



Standard Abstract Form for the 114th Annual Meeting
American Public Health Association
Las Vegas, Nevada, September 28 - October 2, 1986

Persons wishing to contribute presentations or papers considered for the APHA Annual Meeting, September 28 - October 2, 1986 in Las Vegas, Nevada, must submit an abstract of a paper or presentation on the form provided below. The form should be mailed to the designated Section Representative before or postmarked **no later than February 12.**

Rules for Submission

Please do not submit the same abstract to more than one Section or APHA component. Follow instructions below.

ORIGINAL TYPEWRITTEN ABSTRACT MUST BE SUBMITTED

Author
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Type author(s) and co-author(s) name(s) and affiliation(s) using UPPER and lower case letters and underline.

Abstract
Text

TYPE ABSTRACT TITLE IN UPPER CASE LETTERS BELOW AUTHOR(S) NAME(S)
Double space and type abstract text, flush left, single-spaced, within parameters of box, using carbon ribbon, standard size type. Abstract should be of camera-ready quality, suitable for 50% reduction. Trim-size is same as size of box below. Abstracts not meeting these criteria will not be printed in final program.

Complete author and co-author ID forms on reverse side of abstract form in order to receive mailings and be indexed in final program. If the total number of authors and co-authors exceeds three, please continue on another identification form. Send original and four (4) copies of abstract to appropriate chairperson, accompanied by self-addressed stamped envelope for notification of acceptance or rejection. **Deadline for submissions:** must be postmarked by Feb. 12. Notification mailed in June. **Deadline for abstract withdrawals:** June 30. Groups request additional requirements for abstract review, consult the January issue of *The Nation's Health* for each groups requirements. NOTE: Contributed papers may be read only by APHA members; non-members may author or co-author a contributed paper to be read by an APHA member.

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SESSION:

Day _____

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ABSTRACT:

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Section or APHA Group Abstract submitted to Medical Care

Who will present paper? Nancy Stoller Shaw

Is paper suitable for a poster session? Yes _____ No X

Original Abstract enclosed along with 4 copies? Yes X No _____

Is Your Abstract?

- ☐ Research
☒ Policy
☐ Practice

Authors
and Affiliation

Nancy Stoller Shaw, Ph.D., San Francisco AIDS Foundation.

Abstract Title
Text

HOW CRIMINAL JUSTICE SYSTEMS RESPOND TO WOMEN AND AIDS

Risk of AIDS-virus exposure among women is highest in those groups who use intravenous drugs or have multiple sexual partners, especially if those partners are intravenous drug users. Simultaneously, as many as 70% of women in jail and prison are I.V. drug users and/or prostitutes.

This study documents current strategies utilized by courts and correctional institutions to respond to the possibility of infected females. Special attention is paid to the regulation of prostitutes, antibody testing of women suspected of drug use or prostitution, in-jail health care management, and foster care placement for children of antibody-positive or drug-using women.

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AUTHOR/CO-AUTHOR IDENTIFICATION FORM

(Send the Original and 4 copies of the Abstract Form)

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Sex: 1 Male 2 Female (2 Female)
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1 Asian 2 Black 3 Amer Indian 4 Latino 5 White (5 White)
Author Making Presentation 1 No 2 Yes (2 Yes)

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Appendix

WORLD CHARTER FOR PROSTITUTES' RIGHTS

International Committee for Prostitutes' Rights
February, 1985
Amsterdam

Laws

Decriminalize all aspects of adult prostitution resulting from individual decision.

Decriminalize prostitution and regulate third parties according to standard business codes. It must be noted that existing standard business codes allow abuse of prostitutes. Therefore special clauses must be included to prevent the abuse and stigmatization of prostitutes (self-employed and others).

Enforce criminal laws against fraud, coercion, violence, child sexual abuse, child labour, rape, and racism everywhere and across national boundaries whether or not in the context of prostitution.

Eradicate laws that can be interpreted to deny freedom of association, or freedom to travel, to prostitutes within and between countries. Prostitutes have rights to a private life.

Human Rights

Guarantee prostitutes all human rights and civil liberties, including the freedom of speech, travel, immigration, work, marriage, and motherhood and the right to unemployment insurance, health insurance and housing.

Grant asylum to anyone denied human rights on the basis of a 'crime of status', be it prostitution or homosexuality.

Working Conditions

There should be no law which implies systematic zoning of prostitution. Prostitutes should have the freedom to choose their place of work and residence. It is essential that prostitutes can provide their services under the conditions that are absolutely determined by themselves and no one else.

There should be a committee to insure the protection of the rights of the prostitutes and to whom prostitutes can address their complaints. This committee must be comprised of prostitutes and other professionals like lawyers and supporters.

There should be no law discriminating against prostitutes associating and working collectively in order to acquire a high degree of personal security.

Health

All women and men should be educated to have periodical health screening for sexually transmitted diseases. Since health checks have historically been used to control and stigmatize prostitutes, and since adult prostitutes are generally even more aware of sexual health than others, mandatory checks for prostitutes are unacceptable unless they are mandatory for all sexually active people.

Services

Employment, counseling, legal and housing services for runaway children should be funded in order to prevent child prostitution and to promote child well-being and opportunity.

Prostitutes must have the same social benefits as all other citizens according to the different regulations in different countries.

Shelters and services for working prostitutes and re-training programs for prostitutes wishing to leave the life should be funded.

Taxes

No special taxes should be levied on prostitutes or prostitute businesses.

Prostitutes should pay regular taxes on the same basis as other independent contractors and employees, and should receive the same benefits.

Public Opinion

Support educational programs to change social attitudes which stigmatize and discriminate against prostitutes and ex-prostitutes of any race, gender or nationality.

Develop educational programs which help the public to understand that the customer plays a crucial role in the prostitution phenomenon, this role being generally ignored. The customer, like the prostitute, should not, however, be criminalized or condemned on a moral basis.

We are in solidarity with all workers in the sex industry.

Organization

Organizations of prostitutes and ex-prostitutes should be supported to further implementation of the above charter.

Basic jail / prison policy issues:

1. Education and training

2. Relative importance of medical + correctional considerations in reaching policy decisions

Housing, Diagnosis, ^{med,} Surveillance, counseling, ^{cor} arbitrariness

3. Extent + nature of system's resps. for preventing transmission of HIV infection + AIDS:

~~ITILV~~ HIV-Screening + Testing Debates

4. Uniqueness of AIDS and other com. diseases.

Military Testing

People should not be afraid
to be tested —
we need to create the
environment —

Report from Soc/Pol. Grp
Denver — prostitutes tested w/o consent

— self-identification —

Testing —

opp. mandatory testing

+

Contact tracing

Testing

- 1) Education
- 2) Protection
- 3) Counseling

How to identify —

get women to talk abt risk → self-identification

Result reporting required

SC
Fla
Colo
Ariz
Wis

lab. base
report

Bank - cash

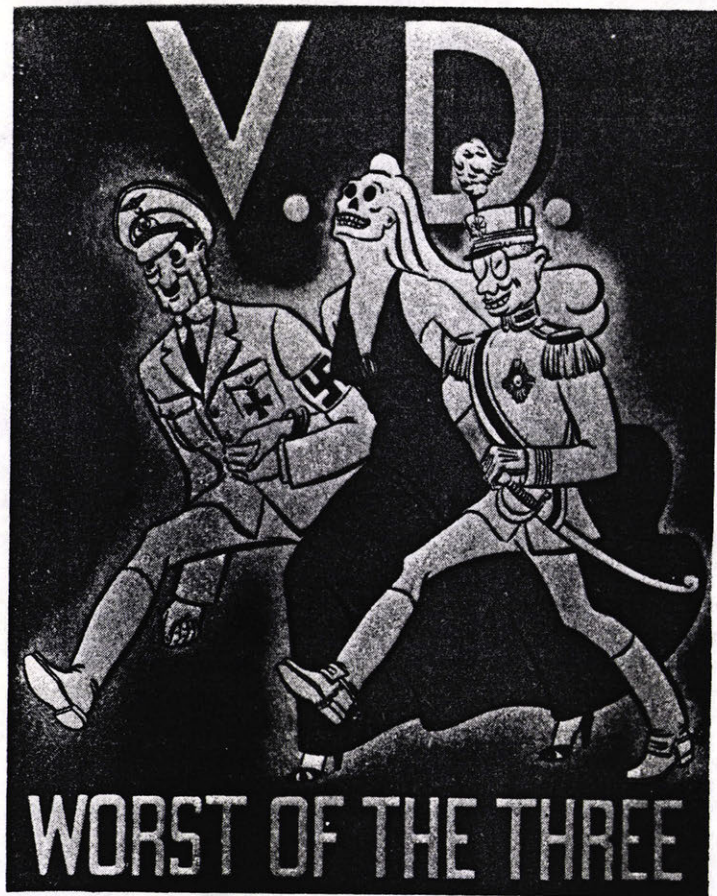
clothes - wash
pack

- Paper - organize

~~Estelle~~
~~Rachel K-11~~

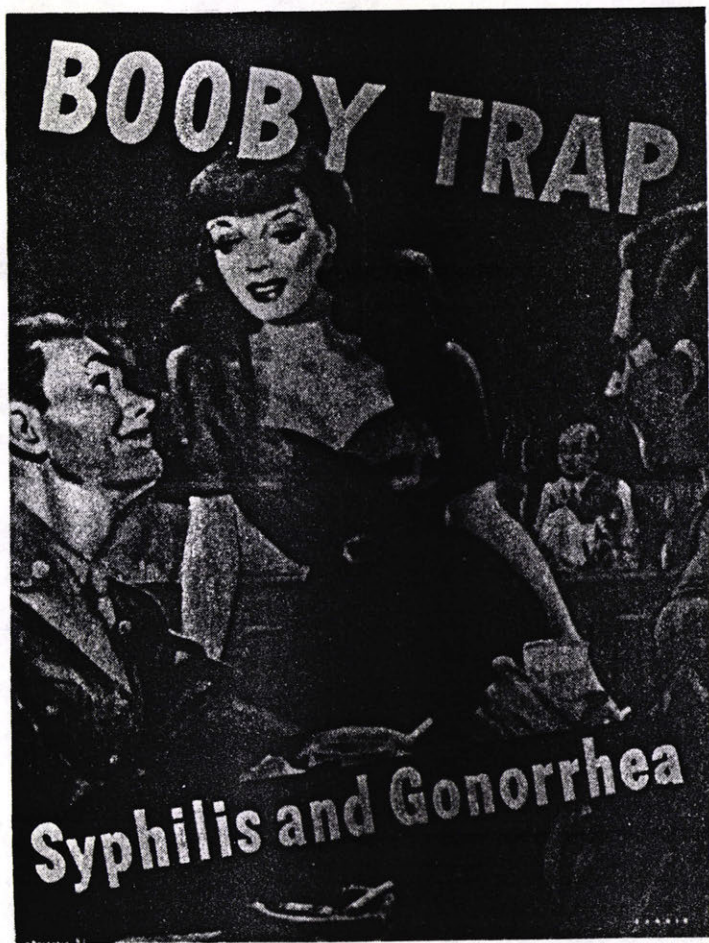


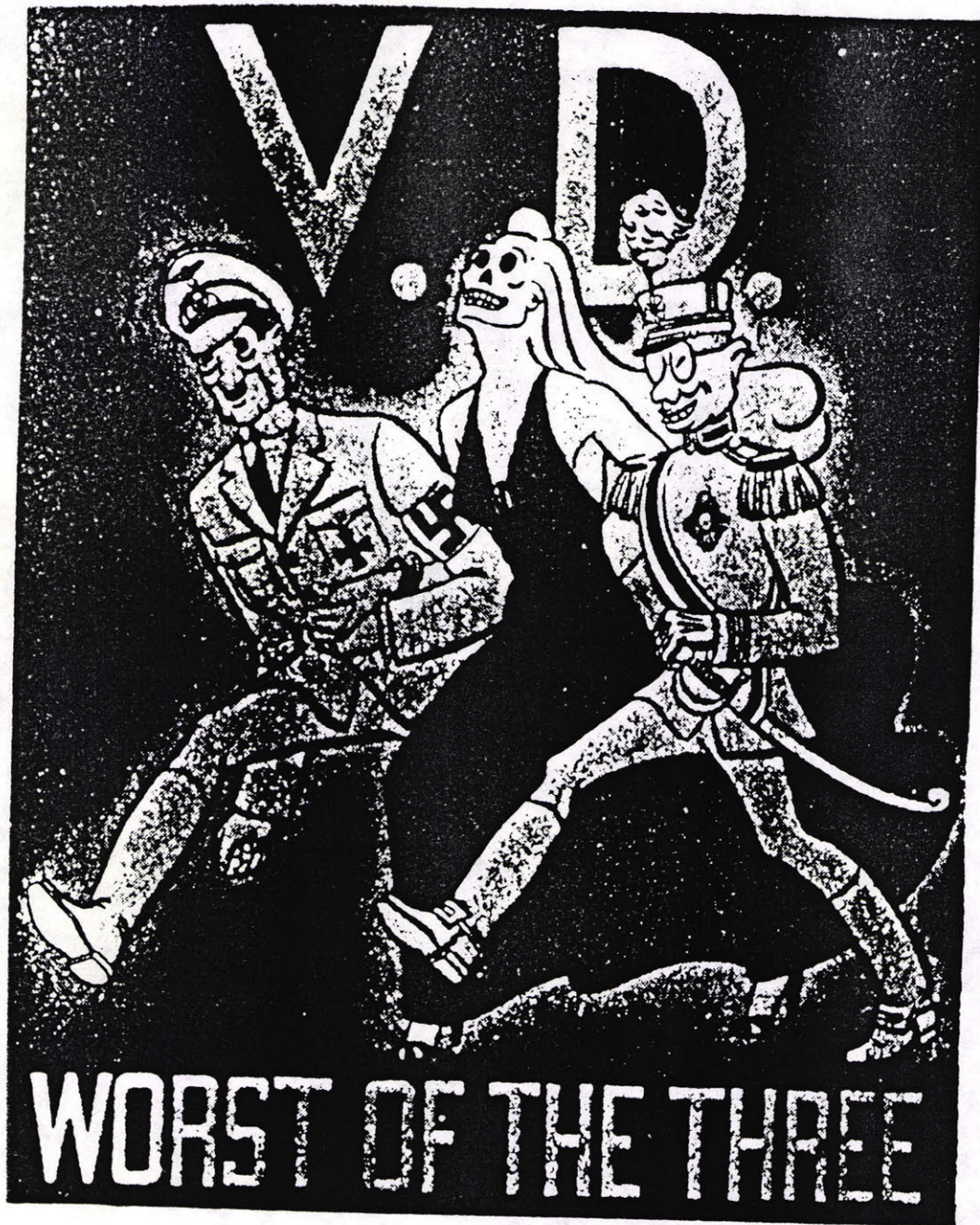
18. This popular poster asserted that even the woman who appeared "pure" could pose dangers for the soldier.



14. Venereal disease, typically portrayed as a woman.

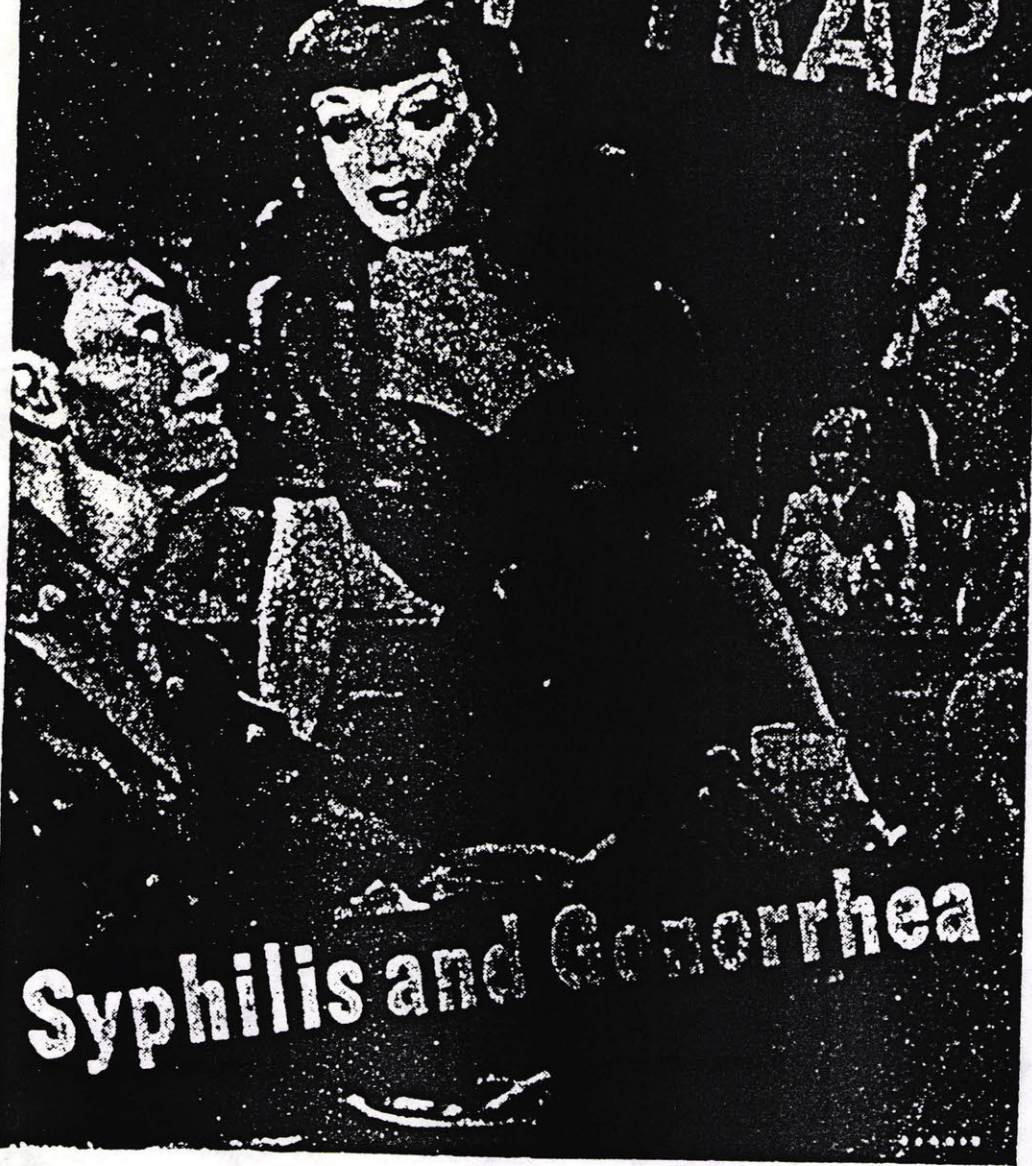
19. The dangers of loose women
and pick-ups, a constant theme.





14. Venereal disease, trayed as a woman.

BOOBY TRAP



Syphilis and Gonorrhea

en
2.

"Reporting" problems

Allan
~~Atkinson~~ Brandt

No Magic Bullet

1) reporting represents state control

2) confidentiality right

↓

I.e. the classic ? of the profession's personal
vs. social responsibility.

Why other diseases are reported but not v.d.s:

- Because of the stigma of v.d., from
which the dr. is trying to save the patient.

B: The reticence delays + reinforces the stigma.

Rise in v.d. is not nec. because of more sex;

it can also be due to less expenditure

on pub health programs - as re gonorrhea
+ syph. in late 50s → 60s after p. health funding
drop in early 50s

Notions of culpability + guilt: "indiv. behavior
is entirely voluntary" - [a simplistic,
naïve view of human nature]

cases in which the carrier refused to reveal his infection to his spouse. Dr. John Stokes of the Mayo Clinic characterized the medical secret as a "blind policy of protecting the guilty at the expense of the innocent." Prince Morrow emphasized the doctor's obligation to prevent further infections. "Does not his silence and inaction," he asked, "make [the physician] an accomplice, a *particeps criminis*?" A prominent New York attorney, William A. Purrington, argued that a physician acted within the law if, protecting an innocent from possible infection: "A physician who knows that an infected patient is about to carry his contagion to a pure person, and perhaps to persons unborn, is justified both in law and morals, in preventing the proposed wrong by disclosing his knowledge if no other way is open."⁴⁹

On the issue of the medical secret, American doctors achieved no consensus. Morrow, for example, despite his inherent sympathy for the innocent woman, argued that the secret "was in the interest of the social order." Some physicians suggested the possibility of "forging" a history of extra-genital infection and then informing the wife, "to take the keen edge off the situation."⁵⁰ E.L. Keyes cautioned that in some cases preventing a diseased man from marrying could be worse than allowing him the risk of infecting his new wife. "To prohibit matrimony in a given case may wreck a man's life even more completely than syphilis could blast his wife's." Charlotte Perkins Gilman, the well-known feminist writer and theorist, dissected the problem of the medical secret in her novel, *The Crux*, published in 1911. When Dr. Bellair, a woman physician, tries to convince Dr. Hale, a male colleague, to reveal a patient's infection to his fiancée, he responds, "You know how I feel about this. It is a matter of honor—professional honor. You women don't seem to know what the word means. I've told that good-for-nothing young wreck that he has no right to marry for years yet if ever. That is all I can do. I will not betray the confidence of a patient." An exasperated Dr. Bellair replies, "Not if he had smallpox, or scarlet fever, or the bubonic plague? Suppose a patient of yours had the leprosy, and wanted to marry your sister; would you betray his confidence?"⁵¹ She marches off to tell the unfortunate woman to break off her engagement. As Gilman made clear, the medical secret was closely tied to the ideology of male supremacy and loyalty in Victorian America. Clearly, many physicians acted to uphold a double standard at the same time that they decried its impact on the family.

The unmasking of the medical secret often did bring marriages to an end. Just as physicians ascribed falling birth rates to venereal infections, so, too, did many attribute a large percentage of the growing number of divorces to these diseases. Doctors noted that the venereal diseases often served as *les maladies revelatrices*, providing proof of infidelity. Commenting on the consequences, Morrow explained:

No other commentary upon the intolerable situations created by the introduction of these diseases into the family is needed than the fact that so many women, loyal to the highest ideals of marriage, devoted to home and family, are driven to the divorce courts as a refuge. No one can condemn a self-respecting woman for separating from a man who has dishonored her with a shameful disease.

Dr. Robert N. W. ... to an alrea ... eternal woe."⁵² ... laws during t ... century, courts ... into marriage a ... however, these groun ... concealed the true ca ... shame," because ... increasing?" asked Dr ... "Of course; cannot y ... increase in venereal dis

Fears about the impac ... sicians to ally with th ... twentieth century. Th ... birth rates between n ... Morrow, noting that " ... respectable" middle clas ... ity caused by venereal ... ability" and disease th ... eugenics movement. " ... well-formed and vigor ... filed, and improving th ... effect of venereal disea ... the sources of life, and ... venereal diseases were ... a strictly hereditary s ... of eugenic interest beca ... syphilitic, the consump ... kind," he explained. H ... the eugenic ideal."⁵⁵

Physicians now frequ ... prior to any hasty marri ... emotion and romance. ... riage is not all romance ... bands and unsound fath ... the man with a profliga ... of danger for his wife a ... several states enacted "e ... groom be examined by ... obtaining a marriage lice ... venereal disease a bar to ... before taking marriage v

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adolescent girl that ninety per
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about venereal disease, preg-
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Prophylaxis insisted, however,
forrow assured the public that
ride rough-shod over conven-
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become victims of the double
ny. "When the girl reaches the
ual cleanliness—and it is her
come her lord and master, and
heal virus," wrote Dr. Egbert
men required this knowledge if
i. Education, he argued, would
ized" morality:

omen—are not offended by our
aged modesty, but of indignation
eir health and life of their chil-
e medical profession.⁹⁹

e Progressive years had consid-
Bureau of Education in 1922
hools offered some form of in-

struction in sex hygiene. The ASSMP maintained figures on the number of pamphlets they distributed as carefully as if they were for vaccinations. By 1913 the Association and its branches had published and distributed hundreds of thousands of flyers with such titles as "How My Uncle, the Doctor, Instructed Me in Matters of Sex," and "A Straight Talk with Employers and Leaders of Organized Labor." Members of the educational crusade reported that, as a result of their efforts, immorality—presumably sexual activity—was on the wane, especially among the young. Dr. James Pedersen, a leading member of the ASSMP, stated that "immorality in many colleges had been reduced by 20 to 40 per cent." The medical director at Columbia University, for example, suggested that because of the sex hygiene program there the rate of venereal infection never reached more than 4 percent of the student body.¹⁰⁰

Ultimately, however, the necessity for sexual control underpinned all educational efforts. In the perceived high rates of venereal disease, physicians saw not only dangers to the family, but a more general and ominous collapse of late-Victorian morality. The constellation of sexual values which the social hygienists prescribed—repression, continence, discipline—mirrored the values of middle-class Victorian society and economy.¹⁰¹ Educational programs were designed less to enlighten than to shore up standards they considered under attack; to return restraint and order to the relations between the sexes. These physicians, trained in a time thought to represent the height of civilized morality, offered no new solutions to the venereal peril. They destroyed the conspiracy of silence—a seemingly radical act—to uphold the conservative sexual mores of their time.

7

Although social hygienists looked to education as the ultimate means of combatting venereal disease, Progressives centered their immediate attention on the repression of prostitution. Physicians and social reformers associated venereal disease, almost exclusively, with the vast population of prostitutes in American cities. They agreed that when a man left the moral path the road usually led to the prostitute, who they argued was the most prolific source of venereal infections. In comparison to prostitution, explained Dr. Ludwig Weiss, "all other modes of propagation [of sexual diseases] are almost *nil*." Estimates suggested that from 75 to 90 percent of all prostitutes harbored infections. Dr. Katharine Bement Davis, Commissioner of Corrections for New York City, reported, for example, that 70 percent of all women sentenced to the city workhouse for prostitution had either gonorrhea or syphilis. At the Bedford Hills State Reformatory for Women more than 80 percent of the inmates between the ages of sixteen and thirty were found to be venereally diseased. Davis labeled these women "plague spots."¹⁰² These reports of the high rates of infection among prostitutes confirmed for many the notion of two types of women—good and bad, pure and impure, innocent and sensual. Venereal epidemiology was socially constructed upon this bifurcation. Accordingly, an "innocent" woman could only get venereal disease from a "sinful" man. But the man could only

get venereal disease from a "fallen woman." This uni-directional mode of transmission reflected prevailing attitudes rather than any bacteriologic reality.

The knowledge that prostitution was not just a moral threat to the civilized sexual code but also a health threat to the family gave the social purity crusade new impetus. Reformers now added the authoritative voice of science and hygiene to the moralistic claims against prostitution sounded in the nineteenth century.¹⁰³ Physicians had come to realize an ugly irony: that the double standard of sexual morality—which countenanced periodic visits to prostitutes to spare the "pure" woman from the "animal" passions of the man—actually led to the woman's demise through venereal infection. Indeed, Prince Morrow coined the euphemism "social disease" because the infections were spread through the "social evil," namely, prostitution. These infections, Morrow declared, "link the debased harlot and the virtuous wife in the kinship of a common disease."¹⁰⁴

In the first decade of the twentieth century virtually every American city possessed a so-called "tenderloin" district where prostitutes openly solicited customers. Bordellos often operated under the protective eye of city and police officials. San Francisco's "Barbary Coast," Washington D.C.'s "Hooker's Division," Chicago's "Levee," and New Orleans's "Storyville" constituted only the nation's most notorious red-light districts. During the late nineteenth century, municipal governments anxious to segregate vice activities officially designated such discrete areas so as not to offend the moral sensibilities of those respectable citizens who wished to avoid this commerce. Purity crusaders had long fought against these enclaves, but without great success. Now armed with the medical knowledge of the impact of venereal disease on the family, as well as new sociological methods to investigate and root out the evil, vice crusaders unleashed a full-scale attack on urban prostitution. "No great wrong has ever risen more clearly to the social consciousness of a generation," noted Jane Addams of Hull House in 1911, "than that of commercialized vice in the consciousness of ours."¹⁰⁵

Nearly every American metropolis organized vice commissions between 1910 and 1916 to investigate and combat prostitution. These groups relied heavily on expert medical testimony in developing their indictment of urban vice. All reports emphasized the impact of prostitution upon the health of the family. "The effect of vice upon the physical health of the community is receiving at present more attention than any other feature of the problem," noted New York's Committee of Fifteen, the first major vice commission established in 1900. The group concluded that it was the community's responsibility to "disembarrass" itself from venereal diseases by controlling vice.¹⁰⁶ The Chicago Vice Commission, which conducted a nationally publicized investigation a decade later, expressed a similar idea in more lurid prose:

Prostitution is pregnant with disease, a disease infecting not only the guilty but contaminating the innocent wife and child in the home with sickening certainty almost inconceivable; a disease to be feared as a leprous plague; a disease scattering misery broadcast, and leaving in its wake sterility, insanity, paralysis, and the blinded eyes of little babes, the twisted limbs of deformed children, degradation, physical rot and mental decay.¹⁰⁷

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The vice commissions unanimously condemned the notion of sexual necessity for men as a myth that encouraged vice.

The commissions' reports identified the moral crisis as one peculiar to urban life. The theme of the anonymity of urban existence recurred in their assessments of the prostitution problem, which frequently recounted the plight of the young man who came to the city only to find loneliness and low wages. As the Committee of Fifteen explained:

The main external check upon a man's conduct, the opinion of his neighbors, which has such a powerful influence in the country or small town, tends to disappear. In a great city one has no neighbors. No man knows the doings of even his close friends; few men care what the secret life of their friends may be. Thus, with his moral sensibilities blunted the young man is left free to follow his own inclinations.¹⁰⁸

These inclinations, according to the commissions, all too often led to the brothel and ultimately to medical and moral degeneration. Moreover, in cities, where the cost of raising and supporting a family was high, eligible bachelors often postponed marriage, which many doctors now suggested contributed to more frequent premarital associations with prostitutes and a rising incidence of venereal infections.¹⁰⁹

The commissions insisted that America's burgeoning metropolises provided ubiquitous opportunities for social contacts which could lead to moral decline. Not only were dance halls and theaters suspect, but parks, hotels, and department stores were also cited as providing outlets for debauchery. As Dr. J.H. Landis commented, "The occasional contact of the sexes found in rural districts has given way to practically constant contact in the cities." Landis feared what he called "sexual explosions" in the urban environment. The vice commissions lamented the passing of what they believed had been a rigorous, uniform moral code. Although much of their rhetoric appears anti-urban in retrospect, most of the members of these committees were long-time city dwellers, businessmen and civic leaders, alarmed by the changes they had observed in their midst.¹¹⁰ Venereal disease, reported in epidemic proportions, seemed to confirm the existence of this more general cultural crisis, the chaotic, alien nature of the modern city.

The vice commissions also examined the reasons why women became prostitutes. Some suggested that they were either enticed or forced into commercialized prostitution through the subterranean "white slave trade." The idea of "slavery" conformed with Victorian notions of feminine purity which held that no woman would enter such a life except under bondage. Muckrakers and purity crusaders frequently drew an analogy between the white slave trade and the cold efficiency of American industry which had recently come to light in press exposés. Borrowing from the anti-monopoly rhetoric of Progressivism, the Survey referred to commercialized prostitution operations as "vice trusts" that, they believed, should be "busted."¹¹¹ George Kibbe Turner, a well-known Progressive journalist, explained that prostitution in Chicago had been organized "from the supplying of young girls to the drugging of older and less salable women out of existence—with all the nicety of modern industry." He concluded, "As

in the stockyards, not one shred of flesh is wasted." The white slave hysteria that swept the nation between 1907 and 1911 culminated in the passage of the Mann Act by Congress in 1910, which forbade the transportation of women across state lines for immoral purposes.¹¹² Just as the interstate commerce clause had been used to attack the trusts, so too was it invoked to attack vice.

Upon investigation, however, little solid evidence of a fully organized traffic in women ever materialized, and reformers looked to somewhat more complex causes to explain prostitution. As the prominent vice investigator George J. Kneeland noted, "The psychology of the relation of prostitute to pimp is a complicated one, difficult to understand. . . . A spark of affection lives at the heart of this ghastly relation." Kneeland reported virtually no indication of locked doors and barred windows in his detailed studies. But the image of enforced labor remained prominent, especially among feminists who recognized the essentially exploitative nature of prostitution. Maude E. Miner, secretary of the New York Probation Association, though admitting that girls were rarely physically abducted, contended that "through the loss of freedom and will of action, they have been bound to prostitution." Miner concluded, "Their demoralization of character has constituted moral enslavement."¹¹³

Reformers increasingly looked to the social and economic conditions of the city to explain a woman's turn to prostitution. Again, the anonymity of the city was cited as an important element. Jane Addams noted with sympathy:

Loneliness and detachment which the city tends to breed in its inhabitants is easily intensified in such a girl into isolation and desolating feelings of belonging nowhere. . . . At such moments a black oppression, the instinctive fear of solitude will send a lonely girl restlessly to walk the streets even when "she is too tired to stand" and where her desire for companionship in itself constitutes a grave danger.

Other observers emphasized that poor housing conditions, particularly in the immigrant ghettos, often led to prostitution. "Who will dare to deny that the thin partition walls and often promiscuous mixing of the sexes in the crowded quarters tend to the demoralization of the young girl blossoming into womanhood?" demanded the prominent New York physician Adolphus S. Knopf. The vice commissions suggested that the transformation of American industry, which brought more women to the workplace, also encouraged prostitution. "Another form [of prostitution] is closely connected with industry," explained the Committee of Fifteen. "A season of non-employment presents them with the alternatives of starvation or prostitution." Moreover, prostitution offered more lucrative rewards to women forced to support themselves and their families than did employment in industry. "Is it any wonder," asked the Chicago Vice Commission, "that a tempted girl who receives only six dollars per week working with her hands sells her body for twenty-five dollars per week when she learns there is demand for it and men are willing to pay the price?" Dr. Ludwig Weiss stressed the problem of the single woman separated from her family, concluding, "The strife of self-support has exposed her to dangers against which she must develop defensive measures."¹¹⁴

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the prostitute, rarely could they offer substantive assistance. The environmental determinants which they identified as contributing to vice were beyond the scope of the commissions that concentrated on exposing conditions. They gave little if any consideration, for example, to the impact of venereal disease on the health of those women forced to take to the streets. The life expectancy of prostitutes was reportedly very short, for many suffered from the consequences of the sexually transmitted diseases that they were attacked for communicating.¹¹⁵ Although many of the commissions suggested that women were victims of prostitution, most of the proposed remedies, especially the repression of street solicitation, labeled them as criminals.¹¹⁶ The vice commissions operated under the Progressive assumption that the revelation of evil would, in itself, have an immediately positive impact.

By the first years of the twentieth century, two opposing strategies for dealing with prostitution had evolved. First, many physicians who believed that prostitution could never be eliminated argued in favor of state regulation. This system, which many French and German cities had adopted, called for registration and periodic medical inspection of all prostitutes to insure their health. Under this plan, known as *reglementation*, houses of prostitution were limited to a specific section of the city and unregistered women, "clandestine" prostitutes, were subject to arrest and fine. Some prominent doctors argued that regulation was the only sanitary, scientific means of controlling venereal disease.¹¹⁷ In seeming disagreement with Victorian moral notions of perfectibility and self-control, these physicians, many of whom had trained in the European capitals where inspection of prostitutes by public health officials constituted modern hygienic practice, accepted the indomitable nature of the male sex drive and the age-old recognition of the inevitability of prostitution. During the last decades of the nineteenth century, under the influence of these doctors, several American cities proposed ordinances requiring official examinations, and such a system was actually adopted in St. Louis for a brief period in 1870.¹¹⁸

The idea of regulated prostitution, however, could not withstand the force of public opinion, and was soon held increasingly suspect by physicians and reformers alike. The complete repression of prostitution emerged as the social reformers' primary goal. When Prince Morrow founded the American Society for Sanitary and Moral Prophylaxis in 1905, for example, he was firmly opposed to regulation. This coalition among reformers on the prostitution problem was probably the result of a growing body of medical literature that suggested the inadequacy of medical inspection—a prostitute could become infected between exams—as well as a desire to attract non-medical reformers to the social hygiene movement. These reformers, veterans of the purity crusades of the late nineteenth century, the settlements, and urban Progressivism, refused to compromise with evil.

They found regulation, quite simply, anathema to the Progressive moral code. First, it suggested a tacit acceptance of the double standard of sexual morality. Second, state regulation of prostitution essentially endorsed the exploitation of women to meet the sexual needs of men. And third, it implicitly validated the notion that the male sex drive could not be controlled, a view subversive of

the social hygiene movement, controlled by physicians and sanitarians, was likely to accept vice as unalterable and to address it solely as a medical problem. Through the vice commissions and the Page Law controversy these two groups were brought together, and reformers began to see the problems of venereal disease and prostitution as inextricably linked.

Calls for a national organization to unite these movements began to be heard. Prince Morrow's death in March 1913 cleared the way for vice crusaders and medical reformers to strike an official alliance. In October, leaders of the American Vigilance Association and the American Federation for Sex Hygiene met in Buffalo to form the American Social Hygiene Association. Grace Dodge and John D. Rockefeller, Jr., two vigorous supporters of the anti-vice crusade, engineered the merger. Rockefeller suggested that consolidation would increase efficiency. "As a business man I naturally appreciate the gain which combination effects," he explained. Charles W. Eliot, former president of Harvard University, agreed to become the first president of the organization at Rockefeller's request. Eliot, however, only served as a titular head. Daily operations were directed by James Bronson Reynolds, a New York attorney active in vice investigations, and William F. Snow, a California physician and public health official. Their joint leadership reflected the organization's foundation in compromise, as well as a residual tension between the two forces.¹²⁸

Rockefeller provided the greatest financial assistance to the Association during its early years, contributing \$5,000 per year between 1913 and 1916 and \$10,000 from 1916 to 1918, as well as helping to raise the remainder of the ASHA's \$60,000 annual budget. Rockefeller's interest in the problems of vice and disease dated back to 1910, when he acted as foreman of a special grand jury appointed to investigate the white slave trade in New York. The jury heard testimony from a wide variety of sources; although evidence was developed that showed that girls had been abducted and sold, no proof of a syndicate was ever demonstrated.¹²⁹ His experience on this jury, however, brought young Rockefeller to the center of social hygiene activities.

Rockefeller had come to believe that the hysteria surrounding white slavery did a disservice to responsible concerns about venereal disease and prostitution. After his service on the grand jury, he began to devise plans for a public commission to study prostitution and the "frightful ravages of venereal disease." He soon became discouraged, however, by the significant political considerations involved in the forming of such a group. Instead, he proposed a permanent organization to investigate the problem and formulate public policies. Together with Paul Warburg, a well-known banker, and Starr Murphy, a prominent lawyer, he established the Committee of Three to review potential projects. In 1911 they created the Bureau of Social Hygiene, which Rockefeller explained would be a permanent, non-political organization dedicated to studying prostitution and venereal disease "scientifically", and "continuously making warfare against the forces of evil."¹³⁰

The Bureau emphasized rational, efficient investigations by experts and scientific management as the primary antidote to vice and disease. As a press release explained, "The name 'Rockefeller' stands for a type of efficiency and

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thoroughness of work."¹³¹ In its first years, from 1911 to 1917 the Bureau sponsored and later published four major studies that were prototypical works of Progressive social science: first, George J. Kneeland's *Commercialized Prostitution in New York City*, a monograph which resembled the vice commission reports without the lurid prose and pat answers; second, Abraham Flexner's *Prostitution in Europe*, a forceful attack on continental systems of regulated prostitution which put to rest, once and for all, debate regarding the viability of *reglementation* in the United States; third, Raymond B. Fosdick's *European Police Systems*, a study which suggested that professionalization of police offered the best opportunity to uproot graft and vice; and fourth, Harold B. Woolston's *Prostitution in the United States*, a comprehensive survey of vice conditions on the eve of World War I.¹³² These books provided the informational base that Rockefeller contended was the first step in formulating a public response to vice. Rigorously researched and dispassionately written, they shaped opinion within the social hygiene campaign and encouraged a more "professional" approach to reform.

The Bureau also sponsored a variety of experimental social programs in an attempt to illuminate new methods for civic institutions to adopt in the battle against prostitution. In 1912 the Bureau underwrote the establishment of a Laboratory of Social Hygiene at Bedford Hills, under the direction of Katharine B. Davis, agreeing to allocate up to \$200,000. Women sentenced to this reformatory underwent a battery of physical and psychological tests aimed at isolating factors which contributed to prostitution. Through these studies, the Laboratory hoped to develop categories of women deemed capable of reformation. Moreover, the Bureau attempted through this research to develop successful methods for the treatment and rehabilitation of female offenders reflective of an emerging trend toward definition of criminal activity in therapeutic terms.¹³³

The Laboratory's research soon came under the influence of eugenicists anxious to demonstrate that most prostitutes showed a genetic predisposition to sexual promiscuity and "psychopathic tendencies." Reports circulated that more than half of all women who became prostitutes were feeble-minded and required lifelong custodial care. Charles B. Davenport, the leader of the American eugenics movement, endorsed these findings, noting, "Evidence is accumulating to show that the primary factor is an inherited predisposition toward an exceptionally active sexual life. . . . The heightened licentiousness is favored by an additional germinal determinant that less licentious persons do not have."¹³⁴ Eugenicist use of the Bureau's research signaled an important change from the socioeconomic explanations for the causes of prostitution voiced by the vice commissions.

The Bureau of Social Hygiene marked a shift from the moralistic, dramatic objectives of the purity crusades toward an emphasis on instrumental reform that was efficient, scientific, elitist. Scientific, hereditarian notions of crime and disease largely displaced explanations which gave weight to environment and individual choice. Ultimately, the Bureau betrayed a fundamental mistrust of public efforts, which Rockefeller had come to believe rested on the whimsy of politics. Though Rockefeller had few objections to the moralistic elements of

the social hygiene movement, he sought to rationalize the claims of the movement by adding a rigorous social science component. Enlightened philanthropy, he contended, would identify the programs and lead to the scientific achievements necessary to end vice.

9

In the first decade of the twentieth century a series of pathbreaking discoveries in German laboratories revolutionized the American medical profession's ability to deal with syphilis. These advances, in conjunction with the efforts of the social hygiene movement, enhanced the status of scientific medicine in matters of sexuality and disease. The instrumental ideals of efficiency, prevention, and cure soon began to influence professional thinking concerning the sexually transmitted diseases. In 1905 Fritz Schaudinn and Eric Hoffmann, two German laboratory researchers, identified the causative agent of syphilis, a pale, spiral microorganism, which they called *Spirochaeta pallida*. The following year August Wassermann and his colleagues, Albert Neisser and Carl Bruck, published an account of their successful efforts in developing a diagnostic test for syphilis. The exam they devised made it possible to detect the spirochete in blood samples through the employment of a complement-fixation reaction, a chemical process based on recent advances in immunology.¹³⁵ American physicians greeted the reports of this work with praise. "Where formerly we were guessing at the nature of a given lesion or condition," explained Homer F. Swift, "we are now able to state with a fair degree of accuracy whether the condition is syphilitic or not." Advances in microscopic technique had also moved gonorrhea diagnostics out of the nether world of medical subjectivity.¹³⁶ As late as 1912, however, few physicians had the necessary laboratory and technical facilities to conduct these tests.

The therapeutic coup came in 1909 when Nobel laureate immunologist Paul Ehrlich, working with the assistance of Sahachiro Hata, discovered Salvarsan, the first effective treatment for syphilis. Ehrlich had searched for methods of assisting the body's natural immunologic response to disease. "The antibodies are magic bullets," he explained, "which find their targets by themselves" In the laboratory, he sought to create chemical compounds which would serve as "magic bullets" against specific diseases. The 606th experiment resulted in an arsenic compound which, when injected into syphilitic rabbits, caused the dramatic disappearance of symptoms, and subsequent research with human subjects confirmed the drug's effectiveness. With the discovery of Salvarsan, also known as "606" or arsphenamine, Ehrlich initiated the modern age of chemotherapy.¹³⁷

Physicians greeted Ehrlich's announcement of his work in 1910 with tremendous enthusiasm and a dash of circumspection. By early 1911, a number of American physicians had experimented with the drug on their syphilitic patients. Though most reported the miraculous effect of Ehrlich's compound, a number of untoward side-effects also came to light. Some patients suffered from the agent's high toxicity, and by 1914, 109 deaths attributed to Salvarsan treat-

100,000 S.F. Heterosexuals May Risk AIDS, Study Says

By David Perlman
Science Editor

At least 100,000 heterosexual San Franciscans may be risking AIDS through potentially hazardous sexual contacts, a citywide survey has disclosed.

Both men and women have run risks of infection during the past year by engaging in sexual relations with many different partners or by sexual contacts with people who are in the highest risk groups — such as

homosexual or bisexual males or intravenous drug abusers.

The study is the first to examine behavior patterns among the city's heterosexual population to offer clues for developing effective AIDS-prevention programs among sexually active heterosexuals.

Sponsored by the city Department of Public Health and the San Francisco AIDS Foundation, the survey comes while the epidemic is beginning to show signs of afflicting population groups other than the gay and bisexual men and intravenous drug users who comprise the largest number of AIDS victims.

From Page 1

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The study was developed by a public opinion research firm called Communication Technologies, which has also conducted three major behavior surveys in the city's gay community. Those surveys have helped the AIDS Foundation develop education programs whose effectiveness have earned praise from experts across the country.

Survey workers administered lengthy and candid questionnaires by telephone to a random sampling of 400 San Francisco adults who define themselves as heterosexual. This is a standard method for obtaining results that can generally be applied with relative accuracy to the population at large.

Most of those surveyed were under 45, were reasonably well-educated and were relatively well-informed about the AIDS problem. All were sexually active.

AIDS specialists have long warned the public that sex with many partners increases the chances for infection. Other surveys have established that about half of San Francisco's gay or bisexual men are virus carriers and that sharing needles during intravenous drug use carries a major risk for spreading the disease.

Ninety-nine percent of the men and 96 percent of the women in the survey disclosed that they had more than one sex partner during the past year. On average, the men reported having sex with at least five women partners, while the women reported sexual contact with more than four men during the year.

Fifteen percent of the men said they had from 10 to more than 20 female partners during the past year, while 10 percent of the women reported from eight to more than 20 male partners.

Three percent of the men and an equal number of women reported having sex with someone they believe uses intravenous drugs; 7 percent of the men had sexual contact with a prostitute in the past year, and 8 percent of the women had sex in the past year with at least one man they knew to be gay or bisexual.

Assessing the degree of risk for all the people interviewed, the survey found that nearly 40 percent of them were either at high or "medium" risk for AIDS last year because they had engaged in sex with intravenous drug users, prostitutes, gay or bisexual men, or with four or more different people.

cause they had engaged in sex with intravenous drug users, prostitutes, gay or bisexual men, or with four or more different people.

"This is an important study, and it speaks to the urgent need for a real education program that lets these people know they're putting themselves at risk for a fatal illness that can't be treated with a simple shot of penicillin like other sexually transmitted diseases," said Dr. Dean Echenberg, chief of the Health Department's bureau of communicable diseases.

"It actually understates the seriousness of the problem, because the survey could not reach those heterosexual people who may be at the very highest risk, such as adolescents who are poorly informed and members of low-income minority groups."

National figures from the national Centers for Disease Control in Atlanta show that AIDS has stricken nearly 25,000 Americans and killed nearly 14,000. About 4 percent — half men and half women — are heterosexuals.

In San Francisco, of the 2348 AIDS cases reported so far, about 70 have been listed as heterosexual. They include drug abusers, transfusion recipients, hemophiliacs and others in unknown categories.

The heterosexual men and women in the survey were generally well-informed about the risks of AIDS and knew the deadly disease is most often spread by sharing drug needles or through sexual intercourse unprotected by condoms.

Yet two-thirds of them said they felt they have run no personal risk of contracting AIDS and continue to engage in such high-risk activities as vaginal intercourse or oral sex without the use of condoms. Eight percent said they have used drugs intravenously.

Of all the men and women who have engaged in high-risk behavior, only 5 percent said they have taken the antibody test that can disclose if a person has been infected by the AIDS virus, the survey showed.

Nearly a third said they were unaware of the test, and more than three-quarters said it was "not very likely" or "not at all likely" that they would take the widely available free test within the next six months.

The study, completed at a cost of \$60,000, is being analyzed by the Health Department's AIDS activities specialists and by the AIDS Foundation to develop a "risk-reduction" program to carry the AIDS-prevention message throughout the city.



**RESEARCH
AND
DECISIONS
CORPORATION**

A Report On:

**DESIGNING an EFFECTIVE AIDS RISK
REDUCTION PROGRAM for SAN FRANCISCO:
RESULTS from the FIRST PROBABILITY
SAMPLE of MULTIPLE/HIGH-RISK
PARTNER HETEROSEXUAL ADULTS**

Prepared for:

The San Francisco AIDS Foundation

EXECUTIVE SUMMARY

Level of Risk for AIDS

- o The study suggests that risk group members are very sexually active, with many reporting partners in AIDS risk groups. Male risk group members report an annual average (mean) of 5.1 female partners, and women report an average of 4.4 male partners. Three percent report having sex with someone they believe uses IV drugs. Seven percent of men report having sex with female prostitutes during the past year, compared with 1% of females reporting sex with a male prostitute. Eight percent of women reported sex with a bisexual male in the last year.
- o In terms of primary partners, 7% of women say that their partner has used IV drugs. An equal number (7%) of women report that their partner has received a blood transfusion or had sex with another male during the last five years. Twelve percent of men believe that their female partner has had sex with a gay/bisexual man. Six percent said their female partner had used IV drugs, and 3% reported that their partners had blood transfusions over the last five years.

Perceived Impact of Epidemic

- o Almost all risk group members are aware of the AIDS epidemic, but concern is not great. When asked to express their level of concern in terms of a 10-point scale, the mean score was 6.5, considerably below the level of concern reported by the other risk group we have extensively surveyed, gay and bisexual men.
- o Most say that AIDS has not had a significant impact on their sexual behavior or lifestyle. Respondents were asked to quantify the extent of impact that the epidemic has had using a 10-point scale. The samplewide mean was a low 4.0. Among those impacted by the epidemic, about one-third report that the changes took place in the last year-and-a-half (1985 and 1986). Roughly another third gave 1984 as the year in which the epidemic began to influence their behavior. An additional one-third reported that changes began in 1982 or 1983.
- o Less than one-third (31%) say that they feel personally threatened by AIDS. Latinos and those reporting a significant behavioral impact of AIDS are most likely to say they feel personally threatened.

- o Almost 3 in 10 (29%) say they know someone with AIDS. Given the large number of persons with AIDS in San Francisco, it is not surprising that many members of the heterosexual risk group know a person with AIDS.

Knowledge Levels

- o Risk group members are moderately informed about AIDS as a disease. The majority of respondents could identify homosexual men and IV drug users as the major AIDS risk groups, although very few listed heterosexuals as being at risk. In terms of contagion, the vast majority of risk group members do not believe AIDS to be casually contagious. Fifty-eight percent even rated social kissing with a person with AIDS as a low-risk activity. Significantly, however, respondents were skeptical about the safety of safe sex: 47% said that having sex with a person with AIDS was high-risk even if no body fluids were exchanged. Risk group members tend to believe that receiving a blood transfusion is still a high-risk activity. There was significant disagreement among respondents about how long the incubation period is.

Perceived Changes in Risk Behavior

- o Sizeable numbers of heterosexuals at risk for AIDS report that they have reduced their number of sex partners and decreased anal sexual activity since the onset of the epidemic. Many report fewer bisexual male partners and fewer IV drug using partners. The epidemic appears to have had little impact, however, on the frequency of unprotected vaginal intercourse and oral sex. These continue to be the most frequently engaged-in sexual behaviors among multiple-partner heterosexuals in San Francisco.
- o Large numbers of respondents also indicated that they were using less alcohol and drugs and had less interest in casual sex than they used to.

Degree of Openness to Change

- o Few risk group members appear to believe that "using a condom is a turn-off" or that "oral sex is no fun unless semen is swallowed." Also, few "worry about whether potential sex partners will enjoy safe sex." These findings suggest that the overwhelming majority of group members are open to change in risk behaviors. Condom-resistant attitudes were held by one-quarter of respondents, whereas only 8% agreed that safe oral sex is not enjoyable. Twenty-three percent (23%) said they worried about whether potential partners would enjoy safe sex

practices. Men and minorities appear currently to be somewhat less open to change than respondents generally.

Current Sexual Behavior

- o Respondents were asked a series of questions about their sexual behavior during the 30-day period immediately prior to our interview. Within primary relationships, respondents report having sex an average (mean) of 11.7 times during the previous 30 days. The most common practices were vaginal intercourse without a condom, cunnilingus, and fellatio without exchange of semen. Few report engaging in vaginal intercourse with a condom. Almost none reported anal intercourse. Few report fellatio with exchange of semen.
- o Approximately 2/3 (66%) of respondents reported no secondary partners in the 30 days prior to our interview, with just 14% reporting two or more partners. Those reporting activity with secondary partners report an average of 5.6 sexual encounters within the last 30 days -- much lower than the 11.7 times reported by those in a relationship. Those using alcohol and drugs while having sex reported more partners and more sexual encounters.
- o The profile of sexual practices with secondary partners is very similar to that reported within relationships. The most common activity is unprotected vaginal intercourse, followed by cunnilingus and fellatio without fluid exchange. Fewer report engaging in oral sex and swallowing semen and fewer report using condoms during vaginal intercourse. Again, those using alcohol and drugs during sex were more likely to engage in all sexual activities.

Alcohol and Substance Using Behavior

- o Nearly six out of ten respondents (58%) report using at least some alcohol while (or before) having sex, and 27% report using drugs prior to or during sex. Alcohol and drug usage is linked with higher-risk sexual practices, as has been found in previous research with other risk groups. Nearly one-quarter (23%) report that they were very intoxicated on at least one occasion when engaging in sex during the previous 30 days.
- o The study suggests that at least 8% of risk group members have used recreational drugs intravenously, with 2% having done so in the six months immediately prior to the interview. One-quarter (25%) of those with high-risk partners have used IV drugs at least once. Those

whose sexual behavior places them in the highest risk category for contracting AIDS are significantly more likely to have used IV drugs than respondents generally -- 17% vs. 8% for the sample as a whole.

Explaining Behavior: The Importance of Beliefs About Enjoyment, Risk, and Prevailing Social Norms

- o Respondents were asked to rate the importance of sexual enjoyment relative to other aspects of their lives on a 10-point scale, where 10 means extremely important and 1 means not at all important. The overall mean for the sample is 7.8, suggesting that sexual enjoyment is at least somewhat important to risk group members.
- o Respondents were asked to rate their enjoyment of specific sex practices and partners on a 10-point scale. Vaginal intercourse without a condom was the most enjoyed sex practice, and anal intercourse was the least enjoyed sex practice. Having sex with high-risk partners -- gay or bisexual men and IV drug users -- was rated only just above "not at all enjoyable." Vaginal intercourse with a condom was rated significantly less enjoyable than intercourse without a condom, and oral sex without fluid exchange was rated more enjoyable than oral sex with exchange of semen.
- o To put the AIDS epidemic in perspective with other aspects of their lives, respondents were asked how important it was to reduce their chances of contracting or spreading AIDS on a 10-point scale. Overall, the importance of reducing risk of AIDS was rated 8.4, extremely important. This assessment was consistent across demographic subgroups selected for analysis.
- o Respondents were also asked to rate the level of risk attached to specific sex practices and types of partners on a 10-point scale. Overall, the responses indicate that multiple partner heterosexuals in San Francisco are generally aware of the published medical evidence. Those practices involving exchange of fluids -- anal intercourse (8.3), oral sex with exchange of semen (7.3), and vaginal intercourse without a condom (6.9) -- were rated as the riskiest practices. Sex with both of the high-risk group partners, gay or bisexual men (8.7) and IV drug users, (8.5) were rated as riskier than any specific sex practice. Sex with many different new partners was also rated as extremely risky. Men perceived lower risk with almost all the sex practices and indicated that AIDS risk reduction generally was less important to them.

- o The data suggest that risk group members tend to perceive strong peer support for limiting the number of sex partners falling into current established AIDS risk groups. Much less support appears to exist for limiting the overall number of partners and for having only safe sex. Males are less likely than females to believe group norms are changing.
- o Approximately 3/4 of respondents indicated they were familiar with the concept of safe sex, although among Blacks and Latinos awareness levels were lower.
- o Almost everyone (93%) responded that safe sex would lessen the threat of AIDS, and nearly as many (84%) felt that safe sex could be satisfying. These findings indicate an openness to risk-reduction educational messages. The major barrier to behavior change is likely to be the small number of risk group members that believe AIDS constitutes a personal threat to their health and well-being. Until individuals are convinced of a personal threat, their behavior is likely to continue to lag behind their belief in the efficacy or satisfaction of safe sex.
- o Approximately 2/3 (62%) of respondents indicated that they talked in advance to potential partners about sexual practices. Communication was much greater (and less uncomfortable) for those presently in a relationship. Women reported feeling more comfortable about this communication than men.
- o Beliefs about social norms do not appear to be strongly linked with sexual behavior among this sample of multiple partner heterosexuals. Correlations are relatively small, which means that the social norm variables account for little variation in the frequency of the unsafe behaviors selected for analysis. In contrast, the level of enjoyment of unsafe practices is much more highly correlated with behavior, which suggests that a communications strategy of emphasizing the pleurability of safe sex may be an effective way to bring about behavioral change.
- o In some instances, beliefs about the risk of practices were correlated with behavior. This is true for oral sex practices in particular, and suggests that emphasis on risk may be effective in altering unsafe oral sex practices. Research with gay-identifying men indicates that it is easier to substitute safe practices for unsafe ones in oral sex than in other types of sex. These data suggest that the same may be true for hetero-

sexuals, given the relatively high level of enjoyment already attached to safe oral sex practices.

- o Measurement problems and the absence of a fully-articulated model of sexual behavior stand in the way of fully explaining behavior in this and other similar studies. It may be the case that beliefs about social norms play a much bigger role as a determinant of behavior than our analysis of these data suggest. Previous research with gay-identifying men, for example, pointed to beliefs about norms as a major explanatory factor, and risk-reduction education strategy has been largely based on influencing these beliefs. It is undoubtedly the case that altering these beliefs leads to shifts in beliefs about enjoyability, and possibly risk as well. The result is a reduced incidence of unsafe sexual practices. It could also be that beliefs about group norms operate differently within the context of the gay subculture, or that these beliefs influence sexual behavior differently depending on other factors. More research is needed to settle these questions.

Antibody Screening Test

- o The majority of multiple partner heterosexuals appear to be aware of the AIDS disease agent, and over 2/3 are aware that an antibody screening test now exists. Only 5% of respondents indicated that they have been tested. Currently, 3/4 (77%) of those aware are not likely to ever take the test. Only 22% say that they are likely to take the test in the future. The reasons given all relate to the belief that most heterosexuals are not at risk for AIDS.

Risk Reduction Campaign Planning Issues

- o Only 20% of risk group members report seeking information on how to specifically reduce their risk of getting AIDS. Most of these individuals have turned to their physician or to friends as sources of information.
- o There is a high level of satisfaction with risk-reduction information respondents have received. Sixty percent (60%) say they are very satisfied with the information they received.
- o There is considerable interest in workplace-focused educational programs, particularly among less well-educated risk group members. Thirty-one percent (31%) said they would attend a risk-reduction presentation during lunchtime or after working hours at their place of employment. Twenty-six percent (26%) indicated they

were likely to call a toll-free AIDS information hot-line. Eighteen percent (18%) said they were likely to make a special visit to the doctor to get risk-reduction information.

- o When asked what their preferred source of information was, the majority mentioned health professionals and the media. Private physicians, clinics of different types, and family planning programs were mentioned by many respondents. Newspapers and other print media were the most important media outlets. Aside from the two major metropolitan dailies in San Francisco, the Bay Guardian, San Francisco Progress, City Sports, and San Francisco Magazine are read by at least one-quarter of the risk group audience. The overwhelming majority (88%) approved of the use of general circulation publications and broadcast media for sexually explicit risk-reduction messages.
- o In terms of messages, there is strong agreement that safe sex is the best way to protect oneself from all sexually transmitted diseases and that it is important for people to speak up about the need for safe sex. Respondents also strongly agree that safe sex is not just for gays anymore, but for everyone who is sexually active. There is less agreement that more facts are needed before people can take steps to reduce risk of AIDS. Attitudinally, there appears to be an openness to increased future condom usage.
- o Because family planning programs are potentially an effective communication channel for reaching sexually active women, we gathered data on where women seek family planning assistance. Sixty percent (60%) mentioned either a private physician or Planned Parenthood. Fifty-eight percent (58%) of women report use of family planning services at some point in their lives; 27% report going to such a clinic two or more times per year. Females under the age of 30 are the most frequent users of family planning services.
- o Given the importance of primary health care providers in this area, we asked where people seek care. The majority mentioned private practice physicians and hospitals. Hospitals will be an important target for risk-reduction programs because men, Blacks, Latinos, and other groups most in need of information rely on hospitals to a greater degree than risk group members generally.
- o Sexually transmitted disease clinics may also be an important communications channel for risk-reduction messages. Fourteen percent (14%) of sampled respondents

reported use of sexually transmitted disease clinics. Those with highest risk of AIDS are more likely to use these clinics than respondents generally.

- o The overwhelming majority of respondents indicated that they take some steps to reduce risk of pregnancy and condoms are a leading birth-control technique. More than one in five currently use condoms. They are used almost as frequently as the pill with primary partners, and with secondary partners they are the most frequently used technique. Forty-four percent (44%) of men report using a condom at least some of the time with primary or secondary partners.

Demographic Profile of Risk Group

- o The study suggests that two-thirds (68%) of the at-risk population are 25 to 44 years of age -- born between 1942 and 1961. Very few (9%) are 45 years of age or older. In contrast, among all city residents over 18 years of age, 44% are 45 years of age or older.
- o Compared with San Francisco generally, the at-risk population tend to be highly educated, with half (48%) holding college degrees.
- o Three-quarters (74%) know someone who is gay or bisexual well enough to talk to that person at least once a week.
- o Among sample respondents, few (11%) are married. Close to two-thirds (63%), however, say they are presently involved in a primary relationship. In contrast, 1980 U.S. Census statistics indicate that 40% of all San Franciscans are married.
- o Eighty-four percent indicate they have had sexual relations only with a member of the opposite gender over the last five years.
- o Two-thirds of our sample are Caucasian, with the remaining one-third evenly divided between Blacks, Asians, and Latinos. Aside from a slight under-representation of the Asian population, our sample is fairly representative of the population as a whole.
- o Among San Franciscans 18 or over, half are women and half men. However, our sample is comprised of 58% men and 42% women, indicating that men are slightly more likely to be at-risk than women.

The San Francisco Foundation
500 Washington Street
Eight Floor
San Francisco, CA 94111
Attn: Linda Vanderford,
Intake Coordinator

Dear Linda:

This is a proposal from the California Prostitutes Education Project (CAL-PEP) to establish a training program in Marin and San Francisco counties to do safe-sex and health education for prostitutes and their customers, and to train agency staffs in how to conduct safe-sex educational trainings for prostitutes.

CAL-PEP is a California non-profit public benefit corporation which is applying for state and federal tax exempt status. In the meantime CAL-PEP is under the fiscal sponsorship of The Capp Street Foundation, a non-profit organization. CAL-PEP is an off-shoot of COYOTE which has been operating out of Mill Valley since 1981. During the last two years, the primary focus of COYOTE has been disease stigma and the actual disease risk among prostitutes. CAL-PEP was established in 1985 to develop a comprehensive program for 1. health education among prostitutes, and to develop training programs in the form of lectures, forums, and 2. workshops for service providers in contact with prostitutes that will focus on issues of prostitution and sex work, and address the negative beliefs, attitudes and behaviors toward prostitutes and sex workers in order to improve agencies capabilities when interacting with prostitutes and sex workers.

In the past year CAL-PEP has changed its focus somewhat to concentrate on developing and demonstrating a variety of services aimed at meeting the newly identified specialized needs of prostitutes, their customers, and service providers in order to prevent the spreading of AIDS. This proposal addresses the emerging needs for preventive and educational programs in safe-sex practices as a means of limiting the spread of AIDS.

Through this proposed program a number of urgent needs in Marin and San Francisco counties are addressed including:

1. Street prostitutes - the most immediate need for street prostitutes is safe sex education.
2. Street Prostitutes who are IV users - Studies have shown that prostitutes who are IV users are more at risk than prostitutes who don't use drugs. In recent studies a high proportion of street prostitutes seem to be IV users. Besides the AIDS risk, Marin Public Health officials claim that those women also have a high rate of venereal disease. Education and a change in sex, and drug practices is badly needed. This group is estimated to be _____ in number in Marin county alone.

3. There are numerous small scale commercial sex businesses throughout Marin County and San Francisco county. Years of contact with the prostitutes in those businesses has revealed their isolation, fear of public exposure, and ignorance about safe sex. Since the AIDS epidemic, many of those women have expressed panic about the risks they may be taking with their own health and with the health of their customers. Educational materials and personal outreach are needed. This group is estimated to be several hundred.
4. Prostitutes customers - Safe sex takes two educated parties. The most accessible source of AIDS information for prostitutes' clients appears to be the media. They are even more likely to be isolated, fearful of exposure, and ignorant than the prostitutes. There is no subculture of customers. Most concern about prostitutes as an AIDS risk group focuses upon the risk to heterosexual male clients and their unknowing wives. Clearly, responsibility for client health must lie with the client as well as the prostitute. But he can only act responsibly if he has accurate information. The shamed dyad of prostitute and customer needs unprejudicial educational aid to counter popular misinformation and unsafe sexual habits.
5. Agencies - The Marin and San Francisco county health departments, jails, drug and counseling services need both specific health information about prostitutes and general sensitivity training to open communication avenues with prostitutes. An underlying goal of the present pilot project would be to transfer the educational program from CAL-PEP to permanent Marin and San Francisco county officials. Building an educational base in established agencies is therefore fundamental to the project.

As of yet there is no educational program aimed at the prostitute and client dyad on AIDS or AIDS prevention and it is sorely needed. And yet prostitutes are been targeted as spreaders of the disease even though there is no substantial research verifying those allegations. The only solutions suggested to date as prevention have been ones of identification, isolation, and internment.

There are approximately one million women who work as prostitutes in this country at any one time, and as many as 10-15 percent of women have done so at some time in their lives. However, even if the police were able to quarantine all prostitutes, it would not prevent the spread of AIDS. It would only provide an illusion of protection because other women would take the place of the women who had been arrested: some would already be users of IV drugs, others would become IV users, some would contract the virus from infected customers because they failed to practice safe sex. And AIDS would still be transmitted by nonprostitute men and women who were not rounded up by police.

The solution to the AIDS crisis is accurate and explicit education about risk reduction, and adequate funding for research into the causes, treatment, and prevention of the disease.

STATEMENT OF NEED

AIDS is a terrifying disease because it is virtually always fatal, infectious, and sexually transmitted. In addition, the incubation period in adults is from two to five years (some estimate up to 14 years), during which time most researchers believe the virus can be transmitted from one person to another, although the carrier may have no symptoms or any idea that he or she is carrying the virus. The high fear of AIDS underlies a desire for easy "solutions," such as mandatory testing, quarantines, employment discrimination, and possibly mandatory sterilization.

In San Francisco and Marin counties there are over 00000000 prostitutes. 0000000 of which use the services of a public agency. It is ironic that these counties, which have a large incidence of AIDS, have developed no programs for prostitutes. Presently CAL-PEP is the only agency providing any safe-sex education specifically aimed at prostitutes in either of these two counties. Other agencies which provide services to prostitutes have received little or no education about AIDS and prostitutes (other than from the media), nor do they have the means or method to do outreach to prostitutes or their customers to provide them with AIDS information.

(Insert statistics here on agency numbers, prostitute numbers, AIDS programs numbers).

Why are there no programs on prevention geared towards the prostitutes and customer? We see one reason having to do with attitudes toward prostitutes as criminals. Another is prostitution is a political football. Another one is racism; a disproportionate number of women with AIDS have been black. Lastly, as women, they're viewed as vectors, they only exist as the threat they pose not as victims.

PROJECT RATIONALE

In proposing an educational program geared toward prostitutes, customers and service providers, our goal is to provide a service that is dictated by the existing conditions of the prostitute and customer dyad prevailing in this country separate from the AIDS crisis, and to answer the problem of prevention of the disease. Any form of intervention undertaken must consider these present day conditions (and their effects on the individual prostitute) before effective service can be provided. What is needed is a basic orientation to the lifestyle of the prostitute and the effects of the stigma on the prostitute and customer and, ultimately, education emphasizing safe-sex practices.

Three ingredients that we view as necessary for AIDS prevention with the prostitute and customer are risk reduction, advocacy, and education. In order to realize our goals we will

1. need to hire people who are intimately knowledgeable with the lifestyle of the prostitute. This will include ex-prostitutes and advocates who are committed to the needs of the prostitute.
2. We need to work toward reducing the transmission of AIDS. To do this, we need to work closely with agencies who provide services to prostitutes in gaining prostitutes' confidence, and we need to provide direct assistance and education to the prostitute on the street, in the parlor, in the house, as well as to the prostitute using IV drugs and sharing needles.
3. We need to circulate risk reduction material directed towards the prostitute and the customer.

We chose the Marin and San Francisco counties for our pilot project because this area presents the greatest need in terms of a relevant program on prevention. In comparison with the rest of the area it has the highest numbers of prostitutes who are working and receiving the services of agencies.

We recognize that an attempt to change the sex-practices and drug practices of the prostitute, and to improve the relationship between service provider and prostitute will not solve the AIDS crisis. We are well aware of the fact that unless a cure is found for AIDS the spread of the disease will continue. We are also aware that our solution does nothing to eliminate prostitution or drug use. It could even be construed as to encourage both acts.

Yet we must begin to address this crisis in realistic terms. There are approximately one million women who work as prostitutes in this country at any one time, and as many as 10-15 percent of all women have worked as a prostitute at some time in their lives. There is no realistic way this amount of people can be rounded up and quarantined. With a maximum amount of planning and participation by agencies, a sizable contribution can be made to the prevention of AIDS for the well-being of the community as a whole.

PROGRAM DESIGN

To accomplish the objectives stated in this proposal, the following program design will be implemented.

1. Program Development

A. Recruitment and Training of Staff

Staff will be recruited on the basis of experience, knowledge of, and familiarity with, the basic objectives of the program. Staff will be recruited, to

the extent possible, from the Marin/San Francisco area through newspaper advertising, notices in prominent locations throughout the area, and recommendations from the board of directors. Final selection of staff will be determined by the board of directors of CAL-PEP.

B. Development and Printing of Educational Materials.

Educational materials are currently being developed and will continue to be developed for both the prostitute and customer, and for agencies on safe-sex practices.

C. Establishmenet of Program Policies.

Program policies will be created by the board of directors that will include 1. fee charges for agencies and prostitutes based on income 2. Outreach proceedures for street prostitutes. 3. Educational quidelines (what will be taught and what will not be taught).

D. Publicizing the Program.

The program will be publicized in local newspapers known to be used by prostitutes for advertising and by sending materials to sex businesses such as massage parlors, escort services. Brochures and flyers will be sent periodically to community agencies such as counseling clinics, public health departments in both San Francisco and Marin counties, health clinics. We will also utilize existing networks within the prostitute communities to bring in prostitutes to seminars.

E. Planning Outreach Strageties.

Outreach includes: - walking the "stroll districts" - making appointments to visit parlors - contacting escort services - working with pornography businesses to provide safe sex information to customers. Strageties will include decisions as to best ways and places to meet and connect with prostitutes to introduce to the seminars. For example, some of our staff work with the AWARE project in San Francisco which involves walking the streets in order to meet working street prostitutes to invite them to be tested as part of AWAREs research on women and AIDS. In order to meet street walkers one stragety would be to walk the streets and hand out flyers as well as one to one interaction.

F. Educational Trainings for Prostitutes.

Trainings will be planned to last a minimum of 3 hours, and will be conducted as forums in which information is given out by CAL-PEP staff and (experts when

available), then questions and discussion will be elicited. Next the large group will break into small groups to discuss personal working practices, and to examine examples of condoms and spermicides. We've found that this format is the most effective with prostitutes, because for many it is the first time they have been in a group together and they have a great need to share experiences with each other. The information is retained better and a needed sense of safety among the prostitutes develops as a result of this format.

G. Training for Agencies.

Two areas will be covered in working with agencies, 1. AIDS information in general, and 2. Outreach to prostitutes and working with prostitutes once you've got them. This will include how the stigma affects prostitutes' lives, confidentiality, negative assumptions, positive assumptions, and attitudes held by the public about prostitutes, and how this affects prostitutes.

One final aspect in working with agencies will be to explore how the agency can take over the program and have it in-house.

H. Turning the Program over to the Agencies.

We realize that not every agency has the means or desire to run their own safe-sex program for prostitutes. Yet we have been receiving calls from agencies weekly asking us to give a training in how to work with prostitutes more effectively. So while agencies may not actively do outreach to prostitutes they do require training and reinforcement training in working with prostitutes.

I. Recruitment and Selection of Participants

Participants will be selected on the basis of their work in the sex industry. This will include street prostitutes, call girls, massage parlor workers, escort service providers, pornography actresses.

We expect this program to serve 1000 sex workers in the San Francisco and Marin counties. 40% will be women of color, ages will be from 20 to 39, 90% will be women, and 70% will be sex workers who have been arrested at least once. 15-20% will be street walkers.

PROGRAM ACTIVITIES

Seminars will be held regularly once a week at the _____ in San Francisco and once a week at the _____ in Marin on safe-sex practices for sex workers both day and evening hours.

Direct Services

The purpose of these seminars is threefold: 1. to educate sex workers about safe-sex practices and about AIDS. 2. to provide support and encouragement by both group members and leaders, in exploring alternative solutions to work hazards. 3. to assist group members in achieving safe sex in both their work and private life. 4. to inform participants of services available to them for health needs.

The seminars will be run by women who have or are presently working in the sex industry. Seminars will be organized around the following topic areas 1. AIDS virus and transmission, 2. statistics of prostitutes encountering AIDS, 3. AIDS and drug use, 4. AIDS and sex, 5. Alternative sex activities, 6. safe sex paraphenalia such as condoms, etc. 7. AIDS testing clinics,

Coordination with Other Agencies

One of the stated objectives of the program is to assist community agencies in working with prostitutes and doing outreach to prostitutes. This will be done in two ways 1. Open invitations will be extended to local civic groups, church groups, and service agencies to attend seminars geared specifically towards these groups. Initially, these seminars will serve to inform other agencies of our services and activities. 2. Continual mailings to community organizations and agencies in the form of flyers, newsletters. 3. Continual ads will be run in local weekly and monthly newspapers.

Program Evaluation

As California Prostitutes Education Project is to serve as a model program for other communities, a major aspect of its design is a program evaluation. It will work as follows:

The following things will be examined:

1. Utilization of CAL-PEP's service (who, how often, under what circumstances).
2. Assessment of sex workers attitudes toward and opinions of seminars.
3. Success in seminars primary goals and objectives, (this will be achieved through survey).

4. Number of sex workers and agencies who use the service.
5. Measurable impact (defined as using safe-sex practices and passing on to customers) with the sex industry in San Francisco and Marin counties.
6. Impact of program on community agencies (impact defined as number of prostitutes who use service on repeat basis, number of safe-sex seminars agencies give, prostitutes' attitudes and opinions toward the agencies).

Agencies:

A time series design will be utilized with all agencies who receive our services. The first survey will be given before the seminar, the second immediately following the seminar, a third once three months later, and the final 9 months following the first seminar. The primary questions we are answering is

1. did the agency staff know significantly more about AIDS at the end of the seminar(s) than they did at the beginning?
2. did the agency staff know significantly more about prostitutes, their lifestyles, problems, and the effects of the stigma at the end of the seminar than they did at the beginning?
3. Is the agency adding their own safe-sex seminar to their program?
4. Is there a significant change in the receptiveness of staff to prostitutes, if so, how is this demonstrated?
5. Is there an increase of prostitutes using the agency services since the seminar?

Sex Workers:

1. A time design will be utilized with all sex workers who receive our services. A survey will be given to every person prior to participating in the seminars and immediately following the seminar. The primary questions we are asking are: 1. Did the sex worker know significantly more about AIDS at the end of the seminar than they did at the beginning?
2. A time series design will be utilized with all massage parlors and escort services. The first survey will be given prior to any educational training done for the service, immediately following the training, then 3 months following the training, and finally 9 months following the first training. The primary questions we are asking are: Did massage parlor and escort service providers know significantly more about AIDS and safe-sex practices at the end of the training than they did at the beginning? 2. Which sex workers (men or women, Anglo, Black, Spanish, Asian heritage) benefited most/least from the program? 3. Did sex workers use safe-sex paraphenaila and practices more frequently following the training than before?

ADMINISTRATION AND STAFFING

Board of Directors

The existing CAL-PEP Board of Directors will act as the primary policy and decision-making body. The board will meet once a month, and membership will be made up of business, mental health, legal, community (both professional and civic), and ex-prostitutes representation from San Francisco and Marin counties.

The board will be directly responsible for insuring that CAL-PEP is continually providing high-quality services and that responsible personnel are staffing CAL-PEP. The executive director and education coordinator report directly to the board on a monthly basis. The board of directors is also responsible for the maintenance of sound fiscal and personnel policies.

Executive Director

CAL-PEP is responsible for the overall running and day-to-day activities of the program.

Education Coordinator

This is a three-quarter time position. Responsible for working in a supervisory and training capacity in conjunction with the executive director; in charge of organizing and overseeing the direct-service seminars, and production of educational materials, as well as coordination with agencies.

Outreach Coordinator

A full-time position. responsible for organizing outreach to sex workers and agencies. Will assist the education coordinator in organizing and overseeing seminars. Supervises 3 outreach assistants. Will also participate in leading the educational seminars for both agencies and sex workers.

Keywords: NATIONAL, PHS, FEDERAL

PUBLIC HEALTH SERVICE PLAN FOR THE
PREVENTION AND CONTROL OF AIDS AND THE AIDS VIRUS

Report of the Coolfont Planning Conference
June 4 to 6, 1986

FOREWORD

In 1985, the Public Health Service's Executive Task Force on AIDS published a comprehensive plan that included a set of objectives to control and prevent the spread of acquired immune deficiency syndrome by the year 2000. In the year since the plan was developed, considerable progress has been made. Our knowledge base has expanded many fold, and our cumulative 5 years of experience with AIDS and HTLV-III/LAV (HIV)* infection has provided new information that permits tentative long-range demographic projections, a better understanding of pathogenesis, a refined approach to research and development of vaccines and therapeutic agents, a refocus of prevention and control efforts, and the incorporation of patient care issues.

The Public Health Service (PHS) convened a meeting at the Coolfont Conference Center in Berkeley Springs, WV., June 4-6, 1986. Eighty-five experts in various aspects of AIDS, including clinicians, epidemiologists, public health policy makers, and basic research scientists were invited to review and modify the plan according to current information, needs, and demographic projections through 1991. The following plan is the result of that meeting; it represents a renewed commitment by the Public Health Service to prevent and control HTLV-III/LAV infection and its sequelae.

PURPOSE

This document provides a framework for the steps that must be taken in five broad areas--pathogenesis and clinical manifestations; therapeutics; vaccines; public health control measures; and patient care and health care needs--to achieve prevention and control of AIDS. The current plan is based on estimated changes in the demographics of AIDS through 1991. It calls for concerted action by Federal agencies, State and local health departments, professional organizations, and volunteer groups.

*HTLV-III/LAV = Human T Cell Lymphotropic Virus Type III/Lymphadenopathy Associated Virus. The name human immunodeficiency virus (HIV) has been proposed for these viruses by the International Committee on the Taxonomy of Viruses.

GOALS

The following goals were first published in the 1985 plan and remain valid for guiding the continuing National effort.

- o By 1987, reduce the transmission of the HTLV-III/LAV infection.
- o By 1990, reduce increase in the incidence of AIDS.
- o By 2000, eliminate transmission of HTLV-III/LAV infection with a decline in the incidence of AIDS thereafter.

BACKGROUND

Five years have elapsed since the initial report of *Pneumocystis carinii* pneumonia from Los Angeles marked the recognition of what has become known as AIDS. By 1984, a human retrovirus, HTLV-III/LAV, had been determined to be the etiologic agent of AIDS and, by early 1985, serologic tests for antibody to the virus were licensed and widely available.

In retrospect, when AIDS was initially reported in June 1981, some 5 years already had elapsed since the introduction of HTLV-III/LAV into the United States, and 3 years had elapsed since the first clinical cases had occurred. AIDS cases have been reported from all 50 States, the District of Columbia, and four Territories. Cases have been reported from more than 100 foreign countries.

The rapid development and implementation of sensitive and specific assays for HTLV-III/LAV antibodies have permitted screening of donated blood and plasma, and the research use of these and other assays has elucidated the modes of transmission, the natural history of infection, and a better understanding of the clinical manifestations of HTLV-III/LAV infections.

The predominant defect in AIDS is a profound and, so far, irreversible immune dysfunction that results when HTLV-III/LAV preferentially infects the helper-inducer subset of T-lymphocytes. Although the virus can also infect other cells of the immune system, as well as cells of the central nervous system, it is the infection of these T-lymphocytes that ultimately leads to a breakdown in the ability of an infected individual to mount an immune response. In the past 5 years, more effective therapies for some of the opportunistic infections that accompany AIDS have been found, but no cure for AIDS is yet available.

Studies of the molecular biology of HTLV-III/LAV have revealed that a copy of the viral genetic material becomes an integral and permanent component of the DNA of an infected individual. As a result, such an individual is likely a carrier of the virus for the rest of his life and, for purposes of public health control, is assumed to be capable of transmitting the virus to others.

The HTLV-III/LAV genome has been completely sequenced and the function of several of its genes are known. Considerable differences in some genes have been found among various isolates. In addition, related viruses have been identified in man and nonhuman primates. These related viruses cause a range of different diseases. Studies in animals indicate the feasibility of vaccination against retroviruses, and one veterinary vaccine is available for the prevention of feline leukemia virus. Although some promising approaches are under way, as

yet no effective vaccine for AIDS exists.

HTLV-III/LAV is transmitted by sexual, parenteral, and perinatal contact with the virus. Although this infection has been most often recognized in homosexual men and intravenous (IV) drug abusers, it is clear that this virus does not discriminate by sex, age, race, ethnic group, or sexual orientation. Behaviors which are high risk for the acquisition of HTLV-III/LAV infection include sexual contact or sharing of drug injection equipment with an infected person. Studies now clearly demonstrate that AIDS is not spread by casual contact, such as sneezing, coughing or sharing meals with an AIDS patient.

There are 21,517 cases of AIDS reported in the United States as of June 1986. Blacks and Hispanics represent 39 percent of total cases. Women who report no history of IV drug abuse represent half of the 1400 cases in women. Approximately 304 cases of AIDS occurred in infants and children under age 13. Between 2 and 3 percent of the cases have occurred in transfusion recipients or hemophiliacs. With the routine use of the HTLV-III antibody test to screen donated blood and plasma, use of chemical and heat treated clotting factors, and donor deferral practices, we can expect to see this percentage reduced in future years..

Projected Cases of AIDS*
United States

CATAGORY	1986	1991	1991
Cases Diagnosed			
Cumulative cases at start of year	19,000	196,000	155,000 to 220,000
Diagnosed during year	16,000	74,000	46,000 to 91,000
Alive at start of year	10,000	71,000	50,000 to 83,000
Alive during year	26,000	145,000	96,000 to 180,000
Deaths			
Cumulative deaths at start of year	9,000	125,000	103,000 to 137,000
Deaths during year	9,000	54,000	37,000 to 64,000
Cumulative deaths at end of year	18,000	179,000	142,000 to 201,000
Infections			
Persons with HTLV-III/LAV infection	1,000,000 to 1,500,000 (estimate)		

*These numbers refer only to those cases that meet the CDC definition for AIDS (see Morbidity and Mortality Weekly Report, 1985: 34: 373-5) and do not include other manifestations of infection, such as AIDS-related complex and lymphadenopathy syndrome.

Projections:

The following projections, as well as those in the table, are based on the Centers for Disease Control (CDC) surveillance data and epidemiologic studies of populations at high risk to infection with the virus.

- o Twenty to 30 percent of the estimated 1 to 1.5 million Americans infected with HTLV-III/LAV as of June 1986 are projected to develop AIDS by the end of 1991. The latency period between infection and overt AIDS averages 4 or more years in adults, therefore, most persons who will develop AIDS between 1986 and 1991 will be those who are already infected with HTLV-III/LAV.
- o Based on an empirical model that uses reported cases of AIDS, by the end of 1991, the cumulative cases of AIDS in the U.S meeting the CDC surveillance definition will total more than 270,000. During 1991 alone, more than 145,000 cases of AIDS will require medical care and over 54,000 AIDS patients are predicted to die, bringing the cumulative number of deaths due to AIDS to over 179,000.
- o The empirical model may underestimate by at least 20 percent the serious morbidity and mortality attributable to AIDS, because of underreporting or underascertainment of cases.
- o In 1985, 9,000 cases of AIDS were diagnosed in the United States and reported to the Centers for Disease Control. The empirical model predicts that cases will continue to increase through 1991, that there will be nearly 16,000 cases reported in 1986, and more than 74,000 cases projected for 1991. The estimates for 1991 range from 46,000 to 90,000.
- o More than 70 percent of the cases will be diagnosed among homosexual or bisexual men, and 25 percent of the cases will occur among IV drug abusers with some overlap to continue between the groups. Because the periods between infection and disease are long and variable, cases will continue to be reported among transfusion recipients and persons with hemophilia.
- o Additional cases in heterosexual men and women are projected, the 1,100 (7 percent of the total) for 1986 will increase to nearly 7,000 (more than 9 percent) by 1991. This group includes patients who reported heterosexual contact with an infected person or someone in a risk group, as well as cases in groups in which epidemiologic studies suggest heterosexual transmission as the major risk factor. By 1991, more than 3,000 cases will have been diagnosed in infants and children.
- o Through 1985, fewer than 60 percent of cases were diagnosed in persons outside New York City and San Francisco, but by 1991 more than 80 percent of cases are predicted to be reported from other States and localities.

- o Homosexual-bisexual men and men and women who use drugs of abuse intravenously will continue to be the populations at highest risk for HTLV-III/LAV infection during the next 5 years. Using estimates published by Kinsey, over 2.5 million (4 percent) of U.S. men between 16 and 55 years of age are exclusively homosexual throughout their life; an estimated 5-10 million more will have some homosexual contact. An estimated 750,000 Americans inject heroin or other drugs intravenously at least once a week; a similar number inject drugs less often.
- o The prevalence of HTLV-III/LAV seropositivity among homosexual men and IV drug users parallels the frequency of AIDS in various cities. In 1984-85, 20 to 50 percent of homosexual men participated in research studies had evidence of HTLV-III/LAV infection. Similarly, seroprevalence estimates among IV drug abusers ranged from 10 to more than 50 percent in various U.S. cities. By extrapolating all available data, we estimate that there are approximately 1 to 1.5 million infected persons in those groups at the present. Thus estimates of a 20 to 30 percent progression to AIDS by 1991 in this group are consistent with the total number of AIDS cases predicted by the empirical model.
- o Uninfected homosexual men have continued to acquire HTLV-III/LAV infections during the past year, but at a lower rate than would be predicted from the increases in previous years and from the increase in the number of potentially infectious persons. This observation is consistent with changes reported in sexual behavior and declines in other sexually transmitted infections in homosexual men. Nonetheless, due to the large present and future populations at risk, hundreds of thousands of additional homosexual men, IV drug abusers, and others may become infected during the next 5 years.
- o Because of heat and chemical treatment of clotting factor concentrates, donor deferral, and serologic screening of donated blood and plasma, only a very small number of additional infections are likely to occur through blood and plasma transfusions.
- o Current information is insufficient to predict the future incidence of HTLV-III/LAV infection in heterosexual populations, but increases in heterosexual transmission are likely. Those at highest risk will be heterosexual sexual partners of infected persons and those who have sexual contact with past or present IV drug abusers, bisexual men, prostitutes, or others at increased risk for HTLV-III/LAV infection. As is true for homosexual men, sexual contact with multiple partners will increase one's risk for HTLV-III/LAV infection.
- o Additional increases in HTLV-III/LAV infection in infants are expected as more women in child-bearing years become infected.

The following five sections are the deliberations and recommendations made by the work groups at the Coolfont meeting.

I. PATHOGENESIS AND CLINICAL MANIFESTATIONS

Infection with HTLV-III/LAV results in a broad range of clinical manifestations including an acute retroviral syndrome, asymptomatic disease, chronic lymphadenopathy, and serious diseases including Kaposi's sarcoma and other malignant neoplasms, fatal opportunistic infections, and neurological and psychiatric disorders.

The factors that determine the expression and progression of disease in an individual are largely unknown. Techniques are available to diagnose and treat many of these opportunistic diseases, although they often recur. However, once Kaposi's sarcoma or certain opportunistic infections occur, an ultimately fatal outcome for the patient has been the rule.

Conclusions

Clinical and epidemiologic studies need to be conducted to:

- o Clarify the natural history of infection including the role which may be played by exogenous or endogenous factors in determining which clinical manifestations occur; and
- o Continue to expand the spectrum of clinical manifestations.

Basic scientific studies need to be expanded on the virology and immunopathogenesis of HTLV-III/LAV, especially to:

- o Assess target cell susceptibility;
- o Identify viral and host cell determinants of transmissibility and pathogenicity including portals of viral entry, mechanisms of cytopathic effects, and dysfunction;
- o Further elucidate mechanisms of viral latency and activation;
- o Identify and assess direct and indirect immunopathogenic mechanisms;
- o Further delineate the pathogenesis of neurologic and psychiatric abnormalities; and
- o Ascertain more fully the functions of viral gene products and determine the meaning and mechanisms of genetic heterogeneity.

More suitable animal models for HTLV-III/LAV infection need to be developed to allow more comprehensive understanding of pathogenesis and rapid evaluation of treatment and prophylaxis. Dedicated efforts must be made to maximize efficiency of use of limited animal resources.

Improved methodologies are needed to detect infected and infectious individuals and to identify and quantitate virus, viral antigen, and viral antibody.

II. THERAPEUTICS

No drug with proven clinical efficacy for AIDS is currently known. Both antiviral agents and immunomodulators are being developed, and several drugs are under clinical investigation at present. The ability of an agent to reverse the disease process or halt its

progression may vary depending upon the stage of infection. Research is now in progress to develop new methods to inhibit viral replication and correct the immune deficiencies. A safe and effective antiviral agent is not likely to be in general use for the next several years. Experimental products are also under study for treatment of opportunistic infections and neoplasms associated with HTLV-III/LAV infection.

CONCLUSIONS

- o Further expansion of the multi-institutional, multidisciplinary approach to identify and develop agents for the treatment and prevention of HTLV-III/LAV infection and associated diseases, including central nervous system disease, is necessary. Part of this effort must be the establishment of a large capacity screening program to measure the antiviral, immunomodulators and toxic effects of newly identified natural and synthetic compounds.
- o A system for classifying HTLV-III/LAV associated disease manifestations which is useful in the design, implementation and analyses of therapeutic trials must be developed. Standard clinical criteria for the measurement of efficacy and toxicity must be formulated to facilitate the performance of well organized multicenter clinical trials.
- o The most efficient design of clinical trials of candidate antiviral agents will require the use of placebo controls.
- o New therapeutic approaches must be developed to control or eliminate latent virus and to specifically direct antiviral compounds to the appropriate target tissues. Combination strategies to control viral replication and restore the immune system must be developed and evaluated.
- o Since antiviral drugs currently under development are likely to repress rather than eliminate the AIDS virus infection, long-term therapy is expected and with it the emergence of drug-resistant strains.
- o New and/or existing strategies in the diagnosis, treatment, and prophylaxis of the opportunistic infections and neoplasms associated with AIDS all need to be developed, tested, and improved.

III. VACCINES

A number of vaccine candidates for human beings are currently under development and limited clinical testing for some could begin within 2 years. Field trials to demonstrate efficacy may require additional years. Vaccines are not anticipated to be useful in individuals who are already infected. A vaccine for general use is not anticipated before the next decade and its use would not affect the number of persons infected by that time.

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CONCLUSIONS:

- o Vaccines employing recombinant DNA derived antigen, subunit,

killed viruses, synthetic peptide, live recombinant, live-attenuated, and anti-idiotypes will need to be evaluated as potential candidates for human trials.

- o Vaccination methods will need to be devised to induce immunity to antigenically distinct strains of HTLV-III/LAV.
- o Reliable in vitro and in vivo systems need to be developed for the evaluation of vaccine immunogenicity safety and efficacy before commencing trials in humans.
- o A program for clinical and field evaluation of vaccine(s) needs to be established, including resolution of difficult aspects of design such as identification of target populations and the definition of parameters of vaccine efficacy.
- o Protocols need to be developed for the in vitro and in vivo evaluation of anti-HTLV-III/LAV immunoglobulin to explore its value in passive immunization.

IV. PUBLIC HEALTH CONTROL MEASURES

In the absence of a vaccine and therapy, prevention and control of HTLV-III/LAV infection depends largely upon effective approaches to decrease sexual transmission, transmission among IV drug users, and perinatal transmission from infected mothers. A strategy to control and prevent AIDS should involve voluntary counseling and testing* for persons at increased risk of HTLV-III/LAV infection and imparting to infected patients those Public Health Service recommendations concerning personal behaviors that must be observed if spread of the virus is to be halted.

Public health activities directed toward the control and prevention of AIDS have required significant funding and staffing at national, State, and local levels. The projected increases in AIDS and HTLV-III/LAV infection over the next 5 years will pose substantial continuing demands for resources for these efforts.

*Throughout this section, serological testing is intended to be voluntary, conducted with confidentiality, and accompanied by appropriate pretest and post-test counseling.

Conclusions

The recommendations of the conference participants concerning public health measures focused on five areas.

1. Information Base

- o Information is needed to better determine the size of the population at greatest risk in the United States, particularly the numbers of homosexual men, bisexual men, IV drug abusers, and heterosexuals who have multiple partners.
- o Better information is needed on the number of persons infected with HTLV-III/LAV. Extensive and repeated seroepidemiologic surveys are needed to determine the incidence and prevalence of infection by age, race, ethnicity, sex, geographic area and sexual preference.

States should be encouraged to obtain and report data on incidence and prevalence to CDC for publication.

- o The Public Health Service should encourage and assist in the evaluation and comparison of all interventions for prevention and control of AIDS and HTLV-III/LAV infection.
- o PHS should continue to support key epidemiologic studies, such as modes of transmission.
- o The United States should continue to play a role in understanding and assisting efforts to control the disease worldwide, particularly in areas with seemingly different epidemiologic patterns.

2. Information and Education

National information and education campaigns on AIDS and HTLV-III/LAV infection should be targeted to individuals and groups whose behavior places them at high risk for AIDS, other sexually active adults, adolescents, preadolescents, and health care providers. A major target of mass information-education programs is the currently uninfected population, to assure that those persons know how to protect themselves. An additional purpose is to persuade infected persons to take appropriate steps to safeguard their own health and to avoid infecting others.

- o PHS should explore the advantages of using paid radio, TV and printed media advertising as well as public service announcements to inform the public on AIDS and HTLV-III/LAV infection.
- o PHS, State and local health departments, State and local boards of education, colleges, universities, and other organizations should support and encourage comprehensive education about AIDS and HTLV-III/LAV infection.
- o With the assistance of appropriate organizations, programs should be implemented to provide culturally sensitive, meaningful information and education to blacks, and Hispanics including homosexuals, IV drug abusers, blood donors, women both at risk themselves and also at risk for transmitting infection perinatally and other other segments of the public
- o Health care providers need current information and training on the diagnosis, psychosocial counseling and management of HTLV-III/LAV infected persons.

3. Prevention of IV Drug Abuse Transmission

IV drug abusers serve as the major reservoir for transmission of infection to heterosexual adults and their infants, as well as among themselves. As a group, they are not well organized, often poorly educated, and tend to have less interaction with the health care delivery system than other groups who participate in high risk behaviors. Efforts to change drug abuse behavior must proceed with the understanding that addictive behavior is not often changed without specific drug treatment.

- o A systematically increased capacity for treating IV drug

abusers is needed. Until adequate capacity is available, persons in need of treatment should be prioritized. Decisions may vary by locality, but highest priority should be given to those presently on waiting lists for treatment.

- o All treatment and prevention approaches should include information and counseling on sexual and perinatal transmission of HTLV-III/LAV, availability of family planning services, and availability of voluntary serological testing for HTLV-III/LAV.
- o Until treatment capacity is adequate for persons who continue to abuse IV drugs, studies are needed to evaluate the efficacy and feasibility of promoting safer use of drug paraphernalia (for example, increased availability of sterile needles or 'works') and education regarding use of sterile needles and sharing of needles.

4. Prevention of Sexual Transmission

Sexual contact will remain the primary mode of HTLV-III/LAV infection for the foreseeable future, with greater increase in the proportion of heterosexual transmission over the next 5 years.

A central goal of local disease control programs should be to reach the greatest number of HTLV-III/LAV infected persons with testing and counseling (provision of pretest and post-test information, including psychological support) about their infections and methods to reduce the likelihood of transmission to others, in order to change high risk sexual behaviors). At present, only a small proportion of the already infected population has been reached.

Several methods may help achieve this goal, although they may have differing efficacies in various settings and populations. These include encouragement of voluntary serological screening, self referral of sexual and/or drug abuse contacts, notification and counseling of contacts by health authorities, and targeted educational programs.

- o Serological testing of persons whose behavior places them at risk should be encouraged and made widely available. In all communities, appropriate medical care encompasses offering counseling and testing to all persons at risk, including persons with a sexually transmitted disease, IV drug abusers, and persons seen in private practice who engage in high risk behaviors. (Anonymous testing should be available as an option.)
- o Self-referral of an infected person's sexual and needle-sharing contacts should be encouraged. In some areas or populations, additional contact notification activities may be offered to infected persons by the health agency.
- o Research is needed on the efficacy of counseling and/or knowledge of personal serological status or both in modifying sexual and needle sharing behavior to reduce or eliminate the risk of transmission.
- o For persons who know that they are infected with HTLV-III/LAV

yet continue to practice high risk sexual or needle-sharing activities, temporary involuntary isolation should be considered an option only in rare instances and after due process. Enforced isolation is not a practical way to minimize spread of the infection, since infected persons remain infectious for life. Education, counseling, and extension of social services--including drug treatment--are the main interventions for dealing with this problem and are appropriately applied to recalcitrant infected persons and their potential consenting partners. Uninfected persons must avoid behavior which would permit infection from persons who know or do not know they are infected.

5. Prevention of Transmissibility by Blood and Blood Products

The risk of transmission of HTLV-III/LAV by transfusion of blood and blood products is extremely low due to deferral of high risk donors, serological screening of donated blood and plasma, and the heat and chemical treatment of clotting factor concentrates. Nonetheless, some additional measures are appropriate to further reduce this low risk.

- o Increase the effectiveness of deferral by all persons at increased risk of HTLV-III/LAV infection by:
 - Collecting demographic and other data from donors found to have confirmed HTLV-III antibody. This will require some type of case reporting and subsequent interviews, but it is essential to the continued evolution of the high risk donor deferral strategy;
 - Improving communications to potential donors about self-deferral, taking into consideration their language skills and literacy;
 - Exploring the usefulness of providing means at the time of donation for blood donors, who do not self exclude but who have remaining doubts about their suitability, to designate that their donated unit not be used for transfusion.
 - Implementing the use of a signed donor consent form in all blood banks that clearly indicates the absence of specific risk factors for transmission of infections.
- o Continuing to require that blood and plasma establishments maintain deferral lists of donors who have repeatedly reactive ELISA tests.
- o Continuing to encourage development and use of more sensitive serologic tests for HTLV-III/LAV infection.
- o Recommending that current recommendations for HTLV-III antibody testing for donors of organs, tissues, cells and semen be made mandatory.
- o Encouraging increased activities to eliminate unnecessary transfusions.

V. PATIENT CARE AND HEALTH CARE NEEDS

Over the period of 1986 to 1991, AIDS and associated conditions will place an increasing burden on the health care delivery system through an increased number of patients and increased costs of care. The burden will be shared by a larger number of communities, including some which will have a less complete capacity for response. There will be increasing fragmentation and less health care control of services provided if more non-medical, less traditional and some unethical providers become involved.

PHS estimates that the direct health care costs of persons with AIDS will be between \$8 to \$16 billion* in 1991. These sums represents 1.2 to 2.4 percent of the expected total U.S. personal health care expenditures in 1991 of about \$650 billion. Because people with AIDS are concentrated in certain urban centers, however, these costs will be disproportionately borne.

These estimates may be conservative by 10 to 50 percent because of the increase need for care for the large population of patients with the other conditions associated with HTLV-III/LAV infection and the significant non-medical care costs necessary for management of these illnesses. Development of community-based health and social services support systems can reduce costs and enhance care during this five year period.

*The \$8 billion figure is based the projection of 71,000 AIDS patients alive in 1991 and 74,000 new cases by then. An additional 29,000 cases was added to account for the 20 percent underreporting or underascertainment of cases. The cost for treating a patient with AIDS used in the calculation was \$46,000. For the higher range, the \$8 billion figure was

Conclusions:

- o Develop a coordinated Federal, State, and local response to manage the health services and health financing crisis posed by the escalating AIDS epidemic. This response must reflect the pluralistic character of the American health care system, and must involve the coordinated participation of the public, private and voluntary sectors, as well as ambulatory, in-hospital and long term care providers;
- o Explore the feasibility and need for convening a national, blue-ribbon Commission representing the necessary constituencies to canvass needs and resources available and to make recommendations regarding how each sector of our society can help to fill financing and resource needs;
- o Emphasize the needs of institutional and community-based providers for training, continuing education, and psychosocial support;
- o Upon request, assist State, local governments, and community-based organizations to assess, develop and implement comprehensive service delivery systems of care for AIDS patients in a cost-effective manner;
- o Develop organized consortia of service delivery systems

responsive to the care of AIDS patients; such consortia should include all the necessary components of care (that is ambulatory hospital, mental health, and dental health services, counseling, home health care, and hospice care.)

- o Explore efforts to set up regionalized consortia of services for AIDS patients;
- o Utilize studies of the special health services needs and barriers to prevention of HLTV-III/LAV infection in blacks and Hispanics, and best methods of information dissemination to foster inclusion of culturally sensitive service delivery for children with AIDS, IV drugs abusers, hemophiliacs, and minorities in all appropriate metropolitan areas;
- o Initiate demonstrations of the appropriate care needed at different stages of the illness, costs of services, and more cost effective provisions of needed services, including Model Medical Waiver programs;
- o Support health services research on AIDS that emphasizes cost of services for different risk groups, stages of illness, and treatment modalities and assesses potential improvement of methods and increased cost-effectiveness of care.

**National Institute
of Justice**

Research in Brief

February 1986

AIDS in Prisons and Jails: Issues and Options

Theodore M. Hammett

Acquired Immunodeficiency Syndrome (AIDS) has rapidly become one of the most difficult and complex public health issues facing the United States. Since AIDS was first identified in this country in 1981, over 17,000 Americans have developed the disease. The rapid increase in cases, particularly in the past 2 years, and the continued uncertainties as to the future course of the disease's spread have led the President to term AIDS "the Nation's number one health priority."

In the correctional context, dealing with the problem of AIDS may pose

even more difficult problems since inmate populations may include high proportions of individuals in AIDS risk groups, particularly intravenous drug users. Correctional administrators must formulate policies that allow them to manage their institutions effectively, while dealing with a serious health problem that may cause fears among staff and inmates. Administrators face difficult decisions concerning prevention, housing, and the provision of medical care, decisions which are frequently complicated by legal and cost issues.

In response to urgent information needs expressed by corrections professionals, the National Institute of Justice and the American Correctional Association sponsored a study entitled *AIDS in Correctional Facilities: Issues and Options*. The study was based, in large part, on responses to a national mail questionnaire from all 50 State correctional departments, the Federal Bureau of Prisons, and 33 large city and county jail systems. The responses were received between November 1985 and January 1986.

From the Director

Acquired Immunodeficiency Syndrome (AIDS) represents a serious challenge for American correctional systems.

Recognizing that many inmate populations contain a high concentration of individuals at risk for the disease—primarily because of histories of intravenous drug use and, to a lesser degree, homosexual behavior—correctional administrators are concerned with developing effective policies to ensure the health and safety of both inmates and staff.

Often already coping with crowded institutions and limited budgets, they face difficult decisions regarding prevention, institutional management, and the identification and treatment of inmates with AIDS. These decisions are further complicated by a range of legal

issues, the high costs of medical care, and the need to control fear and misinformation throughout the institution.

Recognizing the potential scope of these problems, many correctional administrators have expressed interest in receiving information that can help them in formulating policies on AIDS. To address this need, the National Institute of Justice and the American Correctional Association jointly sponsored the development of a report entitled *AIDS in Correctional Facilities: Issues and Options*.

Given the urgency of the need, the study was an intensive effort, conducted over a 4-month time period. In addition to the dedication of the project director, Theodore M. Hammett, the cooperation of the National Institute of Corrections, the Association of State Correctional Administrators, the Centers for Disease

Control, and the American Correctional Association should be recognized.

This *Research in Brief* summarizes the major findings and conclusions of the full report. Like the full report, it is intended to be informational rather than prescriptive.

Certain principles, such as the importance of inmate and staff education on AIDS, are indisputable. Still, there are many other issues and policy questions that continue to spur debate both within and between the correctional and medical communities.

By outlining these debates and providing the most current information available, the National Institute of Justice and ACA hope that correctional administrators will be better equipped to deal with the problem of AIDS.

James K. Stewart
Director
National Institute of Justice

The study summarizes the latest medical information on AIDS, presents statistics on the incidence of AIDS in correctional facilities, and enumerates the key issues and options facing correctional administrators as they formulate policy responses to this complex problem. This Research in Brief summarizes the major findings and conclusions of that report.

Cause and transmission of AIDS

AIDS is a serious communicable disease that undermines the human body's ability to combat infections. In 1983 and 1984, the probable cause of AIDS—variously called human t-cell lymphotropic virus type III (HTLV-III) and lymphadenopathy-associated virus (LAV)—was identified. Thus far, most cases in the United States have been among homosexuals and intravenous drug abusers, with cases primarily concentrated in large metropolitan areas on the east and west coasts.

End-stage AIDS is almost always fatal. However, a range of milder forms of illness, sometimes called AIDS-Related Complex (ARC), may also appear among those infected with the AIDS virus.

Infection with HTLV-III is transmitted through contaminated blood and semen, primarily during sexual activity and needle-sharing related to intravenous drug abuse. The virus is difficult to transmit and there is absolutely no evidence of its transmission through casual contact, such as coughing, hugging, handshaking, sharing eating and drinking utensils, or using the same toilet facilities.

In 1985, a test was developed and made widely available to detect the presence of antibodies (evidence of the body's attempt to fight off an infection) to HTLV-III. While the test does not detect the presence of the virus itself, seropositivity (i.e., presence of antibodies) means that an individual has been infected with the AIDS virus at

some time, although the body may have subsequently fought off the infection.

The likelihood that HTLV-III seropositivity means current infection with the virus is considered much greater for individuals in identified AIDS risk groups (e.g., homosexual or bisexual males, intravenous drug abusers). Nevertheless, seropositive individuals may never develop any symptoms, let alone develop end-stage AIDS.

Currently, the Centers for Disease Control (CDC) estimate that 5 to 6 percent of seropositive individuals will develop end-stage AIDS while another 25 percent will develop ARC. However, recent research suggests that the percentage of seropositive individuals who will develop AIDS may be somewhat higher. Moreover, CDC cautions that seropositive individuals

may be able to transmit the infection to others, even if they never develop symptoms themselves. Exhibit 1 summarizes the relationships among exposure, infection, seropositivity, ARC, and AIDS.

AIDS in the correctional population

Responses to the study questionnaire reveal that, since 1981, there have been a cumulative total of 455 confirmed AIDS cases in 25 State and Federal prison systems. Twenty large city and county jail systems reported 311 cases of AIDS among inmates. These figures represent *cumulative total cases since the responding jurisdictions began keeping records.*

As of the period November 1985 to January 1986, there were 144 cases of

Exhibit 1

Relationships among exposure, infection, HTLV-III seropositivity, and development of ARC or AIDS

Stage	Meaning	Relationship to previous stage(s)
Exposure	Individual has contact with HTLV-III in a way that makes transmission possible (e.g., sexual contact or needle-sharing activity)	—
Infection	Individual is infected with HTLV-III. Infection may be permanent or body may successfully combat the virus.	Unknown, although multiple exposures probably increase the risk of infection.
Seropositivity	Individual has antibodies to HTLV-III. Infection has occurred at some time in the past, but date of infection or whether individual remains infected cannot be determined.	CDC considers the HTLV-III antibody test a reliable indicator that infection has occurred at some time. Repeat and confirmatory testing increase reliability.
ARC	A combination of conditions that together give evidence of infection with AIDS virus.	About 25 percent of seropositive individuals will probably develop ARC (CDC estimate). This estimate is uncertain due to the lengthy incubation period.
AIDS	Illness characterized by one or more opportunistic infections at least moderately indicative of underlying cellular immunodeficiency.	About 5 to 6 percent of seropositive individuals will probably develop AIDS. (CDC estimate). Recent studies place the fraction as high as one-third. Again, all estimates are uncertain due to the lengthy incubation period.

Opinions or points of view expressed in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

AIDS among State and Federal inmates in 19 systems and 35 cases among city and county inmates in 11 systems.

No known AIDS cases have occurred among correctional staff as a result of contact with inmates. Questionnaire respondents reported nine cases of AIDS among current or former staff, but none of these individuals had been involved in an incident with an inmate in which transmission of the AIDS virus might have occurred. Indeed, most were known or suspected to have been in AIDS risk groups.

The distribution of AIDS cases across correctional systems is highly skewed (Exhibit 2). Fifty-one percent of the prison systems have had *no* cases and 80 percent have had fewer than four cases. Among responding city and county jail systems, 39 percent have had no cases and 70 percent have had fewer than four cases.

At the other extreme, two State prison systems and only one of the responding city and county jail systems have had more than 50 cases. The regional distribution is also highly uneven. Over 70 percent of the cases, both in State prison systems and in city and county jail systems, have occurred in the mid-Atlantic region, with all other parts of the United States contributing much smaller percentages.

The vast majority of correctional AIDS cases, particularly in jurisdictions with large numbers of cases, are believed to be associated with prior intravenous drug abuse. There is substantial debate, but little hard data, on the extent to which the AIDS virus is being transmitted within correctional institutions. The two primary means of transmission are prohibited behavior in all corrections systems. However, logic and common sense suggest that, even in the best-managed correctional facilities, there may be at least some transmission of the infection occurring among inmates.

Correctional policy issues and options

The major policy areas involved in the correctional response to AIDS are education and training; HTLV-III antibody testing; and medical, legal, and correctional management issues.

Exhibit 2

Distribution of cumulative total AIDS cases among inmates, by type of system

Range of total AIDS cases	State/Federal prison systems				City/county jail systems			
	<u>n</u> <u>systems</u>	<u>%</u>	<u>n</u> <u>cases</u>	<u>%</u>	<u>n</u> <u>systems</u>	<u>%</u>	<u>n</u> <u>cases</u>	<u>%</u>
0	26	51%	0	0%	13	39%	0	0%
1-3	15	29	24	5	10	30	16	5
4-10	5	10	30	7	7	21	43	14
11-25	2	4	42	9	1	3	12	4
26-50	1	2	33	7	1	3	40	13
51-100	1	2	95	21	0	0	0	0
> 100	<u>1</u>	<u>2</u>	<u>231</u>	<u>51</u>	<u>1</u>	<u>3</u>	<u>200</u>	<u>64</u>
TOTAL	51	100%	455	100%	33	99% ^a	311	100%

Source: NIJ/ACA questionnaire responses

^a Due to rounding

Education and training

Because there is no vaccine or cure for the disease, education and training programs are the cornerstone of efforts to curb the spread of AIDS in prisons and jails, as well as in the population at large. Education and training programs also provide the opportunity to counteract misinformation, rumors, and fear concerning the disease. For example, the majority of systems responding to the questionnaire reported that inmates and staff worried about the possibility of contracting AIDS; many responses referred to fear of casual contact or types of contact not actually associated with transmission of the virus.

As a result, many correctional administrators feel strongly that education and training are not options but absolute requirements. Ninety-three percent of the responding jurisdictions currently offer or are developing AIDS educational programs for staff; 83 percent offer or are developing such programs for inmates.

Among respondents whose educational programs have operated for some time,

the vast majority believe these programs to be effective in reducing the fears of staff and inmates. Several jurisdictions reported that timely educational efforts had successfully averted threatened job actions by correctional staff unions.

Experience suggests that training and education programs should be instituted before deep-seated fears have developed, and repeated periodically so that the latest medical information can be presented and new staff and inmates can be reached on a timely basis.

Effective education programs may include live presentations by training teams, printed materials, and videotapes. Program curricula and materials should be brief, clear, and straightforward and tailored to the particular knowledge gaps and concerns of the audience. They should discuss the means of transmission of the AIDS virus and emphasize everyone's responsibility to avoid behaviors known to be associated with transmission. They should also guard against encouraging a false sense of security in

any group. At the same time, programs should not create needless fear by advocating unnecessary precautionary measures.

HTLV-III antibody testing

There is substantial debate, both in corrections and in society at large, surrounding the uses of the HTLV-III antibody test and the meaning of the test results. The most controversial testing application in corrections is mass screening: the testing of all inmates or all new inmates, regardless of the presence of symptoms or other clinical indications.

Correctional policies on HTLV-III antibody testing. Only four State correctional systems (Nevada, Colorado, Iowa, and Missouri) have implemented or plan to implement mass screening programs for inmates; no city or county systems responding to the questionnaire have instituted or planned such programs. However, almost 90 percent of the responding jurisdictions do employ testing for more limited purposes. These include testing of risk-group members, testing in support of diagnoses of AIDS or ARC, testing in response to incidents in which the AIDS virus might have been transmitted, testing on inmate request, and testing carried out as part of anonymous epidemiological studies. Exhibit 3 summarizes study findings on correctional testing policies.

Mass screening: the debate. The debate over mass screening for antibody to HTLV-III in correctional institutions involves the following major questions:

- *Should correctional systems take steps not being taken in the community at large?*

Proponents of testing argue that rates of HTLV-III seropositivity are higher among inmates and that the virus is likely to be transmitted within institutions; they believe that screening is necessary to identify infectious individuals and to target prevention programs.

Opponents argue that there is no proof of higher rates of HTLV-III transmission in prison and therefore there is no legitimate reason to screen.

Exhibit 3
**Summary of responding jurisdictions'
HTLV-III antibody testing policies for inmates^a**

Policy category	State/Federal prison systems		City/county jail systems	
	n	%	n	%
• Mass screening (all or all new inmates)	4	8%	0	0%
• Screening of risk groups	2	4	7	21
• Testing <i>only</i> for diagnoses, incident response, or epidemiological studies	39	77	20	61
• Testing <i>only</i> on inmate request	1	2	1	3
• No testing	5	10	5	15
TOTAL	51	101% ^b	33	100%

^aIncludes actual and planned policies. This is a hierarchical categorization. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that do screening of all members of at least some risk groups, but no mass screening, are placed in the "screening of risk groups" category regardless of whether they also do testing for diagnosis, incident response, or epidemiology studies.

^bDue to rounding.

- *What are the policy implications of identifying seropositive individuals?*

Proponents of screening argue that seropositive individuals must be identified so they can be given special supervision, counseling, and other programming.

Opponents argue that mass identification of seropositives would serve no purposes not better addressed by educational programs and would, in fact, create significant correctional management problems—particularly if large numbers of seropositives were identified and there was irresistible pressure to segregate them.

- *How would mass screening affect education and prevention programs?*

Proponents argue that screening is necessary to inform and target education and prevention programs.

Opponents argue that screening needlessly and misleadingly divides the inmate population into a stigmatized class and a "safe" class, thereby undermining the important educational message that everyone should be careful.

- *Is it possible to develop a reliable and confidential screening program?*

Proponents argue that the antibody test is reliable and that confidentiality of results can be maintained.

Opponents argue that the test results are often unreliable and that real and rumored results would inevitably become known to the inmate population and others outside the institution, potentially subjecting actual or supposed seropositives to threats and intimidation while in prison and to discrimination in housing, employment, and insurability after discharge.

- *What are the legal implications of screening?*

Proponents argue that mass screening is legal and proper and, in fact, that failure to conduct mass screening may result in serious legal liabilities.

Opponents point out that laws and policies requiring subjects' informed consent for HTLV-III antibody testing preclude mandatory mass screening and suggest that liability issues can be effectively managed.

● *What are the costs of mass screening?*

Proponents of screening argue that the test can be economically administered.

Opponents argue that when the costs of repeat and confirmatory tests and the costs of separate correctional programming for seropositives are included, the total price could become prohibitive, particularly for large systems and/or those likely to identify large numbers of seropositive inmates.

● *Will mass screening allay or inflame fears?*

Proponents argue that screening could help to calm the concerns of inmates and staff if it found low rates of seropositivity. Moreover, regardless of the seropositivity rates, failure to screen could cause serious public relations problems.

Opponents argue that mass screening will needlessly inflame fears, particularly if the seropositivity rate is found to be high.

● *Are there feasible alternatives to screening?*

Proponents argue that screening is the best method of obtaining the necessary information on HTLV-III seropositivity and transmission.

Opponents argue that there are better ways to identify high-risk individuals and diagnose AIDS and ARC that avoid the negative consequences of mass screening. These include astute medical surveillance and alternative laboratory work for diagnoses.

In addition, anonymous epidemiological studies may permit estimation of HTLV-III seropositivity and transmission rates while avoiding the correctional management and confidentiality problems of mass screening.

Implementation issues. Correctional administrators who decide to implement any mass or selective testing program face a range of issues, including when and where to administer the test, and whether testing should be voluntary, mandatory, or on request.

In 60 percent of the responding jurisdictions, all testing is either voluntary or on inmate request. In 15 percent of the jurisdictions, all testing is mandatory.

There are serious legal and ethical issues involving both whether inmates can be compelled to submit to testing and whether they have a right to testing on request. Laws in some jurisdictions (e.g., California and Wisconsin) prohibit HTLV-III antibody testing without the informed consent of the subject.

Those who oppose mandatory testing argue that, because of the potentially serious negative effects of testing (e.g., discrimination in housing, employment, insurability), medical ethics require that there be a right of refusal, regardless of law or policy.

Some also argue that correctional systems have an obligation to provide the test to any or all inmates who request it. However, if such testing is provided, many physicians believe that inmates should be fully and accurately informed of the potential personal and psychological effects of testing before they make any decisions and that those who are tested be counseled on the meaning and implications of the results.

Medical, legal, and correctional management issues

Correctional administrators responding to the challenging problem of AIDS in prisons and jails must balance medical considerations and medical advice against complex correctional management factors. Decisionmaking is further complicated by legal and cost concerns. The following section discusses these issues.

Medical issues. Perhaps the highest priority in the correctional response to AIDS is providing timely, professional, and compassionate medical care to inmates who become ill with the disease. As in society at large, prompt detection and diagnosis are needed to minimize spread of the disease and alleviate the suffering of patients.

Whether or not HTLV-III testing is used, appropriate diagnostic workups are necessary to identify immunosuppression, ARC, and AIDS. Also, certain tests may be able to detect early evidence of opportunistic infections typically seen in AIDS patients.

Careful surveillance and regular followup are extremely important for

patients with AIDS, ARC, and HTLV-III seropositivity, since life-threatening symptoms can develop very quickly. Because AIDS patients experience serious psychological as well as physical problems, counseling and support systems involving correctional staff and family members are also considered important components of care.

Correctional management issues.

Ironically, the medical treatment of AIDS patients may be the simplest issue confronting correctional administrators. Other questions—where to house and treat the inmate, how to prevent the spread of the disease, and how to pay for medical care—are likely to be even more difficult to resolve.

Housing policies. One of the most critical and difficult decisions for correctional administrators is where to house and treat inmates with AIDS, ARC, or HTLV-III seropositivity. Of course, medical considerations dictate many of these decisions. Most jurisdictions place inmates with confirmed diagnoses of AIDS in a medical facility either within the correctional system or in the community, although the duration of such hospitalization varies considerably.

Preventing the spread of AIDS within the prison and protecting affected inmates from intimidation and violence are important considerations. Other factors in treatment and housing decisions include availability and location of facilities able to provide appropriate care, costs of any new construction or renovations necessary to prepare special units, and staffing of any special AIDS units (correctional as well as medical).

Correctional administrators have a number of options concerning treatment and housing placements for inmates with AIDS, ARC, or HTLV-III seropositivity. The key options are the following:

1. maintaining inmates in the general population;
2. returning inmates to the general population when their illnesses are in remission;
3. administratively segregating inmates in a separate unit or relying on single-cell housing;

4. hospitalization; and

5. case-by-case determination of all housing and treatment decisions.

Exhibit 4 summarizes the housing policies of the responding systems. Two-thirds of the Federal and State systems, and 70 percent of responding city and county systems have written policies in place or in development for managing inmates with AIDS, ARC, and HTLV-III seropositivity.

Most jurisdictions hospitalize or administratively segregate at least some of the three AIDS-related inmate categories.

City and county jurisdictions are more likely to use segregation: 39 percent of responding city and county jail systems segregate all three AIDS-related inmate categories, as opposed to only 16 percent of State and Federal prison systems. Almost one-third of all responding systems have basic policies involving case-by-case determination of treatment and housing programs.

While Exhibit 4 indicates the wide variation in correctional policies on housing and treatment of inmates with AIDS, the four jurisdictions with almost 75 percent of the correctional AIDS cases (New York State, New York City, New Jersey, and Florida) all follow the same combination of policies:

1. medical segregation of AIDS patients, but no segregation of inmates with ARC or HTLV-III seropositivity;
2. careful evaluation and ongoing monitoring of inmates suspected of having ARC or AIDS;
3. no mass screening for antibody to HTLV-III; and
4. extensive staff and inmate educational programs.

All four of these systems report that equilibrium has been reached on the AIDS issue, with no widespread fear among staff or inmates regarding transmission of the virus within the institutions.

Precautionary measures. Correctional agencies have adopted a wide range of precautionary measures to control spread of AIDS within institutions; many are based on Centers for Disease

Exhibit 4

Summary of responding jurisdictions' housing policies^a for inmates with AIDS, ARC, and HTLV-III seropositivity

Policy combination	State/Federal prison systems		City/county jail systems	
	n	%	n	%
• Segregate AIDS cases; ARC cases and seropositives maintained in general population	3	6%	3	9%
• Segregate AIDS and ARC cases; seropositives maintained in general population	10	20	3	9
• Segregate all categories	8	16	13	41
• No segregation of any categories	2	4	0	0
• No policy	8	16	1	3
• Combinations involving case-by-case determination	16	31	10	30
• Other policy combinations	4	8	3	9
TOTAL	51	101% ^b	33	101% ^b

^aFor the purposes of this categorization, segregation means that the *basic* policy is to hospitalize (either within or outside the correctional system) or to segregate administratively the particular category of inmate, regardless of whether these inmates are returned to the general population when their symptoms subside. Single-celling is also included in segregation.

^bDue to rounding.

Control guidelines for clinical staff.¹ The CDC guidelines advise clinical and laboratory staff "to use the same precautions when caring for patients with AIDS as those used for patients with hepatitis-B virus infection...Specifically, patient-care and laboratory personnel should take precautions to avoid direct contact of skin or mucous membranes with blood, blood products, excretions, secretions, and tissues of persons judged likely to have AIDS."

Several physicians interviewed for this study believe that, since the AIDS virus is less hardy and more difficult to transmit than the hepatitis-B virus, precautions designed to prevent transmission of hepatitis-B should more than suffice to prevent transmission of AIDS.

Some correctional agencies have instituted precautionary measures which go far beyond those recommended by CDC. Many of these measures are designed to limit exposure under extremely unusual circumstances or to prevent exposure through casual contact. However, all evidence indicates that AIDS cannot be transmitted by a single exposure of any kind or through casual contact. This is a major theme in most AIDS education programs.

Precautionary measures addressing very rare or casual modes of contact, even if implemented in a good faith effort to reduce the fears of staff and inmates, may ultimately increase those fears by encouraging the view that the disease is spread by the very sort of unusual or casual contacts they seek to prevent. Such a conflict between educational messages and practical measures may not only increase fear within the institution, but also may foster suspicion of the correctional

¹CDC, *Morbidity and Mortality Weekly Report (MMWR)* 1982; 31:577-580; see also *MMWR* 1985; 34: 681-695.

system for, in effect, saying one thing about the transmission of AIDS but doing something else.

Notification and confidentiality.

One of the most difficult and sensitive issues regarding AIDS in corrections is who receives information on the medical status of inmates with AIDS, ARC, or HTLV-III seropositivity. Decisions regarding who should receive HTLV-III antibody test results and who should be notified of AIDS or ARC diagnoses may be dictated by precise legal and policy standards such as requirements for written authorization to release test results or other medical records.

Two-thirds of State and Federal prison systems and 91 percent of responding city and county jail systems have general or specific confidentiality policies covering AIDS-related medical information.

Some argue that decisions regarding disclosure versus confidentiality of medical information in cases of AIDS or ARC should be based solely on legal requirements—that is, no information should be reported to anyone unless it is required by law. This position is based on the premise that correctional systems should bear no greater responsibility for notification than do institutions in the community at large.

Where law or policy allows any discretion, decisions regarding disclosure versus confidentiality invariably raise the question of which should take precedence: the inmate's right to have medical information kept confidential or the correctional system's perceived legal and moral responsibility to protect its staff and other inmates, as well as the public, from HTLV-III infection.

There are valid claims on both sides. On the one hand are arguments that correctional staff have a right to know when they are dealing with inmates who may be infectious or who have a serious communicable disease, and that other inmates, spouses, or sexual partners have a right to know who may be carrying a sexually transmitted disease. Notification to public health departments and inmates' former and/or subsequent correctional systems may also be considered important to facilitate treatment, prevention measures, and contact tracing. Such disclo-

tures may also be designed to reduce or eliminate the correctional system's legal liability should a released or transferred inmate transmit AIDS to others.

On the other hand, the most compelling reason for maintaining confidentiality is that persons known to have AIDS, ARC, or HTLV-III seropositivity may suffer ostracism, threats, and possibly violent intimidation while in prison, and discrimination in employment, housing, and insurance availability after they are discharged.

Because of their rapid population turnover rates, jails face even more difficult policy decisions and logistical problems regarding disclosure and confidentiality of medical information.

The most notable study finding regarding disclosure is that a relatively small number of systems provide test results to inmates (31 percent of State and Federal systems and 52 percent of responding city and county systems). No State or Federal system and a small fraction of city-county systems (19 percent) disclose results to inmates *only*. Seventy percent of State and Federal systems and 61 percent of responding city and county systems provide results to medical staff.

No jurisdictions responding to the questionnaire specifically reported that spouses or sexual partners or previous correctional facilities of seropositive inmates are notified of test results.

Costs of care and associated services.

Questionnaire responses showed that correctional systems are almost universally concerned about the costs of medical care and associated services for inmates with AIDS. Questions regarding range of costs elicited widely varying estimates, but all agreed that medical care for AIDS patients is extremely expensive, whether it is provided in a correctional medical facility, in another public medical facility, or in a hospital in the community, particularly because correctional inmates are ineligible for Medicaid reimbursement.

Correctional systems should plan on spending anywhere from \$40,000 to over \$600,000 for hospitalization and associated medical costs of caring for

each inmate with AIDS.² The costs will vary depending on the amount of acute care required; they will also probably be higher if inmates are placed in hospitals in the community than if they are retained in correctional medical facilities or other public medical facilities.

To the figures for hospitalization and medical care must be added costs of ancillary services such as counseling, possible legal assistance, increased insurance (unless the system is self-insured), and funerals. Obviously, medical care and associated services for inmates with AIDS could have serious budgetary implications for correctional systems.

Legal issues. There is currently very little law specifically on correctional systems' policies regarding AIDS cases, though several cases have been filed in New York and other States. Otherwise, specific AIDS-related legal concerns remain largely hypothetical. Still, there is substantial caselaw on correctional medical care in general, which is important for administrators to consider in developing policies regarding AIDS.

Suits on the quality of correctional medical care³ may be brought on the basis of Federal constitutional standards, State law, or common law. There are three constitutional principles relevant to correctional medical care.

First, under the eighth amendment, inmates are entitled to a safe, decent, and humane environment.⁴ Second, in *Estelle v. Gamble*,⁵ "deliberate indifference to serious medical need" was held to violate the eighth amendment protection against "cruel and unusual punishment." Finally, the constitutional guarantee of "equal protection of the laws" applies to correctional medical care cases, and particularly to

²The low figure is from "Special Report: The AIDS Epidemic," *New England Journal of Medicine* 1985; 312:523; the high figure is based on 2 years at New York City's annual estimate of \$300,000 for patients requiring acute care.

³This discussion is based largely on the presentation of Clair Cripe, Esq., of the Federal Bureau of Prisons, at a meeting of Correctional Commissioners on AIDS, sponsored by the National Institute of Corrections, Atlanta, Georgia, November 6, 1985.

⁴See, e.g., *Rhodes v. Chapman*, 452 US 337 (1981).

⁵429 US 97 (1976).

cases involving AIDS inmates, because of the segregation issues.

Medical care in correctional institutions is usually governed by the same State laws (e.g., medical practice and nursing practice acts) that apply to care in the community at large. Finally, in some States, correctional medical care may be subject to suits for common law torts such as negligence. Medical malpractice suits are also a possibility.

Existing caselaw on AIDS in correctional facilities falls into the following three major categories:

1. Equal protection. Cases filed by inmates alleging denial of equal protection based solely on the fact that they had AIDS (e.g., *Cordero v. Coughlin*).⁶ This case was decided in favor of the correctional department.

2. Quality of care. Cases filed by inmates alleging inadequacies in

medical care and associated services (e.g., *Storms v. Coughlin*).⁷

3. Failure to protect others from AIDS. Cases filed by inmates and potentially also by staff alleging inadequate protective measures and seeking additional steps such as mass screening of inmates and segregation of inmates with AIDS, ARC, or HTLV-III seropositivity (e.g., *Mtr La Rocca v. Dalsheim*).⁸ The *La Rocca* case was decided in favor of the correctional department; other cases on these issues are still pending.

⁷*Storms v. Coughlin* was filed in U.S. District Court for the Southern District of New York. Some of the issues may be mooted by new State regulations, but the plaintiff's attorney believes that there are a number of important quality-of-care issues to litigate. See also *Thagard v. County of Cook*, unreported opinion: No. 85 C 4429 (N.D. Ill., May 20, 1985).

⁸120 Misc 2d 697 (N.Y. 1983). See also *Herring v. Keeney* (U.S.D.C., Oregon, filed September 17, 1985); *Sheppard v. Keeney* (U.S.D.C., Oregon, filed October 7, 1985); *Malport v. Keeney* (U.S.D.C., Oregon, filed October 11, 1985); *Telepo et al. v. Kean et al.* Civil Action 85-1742A (U.S.D.C., New Jersey, filed May 1985).

AIDS poses complex and difficult problems for correctional systems. The only certainty is that the problems will not disappear. Every correctional system should develop comprehensive policies and procedures for managing the AIDS problem in its institutions. The information provided here and in the full report can help correctional administrators consider the range of options available and the strengths and weaknesses of each.

Theodore M. Hammett was project director for Abt Associates, Inc., in the urgent 4-month study that led to this condensed report. To learn about availability of the full report, call the National Institute of Justice/NCJRS at 800-851-3420 and give the title and identifying number, NCJ 100126. (From Alaska, Maryland, and the Metropolitan Washington, D.C., area, call 301-251-5500.)

⁶607 F Supp 9 (S.D.N.Y., 1984)

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in reinfected patients; this hypothesis was made possible because, for the first time, a sufficiently large and well-matched population had been studied. Curiosities suggest strangeness; hypotheses indicate further research.

We agree with the need for further research on the many open points and on the newer agents, provided the benefits already shown are not artificially played down and put into question, and thus withheld from patients.

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GIANNI TOGNONI,
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SIR,—The GISSI team is to be congratulated on completing such a huge trial (11 806 patients) in only 17 months, although it is of some concern that 96 patients were lost to follow-up in a report of "hospital mortality". Hospital mortality was defined as 21 days, which is a very long time to keep patients in hospital after a myocardial infarction. In New Zealand hospital mortality might be defined as 7 day mortality. There is no universally accepted definition and I would make a plea for the term "early mortality" and for the use of actuarial analysis to compare survival throughout the period of study rather than at a fixed time which may have been chosen arbitrarily.

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HARVEY D. WHITE

VERTICAL TRANSMISSION OF HTLV-III

SIR,—Epidemiological data¹⁻³ and experimental observations^{4,5} indicate the possibility of transplacental and perinatal transmission of HTLV-III/LAV. However, the real extent of such transmissions, the stage of the pregnancy at which the risk is greatest, and the mechanism(s) involved are unclear. In Italy cases in children constitute an unusually high proportion of total AIDS cases,⁶ perhaps because of the large numbers of HTLV-III-positive individuals among heterosexual drug addicts as compared with homosexuals.⁷ We have preliminary observations from a sample of 12 babies with HTLV-III antibody positive mothers who have been followed up for 6–12 months after birth. In all cases HTLV-III antibody was sought by ELISA and confirmed by western blot.

Mothers 1 and 3–12 were drug addicts; mother 2 came from Zaire. They all showed significant immunological alterations and 5 mothers had AIDS-related conditions (ARC). Of the 7 babies delivered vaginally, 3 have become HTLV-III antibody positive by 6 months after birth and 1 has AIDS (age 21 months). We have not, however, observed any anti-HTLV-III positivity or opportunistic infections in the 5 babies delivered by caesarean section.

In cases 8, 11, and 12 caesarean section was recommended when analysis of amniotic fluid obtained by amniocentesis weeks at 24–27 (and, in case 12, of fetal blood in week 22) were found to be consistently anti-HTLV-III positive due to the presence of specific IgG of maternal origin. These samples were negative for specific IgM (western blot).

VERTICAL TRANSMISSION OF HTLV-III IN THREE CASES

Case	Maternal diagnosis	Anti-HTLV-III status of child
<i>Normal delivery</i>		
1	ARC	++
2	ARC	+
3	None	+
4	ARC	—
5	ARC	—
6	None	—
7	None	—
<i>Caesarean section</i>		
8	ARC	—
9	None	—
10	None	—
11	None	—
12	None	—

*AIDS.

These data confirm the importance of vertical transmission of HTLV-III which may happen whatever the antibody-positive mother's clinical status.³ Moreover, although few cases were studied, it may be that natural delivery represents a further risk of infection and that this should be taken into consideration in the prophylaxis of vertically transmitted HTLV-III.

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POTENTIAL SOURCE OF ERROR IN HTLV-III ANTIBODY TESTING

SIR,—The test kit for HTLV-III antibodies marketed by Wellcome Reagents ("Wellcozyme") is used by many regional transfusion centres for screening blood donors. The test is a competitive binding ELISA done in a 96-well microtitre plate; negative sera give high absorbance readings and positive sera give low readings. The plate consists of a frame into which are fitted strips of 8×2 round-bottomed wells coated with immobilised chemically inactivated antigen from cultured HTLV-III.

Early in our experience with this kit, and following the manufacturer's instructions strictly, we noticed that absorbance readings were consistently higher in the wells around the edges of the plate than in those in the centre, and this was especially striking in the corners of the plate. This was best observed when all 96 wells were filled with replicates of a known anti-HTLV-III positive serum. Although the positive control serum used to validate the test gave satisfactory results when placed in an inner well (mean absorbance 0.146), in 17 of 40 plates (43%) in which it was placed in an outer well the absorbance (mean 0.270) fell outside the manufacturer's criterion of having an A_{450} less than 25% of the mean value of two replicates of the negative control (mean 1.053).

Investigation of this "edge effect" eliminated as causes several possible variables (some of which have been alluded to elsewhere¹), including warm-up time of reagents, rate of addition of serum or reagents, effect of light on the substrate (3,3',5,5'-tetramethylbenzidine), use of deionised rather than distilled water, or a defective automatic plate washer or reader. Suspicion then focused on the incubation stage. The manufacturer supplies moulded heating blocks which are formed to the shape of the microtitre tray and which retain for extended periods the ambient temperature in which they are stored. These blocks are intended to be kept in an anhydric incubator at 45°C and the test plates are fitted upon them for the 1 h primary incubation period.

A plate was filled with 96 replicates of a positive serum and, after incubation at 45°C for 1 h, strip 1 (containing columns 1 and 2) was interchanged with strip 4 (containing columns 7 and 8) and the test was then allowed to proceed as usual. The edge effect moved with column 1 (fig 1), thus clearly relating it to the incubation phase.

Subsequent tests were done with complete plates (ie, strips of wells within a frame) placed directly on the shelf of an anhydric incubator; with strips placed on the heating blocks without the retaining plastic frame, and either touching one another (as when in the frame) or separated by a substantial air space; and with the plates in a water bath at 45°C, the level of water being kept below 8 mm so that the plates did not become flooded.

Draft No.1

Prepared by Dooley Worth Ph.D. & Don Lorimer

Prepared for The Lower East Side AIDS Task Force

June 1986

WOMEN AND AIDS IN NEW YORK CITY

Within the next two years AIDS will be the leading cause of death for all women of child-bearing age in New York City. AIDS is now the leading cause of death for females between the ages of ~~30-39~~ 25-29 in New York City.

Although there has been extensive information made available on how AIDS is transmitted, most women do not realize they may be at risk of contracting and developing AIDS. Those most at risk are the most poorly informed. The AIDS mortality rate among Black and Hispanic women is four times that among White women. Further, a Gallop Poll conducted for the NYC DOH last year showed that only a small number of teenage women in New York City understood that they could "catch" AIDS by having sex with their boy friends.

FEMALE AIDS CASES

In June 1982 there were 13 female AIDS cases New York City (5.4% of all AIDS cases). By May 28th of this year there were 633 (10% of all AIDS cases). If cases continue to double every year as they have been, we can expect as many as 2,500 female AIDS cases within the next two years. If estimates that there are 5 ARC patients for each AIDS patient are correct, there will be close to 8,000 women in New York with serious AIDS related illnesses. Additionally, tens of thousands of women will be infected with the HTLV-III virus.

Female AIDS Cases By Risk Group NYC 5/28/86

IV Users	<u>Sexual Partners</u>	Blood Transfusions	Other*
58% (368)	20% (126)	3% (21)	16% (93)

*Includes: hemophilia (1), no known risk factor (19), risk factor not discernable (19), under investigation (25), and from countries where most AIDS cases have no known risk (29).

WOMEN WITH BISEXUAL OR IV DRUG USING SEX PARTNERS

To date the emphasis in AIDS education has been placed primarily on reaching IV drug using women. This has resulted in underplaying the risk of women acquiring the disease through sexual contact. The percentage of women who have contracted AIDS sexually has risen sharply, from 11% of all female cases in 1984 to 20% in 1986. The percentage of infected female sex partners of bi-sexuals may now be as high as 20%.

A San Francisco study of bi-sexual men conducted earlier this year predicted that the potential existed in San Francisco for an epidemic spread of the HTLV-III virus among women with bisexual sex partners. The same potential exists in New York, where in addition to women at high-risk of exposure through bi-sexual males, there are even more women at risk who are the sexual partners of men with a history of IV drug use, including released prisoners who have been exposed to the HTLV-III virus in prison through sharing of needles or male/male sex.

There is indication that some women are becoming aware of their risk. Over the last several months there has been a significant increase in the number of women who are calling the New York City Department of Health HTLV-III Hotline (they made up 28% of all calls in the last month). The women calling are seeking AIDS counseling, testing or support. These women realize they are at risk, however, many other women are unaware they are at risk because their sexual partners are bi-sexual or IV drug users. A continuing effort is required to reach and educate these women on risk-reduction.

It is interesting to note that of the 126 female AIDS cases contracted from sexual partners, only 9 have been attributed to bi-sexual men. We do not know if this is the result of under reporting due to a desire to protect families, or whether there are other significant factors which account for the low number of bi-sexually transmitted cases.

WOMEN IV DRUG USERS

New York has a growing population of female IV drug users (approximately 50,000 according to the New York State Division of Substance Abuse).

Most risk reduction programs have focused on this group. Between 50 to 80% of females IV drug users are believed to already be HTLV-III positive. Most of these women (who are in their thirties) are of child-bearing age.

✓ Female AIDS cases related to IV use are predominantly found among young Hispanics and Blacks. Most are introduced to drugs by their sex partners. They require treatment for not just for AIDS and ARC but for their drug use. However, the denial surrounding drug use, AIDS, and its sexual transmission is a obstacle to getting women into treatment and to helping them accept their and their family's risk. Educational efforts in the communities in which the majority of these women live have been inadequate to address these problems. Furthermore, many women lack the support systems necessary to make the changes that would protect them.

The following chart indicates which groups of women are most at risk.

Female AIDS Mortalities Rates By Ethnic Group and Age NYC 1985
[per 100,000]

Age Group	Black	Hispanic	White
15-24	2.2	4.0	0.4
25-44	20.2	15.7	3.6
45-64	2.2	1.6	0.4

Presently we are seeing the highest incidence among women between the ages of 25 and 34. However, because of the long latency period associated with the disease most, teenagers who contract the disease may not be diagnosed until they are in their twenties or thirties.

Female Mortality Rates By Age Group NYC 1985
[per 100,000]

Ages 15-19		Ages 20-24	
Homicide	4.2	Homicide	10.2
Cancer	3.2	Cancer	8.1
AIDS	1.4	Suicide	6.2
Drugs	1.4	Heart	3.7
Suicide	1.4	Accidents	3.4
		AIDS	2.4
Ages 25-29		Ages 30-34	
AIDS	15.1	Cancer	25.9
Cancer	13.2	AIDS	20.9
Homicide	10.2	Cirrhosis	14.9
Suicide	7.5	Drugs	13.3
Drugs	7.5	Suicide	12.0

PEDIATRIC AIDS

The number of pediatric AIDS cases in New York City has grown from 3 in 1977 (when the HTLV-III virus was first present) to 127 in 1986. One to two new pediatric AIDS cases per week are currently being reported to the DOH, an increase over the past year when the DOH received reports of two to three per month.

The number of pediatric AIDS cases in NYC corresponds to the number of female AIDS cases (the ratio is 6/1 [633/127]). The incidence of pediatric AIDS appears to follow that of female AIDS by a year or two. Eighty percent of NYC pediatric AIDS cases are due to their parents IV drug use. Of this number 70% of mothers are IV drug users.

There are an estimated 3000-5000 women in high risk groups who give birth every year. Approximately fifty percent of these women are thought to be infected with the HTLV-III virus. Investigators believe (based on very preliminary data) that 15-30% of these women will deliver an infected infant. The remaining two-thirds of their children could become asymptomatic carriers of the virus, possibly for a lifetime. This means they would have the ability to infect others as they become sexually active or share needles later in life.

The total number of pediatric AIDS cases as of May 28, 1986 was 127. However, in the coming year, the number of HTLV-III infected children is expected to climb to 250-750. Some experts have predicted that the number will be closer to 1000. At least 1/3 of these children are expected to develop AIDS over the next two years. The remaining 2/3's will develop AIDS related symptoms, ARC (some may remain asymptomatic). This roughly corresponds with the expectation that for every pediatric AIDS case which fits the CDC definition there are 2-3 pediatric ARC cases). Of the children who develop ARC, 20-25% are expected to go on to develop AIDS within two years.

Pediatric AIDS Cases By Risk Group NYC 5/1986

Drug Use Both Parents	Drug Use Mother	Drug Use Father	Mother Sex Partner IV	Mother Bi-Sex Partner	Oth.*
26%	41%	12%	2%	1%	18%

*Other includes, blood products (6%), Hemophilia (1%), parents from country/risk not known (5%), risk not discernable (6%).

Pediatric AIDS Cases Maternally Transmitted
Ethnic Breakdown NYC 1986

Black	Hispanic	White
60%	32%	8%

Pediatric AIDS Cases By Borough
NYC 1986

Bronx	Manhattan	Brooklyn	Queens
33%	28%	20%	12%

FAMILIES WITH AIDS

Health care and social service providers have noted a sudden increase in entire families (mother, father and newborns) with AIDS or ARC. Increasingly cases where both parents have died leaving seriously ill younger children and older siblings (who are healthy) are being reported. A multi-disciplinary effort is required to address the needs of such families.

Forty percent of persons who come down with AIDS will spend more than 50% of their time in the hospital. Furthermore, 14% of AIDS patients die during their first hospitalization (at St. Luke's/Roosevelt Hospital [which treats many IV AIDS cases] the percentage is as high as 33%). Female AIDS and ARC cases make up 22% of the current Visiting Nurse Service AIDS home care caseload. Who cares for the children of women hospitalized with AIDS, or those at home that are too sick to cope? What happens to the families with multiple AIDS or ARC cases?

TEENAGE AIDS

This is a problem waiting to happen. Currently, there have only been 30 cases of teenage AIDS in New York, however, the mix of sexually active females with drug using males who may experiment sexually and share needles to economize is a lethal one.

An AIDS education program incorporating sex education which explains AIDS transmission is needed to protect teenage females who are at risk of contracting the disease both through their sexual partners and through IV drug use.

Because of the long latency period associated with AIDS it is becoming apparent that teenagers must be reached and educated before they start experimenting with sex and drugs if we intend to effectively contain the spread of this disease.

WHAT IS NEEDED

WOMEN ARE THE UNACKNOWLEDGED AT RISK GROUP. THEY HAVE NOT BEEN INFORMED OF THE DANGER TO THEMSELVES AND THEIR CHILDREN. ON THE WHOLE, FEW ARE TAKING PRECAUTIONS TO PREVENT AIDS.

IF EFFECTIVE EDUCATION DOES NOT REACH THIS AT RISK GROUP QUICKLY THOUSANDS OF WOMEN AND CHILDREN WILL DIE AS A RESULT.

There is an urgent need for:

1. A \$1 million radio and TV campaign to be developed by the NYC Department of Health to reach minorities and those who do not read; this includes a radio campaign carried on minority stations targeting female teenagers, and the danger of sexual transmission.
2. \$1 million to set up on-going community-based support and education groups for those exposed and infected with HTLV-III/LAV, those who are sick and their support networks. Special programs should be provided for women at risk.
3. An increase in the number of drug treatment slots [equal to demand], in other words any IV users who wants to enter treatment should be able to do so immediately. For the state to do less is to accept responsibility for deaths which result from a lack of treatment availability. Treatment must include detox, methadone maintenance, drug free, and alternative methods.
4. Specific DRG [Diagnostic Related Group] reimbursement for AIDS and ARC which reflects the true cost of hospitalization and diagnostic workup for these groups. All hospitals both voluntary and municipal should continue to accept patients with AIDS and ARC within their catchment areas using empty beds. The state should approve this use immediately.
5. Improved social services for people with AIDS or ARC greatly reduces hospital costs. Case driven management is the most effective means of providing these services as shown by the Protective Services for Adults Program at HRA. The HRA AIDS Program should also utilize case driven management. The ratio of caseworker to client in the program should be no more than 1/25.
6. Foster care for surviving children of women who die of AIDS, family oriented primary care that incorporates health education [including AIDS risk reduction], psychiatric care, and home care for families with AIDS.

7. For appropriate housing and housing subsidies to be made available. It has been estimated by HRA that there are at least 400 people with AIDS who are homeless. All NYC hospitals with AIDS patients are holding patients in acute care at approximately a \$1000/day because they have no place to which they can be discharged. Further, it is a well known, but unpublicized fact that there are over 100 persons with AIDS living in congregate shelters.
8. Nursing home beds to be made available to all those who need them. No nursing home in NYC has accepted AIDS patients, which represents discrimination based on disability.
9. Specific funds to be allocated for parenting, sex and drug education programs in elementary junior high school and high schools that explain AIDS transmission and risk reduction.
10. Comprehensive pediatric services throughout the city to be funded through HHC, and HRA.
11. AIDS transmission and risk reduction education for all persons incarcerated by the NYC Department of Corrections, which emphasizes the risk to their sexual partners and children.
12. An additional \$1 million for the NYC Department of Mental Health to expand its AIDS related counseling programs and to continue its staff training program for mental health facilities.

The cost of addressing this issue now is minuscule compared to the projected cost of treating an increasing number of men, women and children with AIDS in the next five years. NYC expects to spend \$148 million treating AIDS patients in 1986. By 1989 it is expected that \$500 million (NYC estimate) to \$1.3 billion (NYS estimate) will be needed to treat NYC AIDS patients. The current cost of treating AIDS patients in a NYC Health and Hospital Corporation facility (which are receiving most IV cases who have no health insurance), is \$125,000.

It is not too late to prevent an epidemic spread of HTLV-III infection among women and children in New York City.