencies, for info on
the 2/27 event call UCSF AHP 476-6430



Barbara Geller



WOMEN & CLINICAL DRUG TRIALS:

A COMMUNITY FORUM

A PANEL OF AIDS RESEARCHERS, PHYSICIANS AND WOMEN AFFECTED BY HIV WILL TALK ABOUT CLINICAL DRUG TRIALS & WOMEN

----- ♦ -----

WHO: DR. SANDRA HERNANDEZ -- DIRECTOR, AIDS OFFICE
DR. ERIC GOOSBY -- SAN FRANCISCO GENERAL HOSPITAL
SHIRLEY GROSS -- BAYVIEW-HUNTERS POINT FOUNDATION
CATHERINE MAIER -- SAN FRANCISCO AIDS FOUNDATION
Representatives from: PROJECT INFORM, THE COMMUNITY CONSORTIUM,
THE SFGH AIDS CLINICAL TRIALS GROUP, & WOMEN WITH HIV

----- ♦ -----

WHEN: MONDAY, JULY 23, 1990

----- ♦ -----

TIME: 3:00-4:00 WOMEN & AIDS:
COMMUNITY RESOURCES
4:00-6:30 COMMUNITY FORUM:
PANEL DISCUSSION

----- ♦ -----

WHERE: WOMEN'S BUILDING
3543 18TH ST. AT VALENCIA
SAN FRANCISCO

----- ♦ -----

SPONSORED BY: THE SAN FRANCISCO AIDS FOUNDATION / BETA / WOMEN'S AIDS NETWORK / COMMUNITY PROVIDERS AIDS TRAINING PROJECT / BAYVIEW HUNTERS POINT FOUNDATION / PROJECT INFORM / TOM WADDELL CLINIC / CAL-PEP / COMMUNITY CONSORTIUM / WOMEN'S INSTITUTE FOR MENTAL HEALTH / ACT-UP WOMEN'S CAUCUS / PROJECT AWARE / HAIGHT-ASHBURY FREE MEDICAL CLINIC / BLACK COALITION ON AIDS / CALIFORNIA SEXUAL PARTNERS' STUDY/MISSION NEIGHBORHOOD HEALTH CENTER / COMMUNITY UNITED AGAINST AIDS-SIDA / AMERICAN INDIAN AIDS INSTITUTE / WOMEN'S NEEDS CENTER / AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS

----- ♦ -----

WHEELCHAIR ACCESSIBLE / TRANSPORTATION & CHILDCARE PROVIDED

----- ♦ -----

ADVANCE RESERVATIONS ARE REQUIRED. PLEASE CALL 564-8958

FOR ADDITIONAL INFORMATION: CALL THE COMMUNITY CONSORTIUM'S COMMUNITY COORDINATOR-----821-3144

Community Consortium
Building 80, Ward 84
995 Potrero Avenue
San Francisco, CA 94110



Chuck Frutchey
San Francisco AIDS Foundation
333 Valencia Street, 4th Floor
San Francisco, CA 94103

JUN 20 1990

LIVING WITH HIV PUBLIC FORUM

Women and Clinical Trials

- How can I get into a trial?**
- Am I eligible?**
- What are the ethical issues?**
- What are other HIV+ women experiencing?**

Panel Discussion with

***Brenda Lein, ACT-UP Golden Gate**

***Jay Seward, Davies Medical Center's Trial Search
and others...**

**Wednesday June 26, 1991
7-9 pm**

**1855 Folsom Street (at 15th Street)
1st Floor, Room 125**

Parking in rear of building off 15th Street

MUNI Bus Lines: 22 or 33 to 16th/Folsom

FREE. No reservation required.

Childcare provided.

To arrange for interpretation for the hearing impaired, please call by June 21.



FOR MORE INFORMATION CALL: 476-3902

A Public Service of the AIDS Health Project

World AIDS Day 1990 will draw attention to these special problems faced by women, and highlight the need to involve more women in the global fight against AIDS, in the broad framework of health and development, particularly at the country level.

World AIDS Day 1990

World AIDS Day 1990 will:

- Continue to increase awareness about HIV/AIDS.
- Strengthen the worldwide effort to stop AIDS by highlighting the impact of HIV/AIDS on women – not only as a medical problem, but as it affects women as care providers, health workers, educators and mothers.
- Support the strengthening of AIDS prevention and control activities and programmes at all levels, giving particular attention to the special needs of women.
- Promote support and care for all HIV-infected persons and people with AIDS, their families and their friends, and help combat discrimination and isolation.

World AIDS Day will also highlight the link between the status of women within the family and society, and their vulnerability to infection and its consequences. It will draw attention to the special concerns related to HIV/AIDS and pregnancy, childbirth and raising children. It will mean encouraging women and women's organizations to organize World AIDS Day events; strengthening information and education activities for women at all levels of society; and stressing the importance of programmes on AIDS and women as part of national development programmes.

What Can You Do?

You can help expand the global struggle against AIDS – in Africa, the Americas, South East Asia, Europe, the Eastern Mediterranean, and the Western Pacific. You can join the worldwide effort by organizing and holding World AIDS Day activities. You can raise awareness of how we can stop AIDS. You can help those who are already infected or ill, and prevent discrimination against those with HIV/AIDS and their families.

To help you be a part of World AIDS Day, WHO will provide newsletters on women and AIDS, an "Action Kit" providing step-by-step guides for organizing World AIDS Day events, and media materials. WHO regional offices in Africa, the Americas, South East Asia, Europe, the Eastern Mediterranean, and the Western Pacific, and WHO in Geneva will monitor and coordinate events around the world.

What's Next?

WHO will prepare the following materials for World AIDS Day 1990:

- World AIDS Day newsletters
- Special World AIDS Day poster
- World AIDS Day Action Kit
- Special issue of World Health Magazine on Women and AIDS
- Special media materials on Women and AIDS



For more information about World AIDS Day 1990, write to:

World AIDS Day
World Health Organization
1211 Geneva 27, Switzerland



Women and AIDS

World AIDS Day 1990: Women and AIDS

What is World AIDS Day?

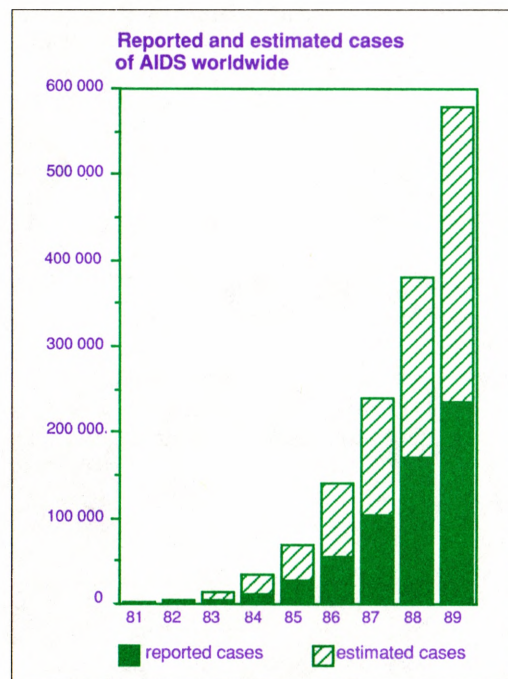
World AIDS Day has a special place in the history of the AIDS pandemic. Since 1988, 1 December has been a day bringing messages of compassion, hope, solidarity and understanding about AIDS to every country in the world, North and South, East and West.

What prompted this extraordinary response? World AIDS Day emerged from the call by the World Summit of Ministers of Health on Programmes for AIDS Prevention in January 1988 to open channels of communication, strengthen the exchange of information and experience, and forge a spirit of social tolerance. Since then, World AIDS Day has received the support of the World Health Assembly, the United Nations system, and governments, communities and individuals around the world. Each year, it is the only international day of coordinated action against AIDS.



Why A World AIDS Day?

World AIDS Day is part of the global effort to meet the challenge of AIDS – an epidemic that continues to worsen in all regions of the world. As at mid-1990, about 250 000 cases of AIDS have been reported to WHO from over 150 countries, but WHO estimates that there have actually been about 700 000 cases. The Day highlights AIDS prevention and control activities already under way, and forges new channels of communication about AIDS. World AIDS Day is now a yearly event in most countries, helping to build a lasting worldwide effort to stop AIDS.



In 1990, the message of World AIDS Day will reach more people than ever before, encouraging them to continue meeting the challenge of AIDS. The first World AIDS Day in 1988 began this process by emphasizing communication about AIDS. The second World AIDS Day in 1989 focused on the importance of youth in the AIDS epidemic. This year, World AIDS Day will focus on women.

Why women?

AIDS affects women, men and children around the world. Worldwide, WHO estimates that now, in 1990, at least six million people are infected with HIV, and that approximately two million – or one third – are women. It is expected that 500 000 people will develop AIDS during the years 1990-1991, including about 200 000 women. By the end of 1992, a cumulative total of over 350 000 cases of AIDS will have occurred among women, or three times as many as had occurred by the end of the 1980s. Thus, the number of women expected to become ill with AIDS during the next two years will exceed the cumulative total of AIDS cases reported to WHO during the first decade of the epidemic.

AIDS has a profound impact on women, both as an illness and as a social and economic challenge. Women play a crucial role in preventing infection with HIV and caring for HIV-infected people and people with AIDS. Women's lack of status within the family and society heightens their vulnerability to infection and other consequences of the epidemic. The stigma attached to AIDS can subject women to discrimination, social rejection and other violations of their rights.

"Women are the key to achieving health for all" Hiroshi Nakajima, M.D., Ph.D., Director-General, WHO

HIV Education Case Studies

**Number 3
May 1991**

*A Review of Community Based HIV Prevention Programs
Funded by The United States Conference of Mayors*

Women and AIDS/HIV

Montgomery AIDS Outreach—Montgomery
Planned Parenthood SE VA—Hampton/Newport News
Empowerment Program Services—Denver
Nevada AIDS Foundation—Reno
Women's Network/Mujeres Unidas—New York City



The United States Conference of Mayors

The United States Conference of Mayors is the official nonpartisan organization of cities with populations of 30,000 or more. There are well over 900 such cities in the country today, each represented in the Conference of Mayors by its chief elected official, the Mayor. The U.S. Conference of Mayors is in its second half-century of service to the Mayors and the citizens of America's principal cities. Throughout its history, the Conference of Mayors has taken the lead in calling national attention to the problems and the potential of urban America. Since its founding it has carried the message of cities to every President, every Congress. This is the heritage of the Conference of Mayors. It is the heritage of every mayor who serves today.

Robert M. Isaac
President
Mayor of Colorado Springs

J. Thomas Cochran
Executive Director

Purpose of Publication

Since 1984, the U.S. Conference of Mayors, in cooperation with the federal Centers for Disease Control, has provided AIDS/HIV education and information to localities. A major focus of this effort is through the Conference of Mayors' two AIDS/HIV grants programs, which provides grants to community based organizations to conduct AIDS/HIV education and risk reduction programs. Under the first grants program, in nine grant rounds the Conference has provided \$4.21 million in funding 135 community based projects to conduct AIDS/HIV education to persons at risk for HIV infection. In addition, the Conference has provided an additional \$754,481 to eight community organizations under its second CDC-supported grants program: AIDS/HIV education and service coordination/case management for persons with HIV infection.

This publication is the third in a series of case studies documenting the efforts of community based organizations funded by the U.S. Conference of Mayors that have responded to the HIV epidemic with effective community based education programs. Although programmatic responses may differ among organizations in different localities, the experiences of these organizations may provide assistance to others. In chronicling the development and implementation of community based organizations with proven track records of conducting AIDS/HIV education, these case studies may serve as guideposts for other organizations seeking to initiate or enhance similar efforts.

HIV Education Case Studies is a publication The United States Conference of Mayors, with support from the U.S. Department of Health and Human Services under grant #U62/CCU300609-08. Robert M. Isaac, Mayor of Colorado Springs, President; J. Thomas Cochran, Executive Director; Richard D. Johnson, Assistant Executive Director; Alan E. Gambrell, Editor; Stuart P. Campbell, Production Editor. Any opinions expressed herein do not necessarily reflect the policies of the U.S. Department of Health and Human Services.

This compilation of five case studies was developed and written by Paula Jones and is based on funding proposals submitted by the organizations, review and analysis of quarterly and final reports of activities of projects submitted to the Conference, and interviews with various organizational representatives. The Conference wishes to thank all those involved in assisting in the development of this publication, including: Carol Lease, Executive Director, EPS; Jan Naccari, Project Coordinator, MAO; Shelly Chase, Executive Director, NAF; and Sherry Norfleet, Director of Education, PPSEV.

© May, 1991, The United States Conference of Mayors

TABLE OF CONTENTS

Montgomery AIDS Outreach	1
Early Outreach	2
Designing the Program	2
Prison Staff	3
Educating the General Prison Population	4
Education and Support for HIV+ Inmates	5
Special Needs for Incarcerated Women	6
Planned Parenthood of Southeast Virginia	7
Recruiting a Hostess	7
Making the Concept Work	7
Difficulties	8
Key to Trust: The Educator	8
Participants Eager to Ask Questions	9
Evaluation	9
Beyond the Project Year	10
Empowerment Project Services	11
Expanded Street Outreach	11
Establishing a Strategy	11
Crack Houses	12
Outreach in Sex Businesses	12
HIV Sessions for Prostitutes	13
Resistance Among Prostitutes	13
Jail Outreach	14
Increasing Numbers of HIV+ Women	15
Nevada AIDS Foundation	18
Planning the Program	18
Providing Information to At-Risk Women	18
Jail Outreach	19
Support Groups	20
Limitations of Part-time Staff	20
Women's Network/Mujeres Unidas	21
Training Staff	21
HIV+ Support	22
Training Trainers in Prison	22

Introduction

Currently in the U.S., HIV/AIDS is one of the top ten killers of women of reproductive age; by 1991, it is expected to be among the top five causes of death. According to the Centers for Disease Control (CDC), women comprise the fastest growing group of people with AIDS in the United States. As of March 1991, 18,181 (or roughly 10.5%) of the 171,876 diagnosed AIDS cases were among females. Adult/adolescent women most commonly became infected with HIV by sharing contaminated drug paraphernalia and needles or by having unprotected sex with an infected partner.

Of adult/adolescent cases, gay/bisexual men comprise 59% of the total. IVDUs constitute 22%, with gay/bisexual IVDUs accounting for 7%.

Specific and tailored educational approaches are required to overcome obstacles and successfully promote behavior change among women-at-risk. This *HIV Education Case Studies* presents profiles on the efforts of five community based HIV prevention programs for women at-risk funded last year under the USCM/CDC HIV grants program. Featured are five USCM-funded projects:

- Montgomery AIDS Outreach Prison Project, targeting women with HIV infection and those at risk of HIV infection incarcerated at Tutwiler Prison in Alabama;
- Planned Parenthood of Southeastern Virginia, Hampton and Newport News, reaching women in public housing units;
- Empowerment Program Services Incorporated, Denver, educating sex industry workers;
- Nevada AIDS Foundation, Reno, focusing on injection drug users, women in correctional institutions, and homeless and battered women; and
- Women's Network/Mujeres Unidas, East Harlem, New York City, targeting Latinas in East Harlem.

Obstacles to Prevention Efforts for Women

Programs targeting women must consider different conditions than those addressed in educational models targeting gay and bisexual men or injection drug users. Cultural sensitivity is also a key factor: women of color are disproportionately affected by HIV, representing 74% of the AIDS cases among women yet comprising only 17.9% of the total female population.

Additional problems that complicate educational messages designed to promote behavior change among women include the following:

- Because the number of women with AIDS is still relatively low, many women do not believe that they are at risk of HIV.
- HIV infection is becoming increasingly identified as a disease of poverty. Due to the severe economic, social, and cultural pressures confronting

poor women, many suffer from low self esteem, are unaccustomed to playing an assertive role regarding sexual issues, and must be empowered to make decisions about sex and behavior change.

- The condom, the most widely promoted method available to prevent HIV transmission during sex, requires the obvious cooperation of the male partner; gaining male acceptance is not always easy or possible. In addition to cultural barriers women face regarding sexual decisionmaking, many women are financially dependent on their sexual partners and do not feel secure enough to insist that their partners use condoms.
- Drug treatment and other social and health services that could reduce some of the factors that contribute to women's vulnerability to HIV are frequently unavailable or not accessible.□

AIDS Outreach in Prison

Reaching Montgomery's HIV+ and Incarcerated Women

Alabama's Julia Tutwiler Prison, a facility of approximately 850 female inmates, houses on average 10 HIV+ women in its AIDS Isolation Unit. The number of women in the Unit varies as women come and go out of the prison system; the treatment they receive remains constant. No contact is allowed with the general prison population nor are the women allowed to participate in prison activities. Disposable utensils are provided with every meal and waste from the unit is burned daily in the yard.

Alabama is one of 17 states in the nation where there is mandatory HIV testing of all incoming prisoners; HIV infected inmates are isolated from the general prison population. Segregation of inmates is not a practice followed or recommended by most correctional systems. In 1990, the American Civil Liberties Union challenged the Alabama Department of Corrections policy of isolating HIV+ inmates. An appellate court ruled in favor of Alabama and the practice of testing and isolating HIV infected inmates continues.

Clearly, isolation does not eliminate the need to provide HIV education to HIV+ inmates; this holds equally true for efforts aimed at the general prison population and staff. Prison provides an opportunity to reach and educate a population generally at disproportionate risk for HIV (i.e., due to high rates of drug use and STDs)—a population that may be extremely hard to reach and educate once released from prison.

Early Volunteer Efforts Basis for Program

Montgomery AIDS Outreach (MAO)—organized in 1987 by volunteers concerned about the lack of HIV-related services in the community—operates one such prison-based effort at Tutwiler. Its prison outreach project, funded by USCM in 1990, conducts HIV risk reduction education for inmates and staff, with specific support and counseling provided to women who have tested positive for HIV and are confined to the AIDS Isolation Unit at Tutwiler.

The project was designed to address HIV education needs within Julia Tutwiler beyond MAO's initial voluntary efforts, which were begun in early 1989 by a small number of volunteers providing three to four hours a month of education, support and social interaction to the women in the Isolation Unit. Their segregation results in denial of services and activities available to other inmates, such as work release, education programs and chapel services.

MAO's role as a service provider at Tutwiler is not uncommon. Volunteers and community organizations, such as prison ministries, are often allowed in the prison system to serve inmates. Tutwiler administrators were impressed by MAO's early efforts in the Isolation Unit and were open to MAO's educational sessions for the staff and general population.

Designing the Prison Based Program

MAO's prison education program was developed by a committee comprised of MAO Board Members and the MAO Administrator—a group which included an educator, a public health officer, a media professional, a legislative budget officer and two social work professionals. The committee received input from prison officials, MAO volunteers and the women in the AIDS Isolation Unit.

In developing the program, MAO also consulted with other social service organizations to avoid overlap with existing services and found that women in the prison were not being served. Input and commitments of support were requested and received from several organizations, including the Alabama Department of Public Health and Alabama Volunteers in Corrections.

MAO reviewed materials from other prison projects in the U.S. This exercise was not particularly useful since other programs focused on changing behavior and/or modifying sexual practices among a male prison population and were not applicable.

MAO's review of materials from other prison projects was not particularly useful since other programs focused on male prison populations.

Prison Staff

Staff Key to Success

In the prison environment, AIDS educators must secure the trust and understanding of prison administrators and staff. Establishing and maintaining a positive and supportive relationship requires ongoing dialogue and may entail modification of educational programs to accommodate the needs or concerns of prison authorities. The following key areas involved negotiation, discussion, and compromise between MAO and prison authorities.

...information on safer sex practices was provided to inmates but graphic illustrations in AIDS brochures were not used.

- **Challenging Alabama's Segregation Policy.** Compromises were made when MAO was asked not to discuss with inmates in the AIDS Isolation Unit the court decision upholding Alabama

Department of Corrections' policy to isolate HIV positive inmates. MAO refrained from doing so even though women in the Isolation Unit were very interested in discussing this issue during counseling sessions. Some tensions did in fact exist between MAO and prison authorities at the start of the project given that MAO supported the ACLU lawsuit opposing Department of Corrections' policy of isolating HIV+ inmates.

- **Use of Frank Safer Sex Information.** MAO and prison authorities also engaged in discussion over the presentation of frank safer sex information in educational sessions, the use of graphic illustrations, and the distribution of condoms during pre-release counseling sessions. MAO worked with the prison authorities to develop an educational format that took into consideration the concerns of the authorities; information on safer sex practices was provided to inmates but graphic illustrations in AIDS brochures were not used.
- **Distribution of Condoms.** The distribution of condoms was another area where MAO negotiated with prison authorities. After six months, MAO was allowed to distribute condoms (which were purchased through Planned Parenthood funding). However, the agreement was to only allow their dissemination in response to inmate requests during release from the facility. In MAO's view, this was—at a minimum—a case of poor

timing: "When someone is getting out of prison, an extra stop, even to get condoms, is one step too many."

MAO described a generally supportive relationship with prison authorities, who became increasingly appreciative of the work of the project. For example, some prison staff served as active participants in educational sessions, with some prison employees taking part, and even leading, sessions.

Educating Prison Staff

One of the first project activities was to educate prison staff in order to create an environment that would be conducive to educating the general prison population and providing support to women in the Isolation Unit. While support of the administration is key to implementation of a program, educating and sensitizing prison staff is also essential. An uneducated staff can spread misinformation and perpetuate many of the myths and stigmas surrounding AIDS/HIV.

MAO conducted a series of 17 one-hour sessions during AIDS Awareness Week (February 26 - March 1, 1990, during the first quarter of the one year project period), attended by 130 guards and other staff. (It was necessary to plan staff training sessions about two months in advance to assure sufficient staff coverage during shifts.)

The sessions consisted of a pre-test, videos, opportunities for questions and answers, distribution of brochures, a post-test and an evaluation of the session. To stimulate discussion, sessions were limited to fewer than 10 participants.

Staff reaction showed that participants found sessions useful and increased understanding of AIDS (according to results of the pre-and post-tests). Staff frequently commented that they wished the sessions were longer.

A follow-up series of staff educational sessions was planned before the end of the USCM project but not carried out because of difficulties in getting prison staff together. Scheduling of sessions had always been difficult because the facility is chronically understaffed. Existing staff shortages at Tutwiler were compounded by Operation Desert Shield. Many of the prison guards serve in the Reserves and were called to active duty in the Middle East.

Educating the General Prison Population: Integrating HIV Into Existing Prison Programs

In addition to education efforts in the Isolation Unit, MAO developed specific project objectives on reaching the general prison population and staff at Tutwiler. Early on, these efforts were modified: the warden preferred to support targeted presentations within existing Tutwiler prison programs—such as the pre-release program. In fact, the warden's support for MAO efforts in existing prison programs was established after she observed the content and quality of MAO's presentations to prison staff during "AIDS Awareness Week," the kick-off event of the USCM-funded project.

The warden's request for targeted sessions exceeded the number planned for in MAO's program plan, requiring modifications in the project to accommodate the increased workload. For example, MAO did not hire a clerical worker as planned in the budget, instead transferring funds to pay for more speakers. Volunteers carried out clerical duties.

A larger volunteer speaker network was also developed. MAO augmented the services of paid speakers by utilizing six volunteers with professional experience in public health, mental health, substance abuse counseling, and social work for prison program presentations. Staff from the health department, Birmingham AIDS Outreach (an AIDS service organization),

An uneducated staff can spread misinformation and perpetuate many of the myths and stigmas surrounding HIV/AIDS

and other health care agencies also assisted MAO. On average, 1-2 speakers participated in workshop presentations in the Pre-release, New Beginnings and WINGS programs. (Over 50 volunteers currently serve in MAO's various programs, including those

working with prisoners and Isolation Unit inmates.)

• Pre-Release Program

HIV education efforts integrated in the Pre-Release program were presented in monthly pre-release sessions. Pre-release is a requirement for all women prior to release from Tutwiler. MAO provided nine two-hour educational sessions for 218 women in pre-release presentations from March - November 1990. Basic "AIDS 101" and

panel discussions (participants include formerly incarcerated women who have modified their high risk behaviors and/or minority leaders and professionals) were interspersed with plenty of time for discussion and questions. The video "Changing the Rules" was shown at some sessions.

• New Beginnings (Skills Development)

MAO also conducted sessions as part of the "New Beginnings" program, a voluntary educational/informational program on a wide range of topics (e.g., HIV education, job training skills). Four one-hour HIV sessions reached 236 women through New Beginnings over a nine month period. One session for the inmates in the New Beginnings program included a panel discussion with HIV+ individuals. "This program was especially well received by the inmates," according to MAO. Since these sessions were only one hour there was no time for videos.

• WINGS (Substance Abusers)

HIV education conducted by MAO was incorporated into the "WINGS" (Women Incarcerated Getting Straight) program, which is tailored for substance abusers. It is mandatory for women in the WINGS program to attend sessions.

HIV educational sessions for women in WINGS reached 128 inmates; seven one hour sessions were held over a nine month period. The sessions emphasized the relationship between drugs and HIV and utilized the video "Needletalk."

As an organization, Montgomery AIDS Outreach Project has a core of over 50 volunteers contributing their time and expertise, including the 18 participating in the Tutwiler Prison Project.

Education/Support Services for HIV+ Inmates

Women in the Isolation Unit frequently expressed the importance of contact with MAO volunteers. Because they are allowed no contact with the general prison population, monthly MAO educational/support sessions served as an important link to the outside world not otherwise available.

The demoralizing effect of the segregated environment on the Unit's women presented a unique educational challenge and made the promotion of behavior change difficult. Despite the support offered by MAO, some women are unable to cope with the adversity and isolation. Several of the women were reported to have returned to using drugs following their release.

Group and individual counseling—focusing on behavior modification—provided the core of MAO's support to HIV positive inmates. Specific topics discussed during sessions included: stress management, nutrition, self-esteem building and self empowerment.

MAO held 12 group sessions with women in the Isolation Unit (one per month), with an average of 8-12 women in each session. An additional four special sessions on improving nutrition and managing stress were held reaching the same number of women per session. Up to 12 regular volunteers accompanied the counselor on her monthly visits to the Isolation Unit. These volunteers provided social interaction and support for the women in the Unit. On occasion, the number of volunteers exceeded the number of inmates.

Individual counseling sessions were held with 16 Isolation Unit inmates prior to their release; the counselor attended parole hearings with six women. As the project progressed, women in the Unit began to rely on telephone contact with the counselor rather than face-to-face encounters. Using the telephone afforded greater privacy than conducting sessions within the crowded Isolation Unit, and since MAO was only at Tutwiler once a month, phone contact was more practical for women with immediate needs.

Release Difficult for HIV+ Inmates

Women from the Isolation Unit scheduled for release receive individual counseling and are provided assistance in planning for their release, making the transition to the community, and family relations. Individual sessions seek to reduce the fears and uncertainties about release.

Hampering MAO's efforts to assist soon-to-be-released inmates is the lack of services (housing, employment and health care) within the community. Once released, HIV+ women often have to choose between paying rent or getting medical attention.

MAO has learned that many women cannot rely on their families for support. While in prison, contact with family members is difficult since many are not financially able to come to the prison: the Isolation Unit's visiting day is scheduled during the week, requiring visitors to take time off work. Lack of resources prevents some families from taking an active supportive role. Misconceptions and fear concerning HIV also drive family member reluctance to become involved.

Effectiveness of HIV+ Efforts

Although MAO used pre- and post-test evaluations in educational sessions, this technique was generally not practical. Many women did not understand the test questions, causing them to feel awkward and uncomfortable. Also, given the limited time with the women, MAO educators sometimes skip-ped the post-test in order to allow more discussion time. MAO found verbal communication and feedback to be a more effective method of evaluating the impact of sessions.

The demoralizing effect of the segregated environment on the Unit's women presented a unique educational challenge.

Two examples included:

- During the June session, a HIV+ MAO volunteer spoke with the Unit's women about coping with both the physical and emotional stress of HIV infection. The MAO counselor noted that "the women seemed to be inspired by her participation."
- Two new residents had entered the Unit and were relatively quiet (i.e., withdrawn) during the session. During individual counseling sessions, the counselor was gratified to discover that the other women in the Unit had done a good job in helping these two women understand the implications of their serostatus.

Special Needs of Incarcerated Women

Tutwiler Prison is the only facility for women in the state; 60 percent of its inmates are Black, the remainder being primarily white. As in other correctional facilities, the inmate population includes many individuals who have a history of drug abuse (10% have been convicted of drug related crimes) and sexually transmitted diseases.

Many of the women have been prostitutes. Many have had unsuccessful personal relationships, are skeptical of authority figures, and come from economically, socially and emotionally deprived environments. Some are functionally illiterate and have underdeveloped communication skills. Many do not have highly developed concerns regarding their personal well-being and the safety of their sexual partners.

All these factors guided development of MAO's education program. Special emphasis was placed on presenting information in a non-judgmental manner so the women would be more receptive to risk reduction messages and using language understandable to the target population. The program also had to take into account the wide range of educational levels of the inmate population—from illiteracy to college degrees. It was necessary to design a program that would convey the dangers of substance abuse and risky sexual behavior without, in MAO's words, "preaching or talking over the head of some, or talking down to others." □

MAO has learned that many HIV+ women cannot rely on their families for support.

Program Goals

MAO's prison project goals are two-fold: (1) to educate women inmates on HIV infection, risk reduction behavior, and maintaining lifestyle changes once released from Tutwiler; and (2) change the behavior and attitudes of prison employees and other inmates toward those with HIV infection. The two efforts go hand-in-hand since MAO's educational efforts would be hampered if participants leaving sessions plunged back into an environment of intolerance or information provided by MAO was contradicted by prison staff or other inmates (e.g., "I don't care what MAO said; you can still get it from a toilet seat").

Specific messages MAO communicates include:

- Inmates infected with HIV/AIDS are provided information about health promotion and nutrition, safer sex practices and, for those that are IV drug users, how to clean needles.
- Individuals in the general prison population are taught to understand HIV and how it is and is not spread. Fears, misconceptions and myths about HIV infection are examined in an effort to develop a more accepting attitude toward persons with HIV infection; conversely, a more accepting environment will encourage HIV infected women to confront their denial and empower them to accept risk reduction and health promotion education.
- Prison employees are educated on how HIV is transmitted, precautionary measures (e.g., protocols for cleaning up body fluids, providing first aid, breaking up of fights) and appropriate responses when interacting with a prisoner infected with HIV. Sanitary precautions to protect HIV-infected inmates from infections/illnesses among the general population are also covered. (This effort is an important component of dispelling inmate misconceptions about AIDS and its transmission.)

Planned Parenthood Conducts Home AIDS Parties

Friday or Saturday night is a popular time to hold an AIDS party. In the housing projects of Newport News and Hampton, Virginia, Planned Parenthood of Southeastern Virginia (PPSEV) during 1990 provided HIV/AIDS education to over 1,000 low income minority women through a demanding schedule of 165 such events—AIDS home health parties, each hosted by a resident of the housing projects.

With its USCM grant of \$40,743, PPSEV hired a full time AIDS educator to coordinate the parties and purchase supplies (e.g. food, plates, door prizes, gift certificates for hostesses). PPSEV worked with the Newport News Housing Authority and Hampton Housing Authority and resident counselors within each of the fifteen housing developments in the area to reach an audience of primarily single (72%) or divorced (14%) African American women (94%). The PPSEV educator's job: to organize home health parties as a comfortable environment for women to discuss sensitive AIDS-related issues.

Wanted: Hostesses

The AIDS educator began outreach in January 1990 by asking housing resident counselors or tenants to serve as home party hostesses, or to identify others who would be willing to host a party. Over the 12 month project cycle, 17 recruitment meetings were held at resident counselor gatherings and tenant meetings to encourage participation.

The popularity of the parties brought in more hostesses throughout the year.

Early on, resident counselors were valuable resources, serving as hosts for the first parties and encouraging the participation of others. The popularity of the parties brought in more hostesses throughout the year. Flyers requesting volunteer hostesses were also distributed, with over 1,000 placed within the community and through various community agencies (e.g., project offices, laundromats, food stamp locations, health departments).

As incentive, each hostess was provided a \$25 gift certificate from a local grocery store. Her responsibility was to invite 6-10 of her female friends to the party. PPSEV never had a shortage of potential hostesses. However, many prospective hostesses could not identify six guests—the minimum required to host a party. The average party included six attendees.

Making the Concept Work: Take Care of Details

The actual intervention has all the makings of a party.

Lunch or dinner is provided; about 65 percent were requested to be held in the evening, with the most popular time being 5:00 on Fridays, with Saturdays as the second choice. The educator was available to schedule parties between noon and up to 7:00 p.m. (PPSEV had expected Mondays through Thursdays to be big days.)

The party begins with each invitee given a ticket for a drawing, which takes place at the end of the evening; the winner must be present to win, ensuring that the women stay for the entire presentation. The prize is a small appliance, like a hand mixer, electric can opener, or small crock pot. A popular second prize is a plastic compact containing six condoms. At the end of the party, participants are encouraged to host a party of their own in exchange for a \$25 gift certificate.

The educator makes all the arrangements for the party in order to limit the amount of effort required of the hostess. (Surprisingly, babysitting turned out not to be a needed service as neighbors were usually available to provide sitter services and the women were more comfortable leaving their children with people they knew.) The educator brings folding chairs, plastic garbage bags to remove trash and bamboo trays for the meals so that tables are not required.

The menu is determined in consultation with the hostess and purchased from nearby restaurants. Subs, pizza, or chicken are the choices. Pizza presented a particular problem: restaurants wouldn't deliver to the housing projects. However, restaurants did allow PPSEV to borrow their pizza warmer carry cases for the evening.

Difficulties

Hostesses Might Forget. Coordinating parties can be difficult because many of the women (about 65 percent) do not have phones. The educator in these instances had to either call a neighbor or make arrangements in person.

It was common for hostesses and attendees to forget about the party. To avoid this, parties were not scheduled too far in advance and were confirmed by phone or in person the day before; postcards were used as reminder cards. Food was not ordered until right before the event.

Crime a Concern. If necessary, the educator brought the TV and VCR for the educational video. It was almost always necessary to provide the video machine since approximately 85% of women in the housing projects do not own a VCR.

The reality of crime in the projects was a significant concern for the educator. For instance, a cover was purchased to disguise the TV/VCR when being carried in and out of the housing projects. As a rule, she drove an older model car and never carried a purse while doing outreach work.

Bad Food, Cheap Gifts. Program organizers were surprised by the extent of distrust of "the system" among the target population and the women's fear that the PPSEV educator was affiliated with the government and would report them for some reason to government agencies. Common concerns among potential hostesses included: drugs or paraphernalia being discovered by the educator in their apartment; criticism over care of children; and evidence of a man in residence.

Potential hostesses were also suspicious about the party arrangements—that they would not receive the gift certificate, that the door prize would be cheap and the food would be bad. Women commented on the quality of the food, which was important to them. PPSEV has worked with restaurants to get good food at reasonable prices.

Potential hostesses were also suspicious about the party arrangements—that they would not receive the gift certificate, that the door prize would be cheap and the food would be bad.

Once, when metal-decorated canisters were substituted for the small appliance door prizes, the women were vocally upset and stated that it was not up to the standards of what "so and so" got at another home party. PPSEV quickly dropped the decorative can concept.

Fear of Guests. Additionally, the women were not always comfortable having guests in their homes because they were ashamed of their apartments due to lack of or poor condition of furniture and the presence of roaches. Several parties were held in the housing project community centers for women who did not feel comfortable having people in their apartments.

Key to Trust: The Educator

The AIDS Educator/Project Coordinator was the most important ingredient to the success of the project, according to PPSEV. Her accessibility to the target population and ability to gain their trust were crucial to the success of this program. She had to convince hostesses that she had no ties to social services, the health department, or the police (due to the participants fear of "the system"). She also had to show understanding of and sensitivity to the daily economic and social pressures confronting the women.

"She [the educator] is easy for [the women] to talk to and they trust her judgment."

"She is easy for [the women] to talk to and they trust her judgment." An example provided by PPSEV was a 16 year old who called the coordinator on the advice of her mother, who had attended a party.

"The girl had just been diagnosed with herpes at the local health department. She needed information and was confused and upset. [The coordinator] let her talk to the PPSEV clinic nurse, who described in detail the infection, medication, etc. The girl then asked to speak to [the coordinator] again just to verify what the PPSEV nurse had told her."

An outsider (i.e., of a different racial, cultural or economic class), according to PPSEV, could never have achieved the level of access gained by the PPSEV educator. For example, when a white PPSEV staff member accompanied the coordinator, participants were reserved and did not pick up condoms until the

white staff member left. This presented a particular problem with PPSEV's evaluation of the educator. A Black staff member from the American Red Cross accompanied the coordinator to a party in order to evaluate her performance since it was believed that the white PPSEV supervisor's presence would disrupt the party.

The ability to identify with the target population was only one of the demands of the AIDS coordinator's job. She also had to be flexible in scheduling parties for evenings and weekends. Burnout was a concern for PPSEV because of the frequency of parties. To help alleviate this pressure, parties were never scheduled on Sunday; if the educator worked Saturday, she was encouraged to take Monday off.

As the project period progressed, the educator became an important resource to the target population on all health issues. She distributed her business card to all party participants and encouraged them to call her if they had additional questions. The educator even received calls at home from participants (which was discouraged), who obtained her number from directory assistance.

Participants Eager to Ask Questions

Participants at most parties were eager to ask questions. Parties typically ran longer than anticipated—on average about 2 1/2 hours instead of the scheduled 1 1/2 hours. On the post-test, 97 percent thought the parties were a good idea; 96 percent would encourage a friend to attend.

According to PPSEV, women were very comfortable asking questions at the parties and did not hesitate to ask "questions about all aspects of sexuality, including different sexual behaviors and sexual orientations. The atmosphere is informal and since the women know one another they indicate a high level of comfort."

The PPSEV coordinator carried a large supply of condoms (lubricated with Nonoxynol-9) and Nonoxynol-9 products to pass around to the women so that

they could become familiar with the products. Many women expressed concern about convincing their male partners to use con-doms and seemed inclined to just utilize the Nonoxynol-9 products instead of broaching the subject.

Some women suggested that men be invited to attend the parties or that separate parties be held for men. (During the summer, with more men hanging around, men asked questions about AIDS and other health questions. PPSEV is looking into "couples" parties.) It was also suggested that parties be held for teenagers; a number of the women attending the parties were in fact in their teens.

Evaluation

"Perhaps the worse difficulty lies in our evaluation component," according to PPSEV, which includes pre-post tests conducted at the parties as well as three month and six month follow-up surveys, mailed to participants. The educator has gotten most participants to complete the pre- and post-tests conducted at the parties (only nine participants out of over 1,000 failed to do so). Some complained but most complied. Some women needed help given low literacy levels. The tests are kept very short and simple due to literacy problems and time constraints.

Pre- and post-test results show an extremely high level of knowledge—averaging over 90 percent on the pre-test and the upper 90s on the post-test. The question "Can you get AIDS from a mosquito bite" scored a low of 85 percent correct on the pre-test, improving to 97 percent on the post-test.

The follow-up surveys, designed to measure retention of information over time, have had low response rates: 24 percent for the three month follow-up and 12 percent for the six month version. The follow-up surveys are the same as the questions asked on page two of the post-test survey conducted at the end of the parties, providing PPSEV with a standard against which to measure change.

Tentative findings of the follow-up surveys (which are still being compiled by a volunteer), compared with

The follow-up surveys, designed to measure retention of information over time, have had low response rates...

Many women expressed concern about convincing their male partners to use condoms and seemed inclined to just utilize the Nonoxynol-9 products instead of broaching the subject.

post-test party test results, indicate that:

- 76% of women discuss safer sex with their partners (although the survey cannot assess how in-depth or what was said); 35% said they did so prior to the party;
- PPSEV's reaction to survey results on discussing safer sex is that a lack of aggressive skills of the women makes it difficult to believe that they have actually discussed "safer sex" with their sexual partners.
- condom use did not go up as much as the women had indicated were their plans in the post-party test (at 3-6 months, 31% indicated they made sure their partners used condoms "all the time," as compared to 50% who promised to use them on the post-party test); and
- the largest increase over time was discussing HIV with family and friends; at 3-6 months, 93% had done so; this compared to only 31% at the parties who indicated they had discussed HIV with family/friends.

Regarding condom use, the women's concern at the parties "about how to get a partner to wear a condom

and how anxious they are for men to have a party indicates a reluctance to [discuss condoms with men] that belies the 50 percent who said they would make sure their partner used a condom all the time." PPSEV expressed a belief that respondents may have been concerned about providing "the appropriate or 'right' answer."

Beyond the Project Year

Despite the end of the USCM contract year, PPSEV's work continues. The Virginia Department of Health, AIDS Activity Program, will fund the program through August 1991. United Way of the Virginia Peninsula will provide matching funds for 10 hours a week of the AIDS coordinator's time for 1991.

The coordinator participates in an informal group of outreach workers—the Tidewater Street Outreach Group—from various agencies in southeast Virginia conducting street outreach. She has accompanied an outreach worker from Tidewater AIDS Crisis Task Force on street outreach, giving her outreach experience in a "high risk" world, according to PPSEV. □

Sex Industry Outreach in Denver

Denver, like most cities, has a persistent "sex industry." Police target the most visible forms of prostitution—street walkers—but the real action takes place in massage parlors, bars, brothels and "out call" services. Bookstores and theaters are also part of Denver's sex industry.

The crack epidemic has given rise to a new form of prostitution. Female crack addicts often resort to prostitution in order to support their habits. These women work in crack houses and serve as an additional enticement to male buyers in the intensely competitive drug business.

Sex-for-drugs, especially engaging in sex for crack, is believed to be a factor in increased rates of STDs and

Sex for drugs is believed to be a factor in increasing rates of STDs and the spread of HIV.

the spread of HIV. HIV seropositive rates among Denver prostitutes are significant; in 1988, 740 female prostitutes were tested, with a 2.77 seropositive rate.

Empowerment Program Services (EPS) has worked with women involved in prostitution since 1986 and began HIV risk reduction/ prevention outreach in 1987—establishing an outreach network at truckstops, adult bookstores, sex-related businesses, law enforcement agencies, and shelters for battered women.

According to EPS data, the average age for beginning prostitution-related activities is 16. Other significant target population characteristics include:

- 80 percent are high school drop-outs;
- 75 percent used drugs before becoming involved in prostitution;
- 85 percent report being sexually assaulted either before or after their involvement in prostitution;
- the primary reason for dropping out of the sex industry is pregnancy; and
- the majority of the prostitutes feel that there are no social services available to them.

USCM Project: Expanded Street Outreach

Funded by USCM in 1990, EPS's one-year program of \$42,000 was designed to provide for salaries of one outreach counselor and one group facilitator to expand existing EPS HIV / AIDS programs and reach two new subgroups of their overall target population: young female prostitutes working in crack cocaine houses in the Denver metropolitan area; and women working in adult theaters/bookstores behind glass, who often "date" customers after hours.

EPS also continued existing efforts of reaching prostitutes through intensified outreach in county jails and pre-trial intervention and diversion projects with the Denver County Courts. This latter effort included particular focus on providing alternatives to women working as prostitutes and wanting to "get off the streets."

The USCM-funded effort was able to build upon existing efforts carried out by EPS, which were initiated with a one year grant awarded in 1989 from The Robert Wood Johnson Foundation. The RWJ funds were used to provide regular HIV education workshops in metropolitan area jails, conduct street outreach (distributing condoms and HIV educational materials) and provide both one-to-one counseling and support groups.

Outreach: Establishing a Strategy

The success of the EPS outreach program rested mainly on the ability of staff to establish rapport with the target population. Seventy-five percent of the EPS staff are minorities, approximating the demographics of the target population; 65 percent are ex-offenders. Of the two EPS outreach workers employed during 1990, both were former IVDUs and prostitutes. They served as role models for many of their former co-workers on the street in reducing risk of HIV infection.

Taking it to the Streets: Crack Houses

In order to avoid overlooking women not reached through other agencies/organizations, EPS also went directly to crack houses. At the beginning of the project period, the EPS outreach worker, accompanied by an outreach worker from another organization for safety reasons, conducted direct outreach inside the crack houses. This practice was discontinued due to concern regarding the safety of the workers. The new strategy was to approach women outside of the crack houses, on street corners or in front of corner stores where they congregated.

The outreach worker watched the women for an opportune time to approach (i.e., in between "tricks"). Her usual approach was to ask a woman if she had heard about Empowerment and their services. A common response was that they knew about EPS but were not interested in services, at which point the outreach worker brought up HIV.

There really wasn't much time to provide in-depth risk reduction information during the "bus stop bench" interventions. The women were given a bag with condoms, lubricant and information on EPS. EPS found a fairly high level of knowledge concerning HIV/AIDS among the women.

EPS's perspective is that when the women are ready, hopefully they will contact EPS for more information or services. EPS readily acknowledges that jails serve as a more effective environment for education than the streets.

At the beginning of the project period, the EPS outreach worker—if working alone (i.e., not accompanied by workers from other organizations)—was only on the street during daylight hours for safety reasons. About half-way through the project period, EPS received funds from the city of Denver to hire another outreach worker, allowing two women to conduct outreach in the afternoon and early evening, weather permitting.

One key modification occurred with the closing of crack houses by police during the third quarter of the funding period; outreach was refocused on the criminal justice system and drug treatment programs.

Outreach in Sex Businesses

EPS sought to reach sex industry workers at their places of employment in an unobtrusive manner. The standard approach was for the EPS outreach worker to identify and visit sex-related businesses (e.g., theaters, bookstores, hotels) and gain their cooperation in supplying condoms, lubricant and risk reduction materials to women working in or frequenting their facilities. EPS staff utilized sex-related publications from the area to identify new businesses to target.

After establishing contact with a business, the outreach worker frequently returned to replenish supplies and ensure that materials were accessible to the women. Some businesses did not display the materials, but provided them to the women if asked.

Accessing Women Through Agencies

Initial project activities involved mapping a strategy for reaching women exchanging sex for drugs in crack houses or at risk of crack addiction. The USCM-funded outreach worker began this process in the first months of the project by establishing contact with the target population through agencies/organizations that already had access to them. EPS took this approach so as not to rely exclusively on direct outreach to women in the crack houses, which was a recognizably difficult task.

The EPS outreach worker developed working relationships with agencies involved with young women at risk of cocaine addiction. This included the Denver Police Department, juvenile and adult diversion programs, counselors and other public school personnel, public health clinics, and recreation centers in high crime areas.

Clients of these agencies were encouraged to attend EPS-sponsored one-to-one and small group counseling sessions held at EPS offices in the area, which provided information on safer sex and proper condom use, especially during oral sex (the preferred form of sex in crack houses according to EPS's analysis). How to clean "works" with bleach was also demonstrated.

During sessions, outreach workers utilized educational videos and distributed information cards and comic books appropriate for the low literacy levels of most participants. The most popular videos with the women were Don't Forget Sherri, AIDS: Changing the Rules, and Best Defense.

EPS outreach workers established contact with 52 sex-related businesses over the one year project period. The reluctance of some businesses to display materials resulted from their claim that women who frequented their establishments were not prostitutes.

EPS outreach workers returned to establishments frequently and found some managers more receptive to EPS educational efforts than others. A successful strategy utilized by outreach workers has been to suggest that women might actually prefer establishments where they can get free condoms.

Over the course of the project period, EPS outreach workers distributed over 27,200 condoms at educa-

Problems in Reaching Sex Workers

As with most programs targeting hard-to-reach women, the overwhelming social and economic problems faced by prostitutes often make it difficult to impress on them the importance of adopting safer behaviors. EPS's outreach and provision of services to sex industry workers was complicated by several factors.

- EPS counselors determined that substance abuse behaviors were largely unchanged despite EPS education and outreach efforts.
- The lack of transitional housing for women following release from jail forced many women to return to the streets and associate with acquaintances still abusing drugs. Many women who want to get off the streets have no means to change their environment because of the lack of affordable housing. Public shelters are an important temporary transition, but limitations on stays to 3-6 months are a problem. Also lacking, according to EPS, is a residential setting with treatment services available to provide support, therapy, and services needed to stay out of prostitution.

Even when the outreach worker was able to get women to take advantage of EPS services, there was no guarantee that clients would complete the program. Despite EPS efforts to provide vocational training and job referrals, low education and skill levels of clients made it difficult for EPS to provide jobs in which the women could earn as much money as with prostitution. The average literacy level of clients is grade seven; the average job placement wage of EPS participants is \$5.52 per hour, which compares very unfavorably to prostitution wages.

tional sessions, on the streets and through sex-related businesses.

HIV Sessions for Prostitutes

To compliment outreach to sex-related businesses, EPS conducted educational sessions for prostitutes, held at locations such as a rented hotel room, hair salons, or the EPS office about every two months. Child care was provided for women who attended group sessions.

A successful strategy has been to suggest that women might actually prefer establishments where they can get free condoms.

In conjunction with the local and state health department, sessions covered negotiation skills, safer sex as erotica, early recognition of STD symptoms, nutrition, and health strategies. To attract participants, a drawing for a cash prize was sometimes held. Promotional fliers, passed out and posted, announced the sessions and drawings.

Prostitutes Resistant to HIV Testing

During the course of the project period, EPS outreach workers discovered that prostitutes were unlikely to go to community health facilities for HIV testing due to shame about their profession and a distrust of the system. In order to make testing more accessible, EPS arranged for the Colorado State Department of Health to offer confidential testing once a month in their offices. During the second and third quarters of the project 19 women were tested. During the fourth quarter, the Colorado State Department of Health opened a free confidential testing site across the street from the EPS office, making it unnecessary for EPS to continue this service.

Breaking Down Barriers: Reaching Women Working Behind Glass

EPS identified women who work in bookstores in glass booths as an especially hard-to-reach population. These women frequently join their customers after work and do not solicit on the street. For this reason, outreach workers do not have access to these women, nor are they reached through educational efforts in the prison/court system since these women are not typically picked up by the police. An effective strategy for reaching these women has not yet been developed.

Jail Outreach

EPS carried out a series of jail outreach workshops designed to address its objective of reaching 50 percent of all women in the area arrested for solicitation or drug-related charges associated with crack cocaine. Weekly workshops were provided at the Denver County Jail, bi-monthly workshops at the Adams and Arapahoe County Jails, and monthly sessions in the Jefferson County Jail.

EPS readily acknowledges that jails serve as a more effective environment for education than the streets

that they had been providing services to the women in the jails prior to initiating their HIV outreach efforts and already had the trust and the respect of the authorities for their work.

Safer sex demonstrations were part of two-hour EPS workshops, which included a video on AIDS, complete pre- and post-tests, an evaluation of the workshop, and demonstration of condom use on "Harry," EPS's dildo for oral, vaginal, and anal sex. Needles and syringes were not used for demonstration purposes but there were graphic demonstrations of how to clean "works" in the videos. A question and answer period included discussion of resources available after release and planning for the transition from jail (e.g., drug treatment, employment, housing). EPS varied the topics of their sessions to prevent the women from being bored by repeat information and not returning for additional sessions. Assertiveness training, self-esteem building, refusal skills and domestic violence were regularly addressed. HIV risk reduction information was integrated into every session.

At the 155 HIV risk reduction sessions held over the course of the project period the following number of women were reached in the four facilities:

- | | | |
|--------------|-----------|--------------------|
| • Denver: | 709 women | weekly sessions |
| • Adams: | 136 women | bi-weekly sessions |
| • Arapahoe: | 161 women | bi-weekly sessions |
| • Jefferson: | 97 women | monthly sessions |

EPS staff estimates that 10 percent of the participants at each session had already attended an EPS workshop

Pre-Trial Intervention/Diversion

EPS set an objective of serving 40 women through the project year in comprehensive employment, training, and counseling services. Ninety-three were referred to EPS and made follow-up calls after their release to set-up intake appointments. Sixty-two actually followed through and scheduled initial appointments.

EPS has experienced a low return rate in its job readiness training, peer support, drug/alcohol, and HIV support groups, with an overall 24 percent return after initial visits. By the end of the project period, 19 women had completed job readiness training and were employed. An additional 14 women had completed the job readiness training but had not secured jobs.

Support Groups: Meeting the Needs of HIV+ and Worried Well

EPS also conducted weekly support groups. This effort started with a single group serving only HIV+ women but because of low attendance EPS opened sessions to women who thought they might be HIV+ but had not been tested. Eventually many of these women were tested. As the group evolved, it became clear that the needs of HIV+ women and those who had not been tested (most still working as prostitutes) were very different. HIV+ women were concerned about deteriorating health, care for children after death, medical care, and accessing social services. Women not knowledgeable about their status were more interested in issues such as transmission and risk avoidance, substance abuse treatment, and getting off the streets and out of prostitution in order to get their lives together.

The group was split, with prostitutes meeting on one night in the early evening and the HIV+ women meeting on another. Following the division of the groups, low attendance once again became a problem in the HIV+ group; sometimes only one woman was in attendance. Several of the women who had been involved in the group were experiencing deteriorating health, not physically able to attend sessions, and in need of specific services.

Future: Increasing Numbers of HIV+ Women

EPS secured funding to continue its HIV risk reduction project with resources provided by the Colorado Department of Health, Denver AIDS Prevention, and a HRSA demonstration grant. Local churches provide EPS with funds and support to help meet the needs of HIV+ women and their families that were not covered by existing programs.

EPS reports more women utilizing its client services. In particular is an increase in women with HIV infection and with children who are migrating from other states where services are scarce.

EPS is focusing new attention on case management for HIV+ women and hopes to eventually open a house for women with HIV infection. □

City	Organization	Budget	Staff
Montgomery, Alabama	Montgomery AIDS Outreach	\$33,201	Part-time Coordinator, 18 regular volunteers, Counselor (hourly rate)
Hampton and Newport News, Virginia	Planned Parenthood of Southeastern Virginia	\$40,743	Full-time Project Coordinator (flexible hours), program director, financial officer, and sec- retary (partial time)
Denver, Colorado	Empowerment Program Services, Inc.	\$42,000	Full-time outreach worker, part-time group facilitator
Reno, Nevada	Nevada AIDS Foundation	\$22,755	Part-time coordinator, counselor (hourly rate)
New York, New York	Women's Network/Mujeres Unidas	\$41,750	Full-time educator/ coun- selor, AIDS program co- ordinator and executive director (partial time)

Target Population

Incarcerated women (including HIV+ women in the Isolation Unit) and prison staff at the Julia Tutwiler Prison

Black women residents of public housing in Newport News and Hampton, Virginia

Black, Latino, and Native American female prostitutes (including women who exchange sex for drugs), pornography performers (women performing behind glass in adult bookstores) and women arrested on drug-related charges

Women in high risk situations (correctional facilities, housing shelters, substance users) and women in general

Latinas living in East Harlem

Intervention

- Conducted monthly support and education sessions for 8 - 12 HIV+ women.
- Conducted 17 one-hour HIV education sessions (AIDS "101," risk reduction information, AIDS in the workplace) reaching 130 prison staff (5 - 10 participants per session).
- Conducted nine two-hour sessions reaching 218 women in mandatory pre-release HIV risk reduction/prevention sessions.
- Conducted 11 one-hour AIDS "101" and risk reduction presentations to 364 women participating in prison programs ("New Beginnings" and WINGS).

- Held 165 home health parties hosted by women residents reaching 1,086 women consisting of pre-test; HIV information sessions; meal; video and discussion; condom, lubricant and spermicide demonstration; post-test; drawing for door prize.

- Ongoing street outreach to prostitutes.
- Conducted 155 education sessions in four area jails reaching 1,103 women.
- Provided services (employment training and counseling) to 33 women referred to EPS by pre-trial intervention.
- Outreach to target population and promotion of EPS services through organizations serving women at risk.
- Distribution of condoms and risk reduction information to 52 sex related businesses (to increase availability of information and condoms to women working the street).

- Held 51 presentations to over 600 women in transitional housing facilities, churches, businesses and organizations serving women.
- Weekly educational sessions at regional detention center (began during second quarter), bi-weekly educational sessions at the juvenile detention facility (began during third quarter) targeting women in high risk situations.
- Conducted 38 support group sessions (weekly) for HIV+ and at risk women. Attendance averaged 1 women per session.

- HIV education and training for Women's Network regular staff.
- Provided one-on-one and phone HIV risk reduction/prevention counseling to 350 clients.
- Educator/counselor made 350 referrals to social services, 57 referrals to HIV testing and provided advocacy services on 270 occasions.
- Co-facilitated weekly support group for 6-12 HIV+ individuals.
- Conducted 24 peer training sessions at Taconic Correctional Facility for Women.
- Educator/counselor provided information and counseling to 48 incarcerated women who phoned collect from the prison.

Nevada AIDS Foundation Women at Risk Outreach Program

While low in comparison to large urban areas, local and state officials were alarmed when the number of HIV infected women in Northern Nevada went from one in 1987 to sixteen by June 1989. This magnified an obvious gap: no local programs addressed the specific needs of women with or at risk of HIV infection.

The Nevada AIDS Foundation (NAF) sought to fill that void in 1989 by developing the Women at Risk Outreach Program. NAF is a CBO founded in 1985 to meet the needs of persons with AIDS, provide AIDS education to the public, and maintain an information and referral telephone service in the Washoe (Reno) County area.

With a \$22,755 grant from USCM awarded in December 1989, NAF proposed to reach 150 women at increased risk of HIV infection through workshops and follow-up sessions. The Women at Risk Outreach Program targeted injection drug users, women in correctional institutions, and homeless and battered women—all through organizations serving these populations. In addition, the funded project conducted support groups for HIV+ women.

Planning the Program

Prior to submitting their proposal to USCM, NAF consulted local experts, including the Washoe County AIDS Coordinator, in designing the program. The proposed program was modeled on existing NAF programs consisting of Smart Sex workshops and edu-

Certain components...were modified to address concerns and issues not part of the original model for the gay, male community.

cational seminars. Certain components, especially the Smart Sex Workshop, were modified to address concerns and issues not part of the original model for the gay, male community.

Collaboration. Collaboration with other organizations was also essential for the project. Two local organizations, the Committee to Aid Abused Women and Step II (a reentry program for women substance abusers), agreed to work with NAF in reaching targeted women from the onset.

The first few months of the project were spent building relationships with other CBOs. Working relationships were established with the American Red Cross, Nevada Hispanics Services, Nevada Urban Indians, Nevada Network Against Domestic Violence, Community Services Agency, University of Nevada Women's Center, YWCA, Reno Housing Authority, Reno Police Department and the Washoe County Sheriff's Department.

Outreach a Collaborative Effort. Outreach is a collaborative effort and was reflected in NAF's sensitivity to the needs of host organizations. For example, correctional facility management insisted that all educa-

tional materials be pre-screened and objected to the use of needles and drug paraphernalia for demonstration purposes during HIV/AIDS workshops at the regional detention center. In response, NAF staff agreed to discuss cleaning of needles and "works" without demonstrations.

Selecting Educational Materials. During the outreach effort and before conducting any workshops, NAF convened their local review panel to select materials for both staff training and presentation at workshops. The review panel selected two videos "AIDS: Changing the Rules" and "The Latex Follies" for presentation at workshops. Brochures approved for distribution included Condoms for Couples, Pregnancy and AIDS, Women and AIDS, Information for People of Color, and AIDS Kills Women and Babies.

Providing Information to Women at Risk

A half-time coordinator was hired to conduct workshops and follow-up sessions at:

- local correctional facilities,
- emergency and transitional housing facilities,
- Job Corps,
- the Adolescent Care and Treatment Center,
- Community Runaway and Youth Services, and
- United Way agencies serving the target population.

Because of the success in establishing ties to other organizations, NAF was eventually able to reach more than 600 women through 51 presentations during the one year project period, instead of the original goal of reaching 150 women. This was accomplished despite

outreach being delayed by one month due to difficulties in recruitment of qualified staff.

In the first six months (January - June 1990), 143 persons attended workshops in churches with congregations predominantly of people of color, local businesses, and emergency and transitional housing facilities. The efforts in businesses and churches tended to reach a more general population and not women at risk. This was because in the early months of the

The original work-plan called for half day workshops, but the length of the sessions was reduced to 1 1/2 hours in order to facilitate scheduling within collaborating facilities and because NAF staff believed that shorter sessions would better hold the attention of the target population.

original workplan called for half day workshops, but the length of the sessions was reduced to 1 1/2 hours in order to facilitate scheduling within collaborating facilities and because NAF staff believed that shorter sessions would better hold the attention of the target population. Because the shorter sessions cut down on the amount of information that was provided to participants, follow-up sessions were often scheduled, especially in the jails.

At the workshops, women received information on negotiating skills, esteem building, safer sex practices

project NAF was building coalitions with agencies serving high risk women—an effort which paid off later in the project year as NAF focused primarily on women at risk.

Anywhere from 9-45 women attended each training workshop conducted at the facilities of collaborating CBOs. Workshops were promoted within organizations by staff working with women at risk. The

Reaching Professionals

The longer half-day educational format (1 1/2 hours) was maintained for training professionals working with women at risk. During the project period, NAF provided training for 112 employees in shelters, rehabilitation centers, the Sierra Nevada Job Corps and other organizations to help them better understand and work with women at risk of HIV infection.

and the cleaning of needles. Pre- and post-tests were used to measure increases in knowledge among participants and anonymous questionnaires concerning the women's reactions to the risk reduction measures proposed were utilized to measure the effectiveness of workshops in promoting behavior change.

As the project progressed, more and more requests for workshops were received from businesses, churches and women's clubs. NAF attempted to meet these requests but maintained their focus on reaching women at disproportionate risk.

Jail Outreach

During the second quarter (April - June 1990) NAF began weekly workshops at the regional detention center. In the first month, 21 women attended HIV educational sessions. Over the course of the project, attendance averaged five women per session. NAF experienced difficulty gaining the cooperation of jail staff in promoting sessions within the facility and also had to compete with other activities, like watching television.

On occasion, a highly motivated inmate was able to increase attendance by encouraging other women to attend. These women would frequently attend as a group during the entire course of their detention (four weeks average).

In an effort to attract more women, the educational format was expanded in November to include women's health issues.

At this session, 33 women attended, as compared to the average of five in earlier, HIV-specific, sessions.

On occasion, a highly motivated inmate was able to increase attendance by encouraging other women to attend.

By the end of the second quarter after negotiations with the center administrator, NAF received permission to conduct bi-weekly educational sessions for both young men and women at the Wittenburg juvenile detention center. Attendance was mandatory at these sessions with participants averaging 30 per session. These sessions continued until the end of the project period.

Of the 51 presentations conducted by NAF during the project period, over half took place at the regional detention center and the juvenile detention center.

While attendance was significantly lower at the jail based sessions than in the sessions conducted at other CBOs, churches and businesses, NAF believed that this effort was necessary because of the high risk activities practiced by many of the women inmates.

Support Group for HIV+ Women

Support group sessions for women infected with HIV, conducted by a certified counselor, were also part of the funded program. These began in March 1990, after a slight delay in recruiting qualified staff. The coun-

Despite outreach efforts, group attendance [for HIV+ sessions] was smaller than expected.

selor addressed the psychosocial needs of clients and worked with women to help them adopt behaviors to prevent reinfection and further transmission of HIV. To spread the word about

the support sessions, NAF contacted local medical professionals, hospitals, the local health department and other counselors. The sessions were also advertised in the local weekly newspaper.

Initially, the program plan called for quarterly anonymous surveys of participants to ensure that sessions met their emotional and educational needs. Despite outreach efforts, group attendance was smaller than expected (sometimes only two participants). The counselor thought that client perceptions regarding maintenance of anonymity would be a problem due to the small number of responses. The counselor also thought that time necessary to administer the survey would be better utilized by continuing discussion.

During the course of the project period, NAF conducted 38 weekly HIV support group meetings that

averaged 1-2 participants at each session. NAF promoted the support group in the initial stages of the project and at all the educational workshops conducted in the community but acknowledged that more outreach may have been necessary.

Given the low attendance of HIV+ women, NAF eventually opened group sessions to other women concerned about HIV. In NAF's

view, women concerned about HIV may share some of the high risk behaviors as those already infected; their inclusion in the sessions did not, according to NAF, detract from discussions concerning behavior modification.

Given the low attendance of HIV+ women, NAF eventually opened group sessions to other women concerned about HIV....their inclusion in the sessions did not, according to NAF, detract from discussions concerning behavior modifications.

Limitations of Part-Time Staff

Since the outreach coordinator was employed on a half-time basis and had another part-time job, it was difficult to be entirely flexible in scheduling and accommodating all requests for workshops. Additionally, it became apparent during the project period that there were sufficient requests for workshops to warrant a full-time outreach coordinator. NAF is currently seeking additional funding in order to expand the program to meet that demand. □

Mujeres Unidas: Integrating HIV Into Existing Services

A crowded hallway of the East Harlem Building for the Community comprises offices for the Women's Network/Mujeres Unidas AIDS Project. The AIDS project is one of the most recent programs to be housed at East Harlem Building—a community service center founded in 1976, which currently includes a youth program, weatherization program and the Women's Network.

The Women's Network/Mujeres Unidas project was initiated in 1983 to give women in East Harlem a chance to focus on options to improve their life situations (e.g., employment training, ESL programs, GED).

The AIDS Education Project is the newest effort of Women's Network. Established in 1989, it began training bilingual women in East Harlem as volunteer HIV/AIDS peer educators, called interns, to conduct educational workshops for women of the community.

Despite the early efforts of the interns, there remained significant gaps in outreach to women of the community. The USCM-sponsored program, funded for \$41,750 in 1990, allowed the Women's Network to hire an HIV educator/counselor, making HIV education and referral a part of its basic client services. A volunteer intern was promoted to the position to provide one-on-one counseling, identify HIV resources for women (in part, through a resource directory she developed), and assist clients to access services.

Training Staff

Even though the AIDS Project is housed in the same building and under the auspices of the Women's Network, many of its social service counselors did not have knowledge or feel comfortable talking to their clients about AIDS. To fully integrate the services of the educator/counselor, Women's Network trained the entire staff concerning HIV so that regular counselors could address HIV-related issues and refer clients

To fully integrate the services of the [USCM-funded] educator/counselor, Women's Network trained the entire staff concerning HIV....

to the HIV educator/counselor for further counseling or services when appropriate.

Counseling and clerical staff received training from the Hunter's College School of Health Sciences Community AIDS Education Center. Staff progress in incorporating HIV information into regular counseling sessions

and client interaction was discussed at staff meetings to determine need for additional staff training. Two follow-up sessions, carried out based upon assessment by the educator/counselor, addressed:

- available HIV resources;
- referral needs of clients (e.g., HIV testing and treatment, drug treatment, housing and support services);
- counseling services available (e.g., crisis interven-

tion, psycho-social, pre and post test); and

- staff support needs in dealing with HIV-related issues (burnout, lingering fears).

As a result, Women's Network staff have become more comfortable dealing with HIV-related issues and regular counseling staff now refer clients to the HIV educator/counselor for further counseling and referral. Additionally, the educator/counselor regularly provides updates to counseling staff on new resources and services for clients.

Lack of Services, AIDS Stigma Hinder Efforts

The amount of time it took to fully integrate the HIV/AIDS education and referral component into the general Women's Network program demonstrated only one of the barriers to reaching women. The lack of services for HIV infected women was also a problem, making referral a difficult and frustrating process. Services are especially scarce for women with HIV-related illness and in need of care but not eligible for public assistance and Medicaid because they fail to meet criteria for an AIDS diagnosis.

The lack of services for HIV infected women was also a problem, making referral a difficult and frustrating process.

Reluctance of women to utilize HIV prevention services was another. During the first three months of the project (January-March 1990), counseling and referral was slow with only seven clients served in person. Twenty-four clients were assisted through phone contact. Project staff attributed this initial reluctance to the stigma attached to the disease; clients were clearly more receptive to discussing AIDS anonymously over the phone.

During the second quarter (April-June), 86 clients received education and counseling either in person (16 new clients and 10 return clients) or over the phone (60 clients). Referrals (HIV testing, drug treatment and transitional housing) were provided to 16 clients.

From July-September, the educator/counselor provided in-person and telephone education, counseling, advocacy and referrals to a total of 246 clients. These contacts included: 210 telephone inquiries, 31 one-on-one sessions with return clients and 36 one-on-one sessions with new clients. Seventeen clients were seen on an ongoing basis by the educator/counselor. Services provided by the educator/counselor included HIV counseling and referral to HIV testing, drug treatment, legal assistance, emergency shelter, employment, emergency food and clothing and support groups.

By the end of the project period, Women's Network provided one-on-one HIV counseling to 90 clients and information and counseling over the phone to an additional 260 clients. Fifty seven individuals were referred to HIV testing and counseling. The educator/counselor made 350 referrals to social services and provided advocacy services to 270 clients (some clients were seen more than once).

Women's Network estimates that each person receiving HIV risk reduction information will pass the information on to 5-10 additional people who, in turn, pass on the information. While one-on-one counseling is time intensive, the overall impact of the program in the community extends beyond the 350 phone and in-person sessions.

Querer es Poder: HIV+ Support

The educator/counselor also co-facilitated with staff from the Hispanic AIDS Forum the "Querer es Poder" (Empowerment is the Key) support group for HIV+ individuals with. Meetings were held once a week on Monday nights and had a steady attendance of 6-12

individuals. New participants entered the group as others left once their immediate needs had been met. Women's Network staff would like to start a daytime support group in response to client requests.

Training Trainers in the Prison

During the first six months of the project, Women's Network conducted a series of ten training sessions at the Taconic Women's Correctional Facility, reaching 39 women. Each week, either the program coordinator or the educator/counselor, accompanied by an intern, conducted sessions to train women to become education interns within the facility. By the end of the project period, a total of 24 educational sessions had been conducted.

Due to their training efforts at Taconic and an article in "SIDA Ahora" (a publication of the PWA Coalition of NYC targeting Latinos that is made available to incarcerated individuals) written by the Women's Network AIDS Education Coordinator, Women's Network became a trusted source of information and counseling. The educator/counselor began to receive collect phone calls from women at Taconic, Bedford Hills and other correctional facilities. While there are AIDS Hotlines available to the general public, incarcerated individuals do not have access to 800 numbers. Women's Network received 48 collect, long distance phone calls from incarcerated women. Thirty-two of the women were HIV+ and did not have access to information about their condition within the facility. The remaining 16 callers all stated that they had HIV+ relatives and wanted more information on HIV and their own potential risk. (Woman's Network is no longer able to accept collect phone calls due to the expense.)□

Due to their training efforts at Taconic and an article in "SIDA Ahora" (a publication targeting Latinos) Women's Network became a trusted source of information and counseling.

UNITED STATES
CONFERENCE
OF
MAYORS

1620 Eye Street, N.W.
Washington, DC 20006

First Class
U.S. Postage
PAID
Permit No. 4780



Printed on recycled and recyclable paper with soybean ink