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Briefing on CDC'S [Centers for Disease Control] Campaign, 12/21/93

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Clinton Presidential Records

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**PLEASE READ BEFORE
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Day: Tuesday
Date: December 21, 1993
Time: 10:30-11:30 AM
Location: Secretary's Conf. Room
Subject: Briefing on CDC's Prevention
Campaign

**PHOTOCOPY
PRESERVATION**

Ogilvy & Mather

One Midtown Plaza, 1360 Peachtree Street, Atlanta, Georgia 30309
Telephone: (404) 888-5100 • Telex: 542452

Memorandum

Date: October 20, 1993

From: Deanna Miller

To: Kristine Gebbie
John Gurrola

cc: S. Gainous
T. Gentile
K. Schlesinger

CDC & P Prevention Marketing Plan PSA Materials

Per your request for the APHA conference on Friday, October 22, we have provided a slide from the Prevention Marketing Plan English public service announcement "Automatic" that we are currently producing.

I hope this slide will be of help during your presentation.

Thank you!

Deanna Miller



Morbidity & Mortality Weekly Report: The Effectiveness of Condoms

UPDATE



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
and Prevention (CDC)
Atlanta, Georgia 30333

**PHOTOCOPY
PRESERVATION**



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

Dear Colleague:

On August 6, 1993 the Centers for Disease Control and Prevention (CDC) released a *Morbidity and Mortality Weekly Report (MMWR)* containing an article about condom effectiveness. This article was co-authored by CDC, the Food and Drug Administration (FDA), and the National Institutes of Health (NIH), and updates the 1988 *MMWR* article on the same subject.

As advocates of public health, we have a responsibility to promote HIV prevention through factual disclosure of information using the best science available. The joint efforts of CDC, FDA, and NIH have provided compelling evidence that further substantiates our earlier findings and recommendations about condom effectiveness.

Enclosed is an information kit designed to update you about recent scientific findings on condom effectiveness. This material and information may help in your efforts to inform the public and prevent new sexually transmitted diseases and human immunodeficiency virus infections in your state and local communities.

A referral list is included in the information kit. If you need additional information or clarification, please do not hesitate to contact the CDC programs listed.

Sincerely yours,

A handwritten signature in black ink, which appears to read "James W. Curran", is written over the typed name.

James W. Curran, M.D., M.P.H.
Assistant Surgeon General
Associate Director for HIV/AIDS

Enclosure

CDC HIV/AIDS PREVENTION

CENTERS FOR DISEASE CONTROL AND PREVENTION

Facts about

Condoms and Their Use in Preventing HIV Infection and Other STDs

With more than 1 million Americans infected with HIV, most of them through sexual transmission, and an estimated 12 million other sexually transmitted diseases occurring each year in the United States, effective strategies for preventing these diseases are critical.

The proper and consistent use of latex condoms when engaging in sexual intercourse—vaginal, anal, or oral—can greatly reduce a person's risk of acquiring or transmitting STDs, including HIV infection. In fact, *recent studies provide compelling evidence that latex condoms are highly effective in protecting against HIV infection when used properly for every act of intercourse.*

Latex condoms are highly effective when used consistently and correctly—new studies provide additional evidence that condoms work

As these studies indicate, condoms must be used *consistently and correctly* to provide maximum protection. *Consistent use* means using a condom from start to finish with each act of intercourse. *Correct condom use* should include the following steps:

- Use a new condom for each act of intercourse.
- Put on the condom as soon as erection occurs and before any sexual contact (vaginal, anal, or oral).
- Hold the tip of the condom and unroll it onto the erect penis, leaving space at the tip of the condom, yet ensuring that no air is trapped in the condom's tip.
- Adequate lubrication is important, but use only water-based lubricants, such as glycerine or lubricating jellies (which can be purchased at any pharmacy). Oil-based lubricants, such as petroleum jelly, cold cream, hand lotion, or baby oil, can weaken the condom.
- Withdraw from the partner immediately after ejaculation, holding the condom firmly to keep it from slipping off.

The protection that proper use of latex condoms provides against HIV transmission is most evident from studies of couples in which one member is infected with HIV and the other is not, i.e., "discordant couples." In a study of discordant couples in Europe, among 123 couples who reported *consistent* condom use, *none* of the uninfected partners became infected. In contrast, among the 122 couples who used condoms *inconsistently*, 12 of the uninfected partners became infected.

Myths About Condoms

There continues to be misinformation and misunderstanding about condom effectiveness. The Centers for Disease Control and Prevention (CDC) provides the following updated information to address some common myths about condoms. This information is based on findings from recent epidemiologic, laboratory, and clinical studies.

► *Myth #1: Condoms don't work*

Some persons have expressed concern about studies that report failure rates among couples using condoms for pregnancy prevention. Analysis of these studies indicates that the large range of efficacy rates is related to incorrect or inconsistent use. The fact is: latex condoms are highly effective for pregnancy prevention, but only when they are used properly. Research indicates that only 30 to 60 percent of men who claim to use condoms for contraception actually use them for every act of intercourse. Further, even people who use condoms every time may not use them correctly. Incorrect use contributes to the possibility that the condom could leak from the base or break.

► *Myth #2: HIV can pass through condoms*

A commonly held misperception is that latex condoms contain "holes" that allow passage of HIV. Although this may be true for natural membrane condoms, laboratory studies show that intact latex condoms provide a continuous barrier to microorganisms, including HIV, as well as sperm.

► *Myth #3: Condoms frequently break*

Another area of concern expressed by some is about the quality of latex condoms. Condoms are classified as medical devices and are regulated by the FDA. Every latex condom manufactured in the United States is tested for defects before it is packaged. During the manufacturing process, condoms are double-dipped in latex and undergo stringent quality control procedures. Several studies clearly show that condom breakage rates in this country are less than 2 percent. Most of the breakage is due to incorrect usage rather than poor condom quality. Using oil-based lubricants can weaken latex, causing the condom to break. In addition, condoms can be weakened by exposure to heat or sunlight or by age, or they can be torn by teeth or fingernails.

Preventing HIV Infection and Other STDs

Recommended Prevention Strategies

Abstaining from sexual activity is the most effective HIV prevention strategy. However, for individuals who choose to be sexually active, the following are highly effective:

- Engaging in sexual activities that do not involve vaginal, anal, or oral intercourse
- Having intercourse only with one uninfected partner
- Using latex condoms correctly from start to finish with each act of intercourse

Other HIV Prevention Strategies

► Condoms for Women

The FDA recently approved a female condom, which will soon be available in the United States. A limited study of this condom as a contraceptive indicates a failure rate of about 26 percent in 1 year. Although laboratory studies indicate that the device serves as a mechanical barrier to viruses, further clinical research is necessary to determine its effectiveness in preventing transmission of HIV.

► Spermicides

The role of spermicides in preventing HIV infection is uncertain. Condoms lubricated with spermicides are not likely to be more effective than condoms used with other water-based lubricants. Spermicides added to the tip of the condom are also not likely to add protection against HIV.

Making Responsible Choices

In summary, sexually transmitted diseases, including HIV infection, are preventable, and individuals have several responsible prevention strategies to choose from. But the effectiveness of each one depends largely on the individual. Those who practice abstinence as a prevention strategy will find it effective only if they always abstain. Similarly, those who choose any of the other recommended prevention strategies, including condoms, will find them highly effective if used correctly and consistently.

For further information, contact:

CDC National AIDS Hotline: 1-800-342-AIDS
Spanish: 1-800-344-7432
Deaf: 1-800-243-7889

CDC National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20849-6003

Man-To-Woman Sexual Transmission of HIV: Longitudinal Study of 343 Steady Partners of Infected Men

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Summary: To study incidence and risk factors of heterosexually transmitted HIV infection, we followed a cohort of 343 seronegative women, stable, monogamous partners of infected men whose only risk of acquiring HIV was sexual exposure to the infected partner. Nineteen seroconversions occurred in 529.6 person years (py) of observation, yielding an incidence rate of 3.6 per 100 py. The incidence rate was 7.2 per 100 py among women who did not always use or never used condoms and 1.1 among those who always used them [relative risk (RR) 6.6, 95% confidence interval (CI) 1.9–21.9]. Anal sex was associated with a risk increase in only those women not always using condoms (RR 1.4, 95% CI 0.4–4.8). No seroconversions were observed among 22 women using oral contraceptives. One of the women using intrauterine devices seroconverted. In couples who did not always use condoms, seroconversions occurred more frequently in partners of men with symptomatic diseases, with a low CD4+ cell number (<400 per mm^3) or with a detectable p24 antigen. In couples not always using condoms and where the man had a low CD4+ cell count, the joint presence of blood viral antigens and AIDS symptoms conditioned a fivefold increased risk of seroconversion of the woman (RR 5.4, CI 1.4–20.3). At multivariate analysis, women with longer relationships (≥ 1 year) showed a lower risk of seroconversion (RR 0.3, CI 0.1–0.8), and those partners of men positive for p24 antigen in serum had an increased risk of seroconversion (RR = 4.0, CI 0.1–0.8). **Key Words:** Heterosexually transmitted HIV—Seroconversion—Risk factors.

Several cross-sectional studies on heterosexual HIV transmission have been conducted on steady partners of infected men (1–11) and on prostitutes

or women with multiple partners (12–18). These surveys consistently showed a protective role of condom use (9,11–15) and a risk associated with anal sex (11,19), but they also reported different prevalence rates (15–50%) and inconsistencies in other potential risk factors. Most studies failed to show any relationship between infection and duration or frequency of sexual exposure (9,11,20). It

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remained unclear whether sexually transmitted diseases (STDs) or genital infections, signs of HIV infection or factors that enhance the transmission of the virus, are indicators of high-risk sexual behavior (11,16,21,22). Different results were reported on the infectiousness of the infected partner, since only few studies found a direct relationship between stage of HIV disease and risk of transmission (3,23).

In cross-sectional studies it is generally impossible to quantify the duration of exposure of the unaffected partner. In fact, the duration of infectivity of the index case is generally unknown, and the date of transmission from the index case to his/her partner cannot be retrospectively assessed. The risk of transmission and the role of potential cofactors can be better detected by longitudinal studies on stable, monogamous couples discordant for HIV. In these couples the duration of exposure is a controlled factor, and the possibility of biases related to the presence of multiple partners is lessened. However, these couples are expected to have a low rate of seroconversion because of personal and media counseling (24), and a large group must be followed up to provide reliable estimates.

We have previously reported the results of a cross-sectional study of 364 women whose only exposure to HIV was sexual intercourse with an HIV-infected man (25). We have continued to follow those couples who were discordant for HIV infection to determine the incidence and risk factors for man-to-woman sexual transmission.

METHODS

The couples were recruited in 16 participating centers: eight hospital departments of infectious diseases, five intravenous drug user outpatient clinics, and three centers for HIV surveillance. All of the HIV-infected subjects attending the centers (who were or had previously been intravenous drug users or recipients of blood or blood derivatives as well as men reporting homosexual contacts) were asked about their steady heterosexual partners. Each partner who was not already known to be HIV-infected was invited for an interview and screening tests. The presence of serum antibodies against HIV was assessed by immunoenzymatic methods using commercially available kits. Positive sera were tested again with a second immunoenzymatic test and confirmed by Western blot. Seroconversion was defined as the development of a positive ELISA test and Western blot according to international criteria. Information on intravenous drug use, sexual intercourse with other subjects at risk, blood transfusions or blood-derivative therapies, and prostitution was collected in order to exclude subjects with risk factors other than sexual exposure to their infected partner.

Between February 1, 1987, and May 30, 1991, 368 women seronegative at the first visit were asked to return to the center

at least every 6 months for interview and to repeat the HIV antibody test. Of these women, 343 (98.2%) came for at least one follow-up visit and were included in this study.

At each visit a structured interview was administered to the woman by the attending physician. The questionnaire elicited information about history of STDs, frequency and type of sexual intercourse, and contraceptive methods used since the last follow-up visit. The last available questionnaire and the man's concurrent status were used for the analysis.

Ethical Considerations

Men and women were separately advised on risk and prevention of sexual HIV transmission by the same physician. The use of condoms was strongly and repeatedly recommended. Since the results of the cross-sectional study suggested an increased risk of HIV infection for women using intrauterine devices (IUDs), it was suggested that they have the device removed.

Analysis

Incidence of seroconversion was evaluated by the person-year method, and seroconversion rates were derived (26). The time of seroconversion was conventionally considered as the midpoint between the first seropositive and the last seronegative test. Relative risks (RR) were estimated as incidence rate ratios, and confidence intervals (CI) of the relative risks were calculated with Wolff's method (27,28).

For the study of risk factors, frequency of intercourse was divided into two categories: twice a week or less and more than twice a week. The type of sexual intercourse was dichotomized as ever or never anal. Condom use was grouped into three frequency categories: always, not always, and never. A history of STDs was never reported. The only reported genital disease was vaginitis (diagnosed by a physician or described as vaginal discharges). The last available information on the infected partner (CD4⁺ cell count, disease stage, p24 antigen serum positivity) was collected from the standard medical records used by all centers. Men were classified according to disease stage into symptomatic (CDC group IV) and asymptomatic (CDC groups II and III).

Condom use prevents the contact of infected semen with genital mucosa and is expected to act as an effective modifier of other risk factors. For this reason two analyses were carried out, separately for women always using seropositives (consistent use) and not always or never using condoms (not consistent use).

A multivariate analysis using Cox's proportional hazard model was carried out, including all the variables considered as potential risk factors for transmission, to estimate the independent contribution of each variable to the risk of infection.

RESULTS

The general and clinical characteristics of the 343 couples included in the study are shown in Table 1. The couples had a mean duration of their relationship of ~4 years, and the women were mainly between 20 and 30 years old (Table 1). Most men acquired the infection through intravenous drug use

TABLE 1. General and clinical characteristics of the women and of the infected men

Mean duration (months) of the relationship at enrollment (range)	44.3 (1-134)
Mean age (years) of the women (range)	25.5 (15-51)
Mean CD4 ⁺ cell number per mm ³ of the men (range)	134 (10-1,346)
Men with AIDS	47 (13.7%)
Men treated with zidovudine	92 (26.8%)
Man's method of infection	
intravenous drug use	270 (78.7%)
other	73 (21.3%)
Mean follow-up time (months) to seroconversion of the women (range)	14.1 (2-36)

(78.7%). Forty-seven men (13.7%) had a symptomatic infection, four became symptomatic during follow-up, 92 (26.8%) were treated with zidovudine. Nineteen women seroconverted after a mean time from inclusion of 14.1 months. The first seroconversion was observed 2 months after inclusion and the last one after 3 years.

Risk of Seroconversion and Condom Use

The 343 women who had at least one follow-up visit made up a total of 529.6 person years (py) of observation. The median follow-up was 24 months (range 1-55). The incidence rate based on the 19 observed seroconversions was 3.6 per 100 py. Thirty-eight women, followed for a total of 41.7 py altogether suspended sexual intercourse with their infected partners at or just before the time of enrollment: no seroconversions occurred in this group, which was excluded from further analyses. Among the remaining 305 women, the yearly seroconversion rate was 3.9%.

Three seroconversions were noted among couples always using condoms (Table 2), and most seroconversions (16/19, 84%) occurred in couples never or not always using this device. The risk of infection was increased sixfold among women with nonconsistent use of condoms (never or not always) (RR 6.4, CI 1.9-21.9).

TABLE 2. Incidence rates (IR) and relative risks (RR) of seroconversion by condom use

Condom use	N	py ^b	HIV ⁺	IR	RR (95% CI) ^a
Never	79	139.3	8	5.7	1
Not always	55	82.5	8	9.7	1.7 (0.6-4.5)
Always	171	266.0	3	1.1	0.2 (0.1-0.7)

^a 95% confidence interval.

^b Person years at risk of acquiring the infection.

Relationship Length, Sexual Behavior, and Vaginitis

Women who had, at the time of inclusion, been in their relationships ≤ 1 year had a higher incidence of seroconversion when compared with women with longer relationships (Table 3). This finding was observed in both groups of condom use. In the group with nonconsistent condom use, a small and not statistically significant risk increase was seen for higher frequencies of sexual intercourse and for a history of vaginitis. In the same group, anal sex was associated with a 40% risk increase that did not reach statistical significance.

Twenty-two women used oral contraceptives (11 in association with condoms), and none of them seroconverted. Despite counseling two women continued to use intrauterine devices, and the one who did not use condoms seroconverted.

Man's Disease Stage, CD4⁺ Cell Count, and p24 Antigen Positivity

Women in the group of nonconsistent condom use had incidence rates about three times higher when exposed to symptomatic partners or those with low CD4⁺ cell count (Table 4). A detectable p24 antigen in the man was associated with increased risks both in condom users and nonusers.

Analysis of Couples with Inconsistent Use of Condoms and Where the Man Has a Low CD4⁺ Cell Number

Since a low CD4⁺ cell number and the presence of detectable HIV-1 antigens in blood are frequently associated with advanced stages of disease, we focused the analysis on 87 couples with nonconsistent use of condoms and where the infected man had a CD4⁺ cell count <400 . As shown in Table 4, this subgroup was 28.5% of the entire population but contributed to 14 of 19 (73.7%) of the observed seroconversions (incidence rate 9.3 per 100 py). Taking partners of men asymptomatic and negative to HIV antigen (incidence rate 4.7 per 100 py) as the reference category, the incidence was about three times higher among partners of symptomatic or antigen-positive men (12.4 and 13.3, respectively, per 100 py). The joint presence of the antigen and of symptoms of AIDS had an additive effect on the incidence rate of seroconversion of the woman (25.2 per 100 py).

TABLE 3. Incidence rates (IR) and relative risks (RR) of seroconversion by relationship duration, sexual behavior, history of vaginitis, and oral contraceptive use

Variables	Condom use									
	Not always-never					Always				
	N	py ^a	HIV ⁺	IR	RR (95% CI) ^b	N	py ^a	HIV ⁺	IR	RR (95% CI) ^b
Relationship length										
≤1 yr	33	39.2	4	10.2	1	26	40.5	3	7.4	1
>1 yr	101	181.8	12	6.6	0.7 (0.2-2.0)	145	225.4	0	0	0
Frequency of intercourse										
<2 weeks	74	129.3	9	6.7	1	100	159.4	1	0.6	1
>2 weeks	60	92.6	7	7.6	1.1 (0.4-2.9)	71	106.6	2	1.9	3.0 (0.3-32.9)
Anal intercourse										
No	113	189.8	13	6.9	1	159	246.1	3	1.2	1
Yes	21	32.1	3	9.3	1.4 (0.4-4.8)	12	20.0	0	0	0
Vaginitis										
No	123	200.2	14	7.0	1	162	246.5	3	1.2	1
Yes	11	21.6	2	9.2	1.3 (0.3-5.8)	9	19.6	0	0	0
Oral contraceptive use										
No	123	203.7	16	7.9	1	160	251.0	3	1.2	1
Yes	11	18.1	0	0	0	11	15.0	0	0	0

^a Person years at risk of acquiring the infection.^b 95% confidence interval.

Multivariate Analysis

The use of condoms during all sexual intercourse was associated with a 90% risk reduction. Women with relationships lasting >1 year had a 70% statistically significant risk reduction. A low and nonsignificant risk increase was found for women reporting intercourse two or more times weekly and for those practicing anal sex. Among the indicators of a partner's infectiousness, the increased risk of infection in female partners of men positive for HIV p24 was higher than in univariate analysis (RR 4.0, CI 1.2-13.3). A borderline statistically significant risk increase remained for female partners of symptomatic men.

DISCUSSION

The results of this study confirm in a prospective setting the protective effect of condom use. The annual seroconversion rate was 5.7% and 9.7%, respectively, in couples never or not always using condoms and was reduced to 1.1% in those who always used this device. Inconsistent use of condoms, in this study, had no effect on the risk of acquiring the infection, since no significant difference was noted between those never or not always using condoms.

Condom use reduced so dramatically the number of seroconversions that the role of many reported risk factors was not recognizable in the group of

TABLE 4. Incidence rates (IR) and relative risks (RR) of seroconversion by characteristics of the infected man

Variables	Condom use									
	Not always-never					Always				
	N	py ^a	HIV ⁺	IR	RR (95% CI) ^b	N	py ^a	HIV ⁺	IR	RR (95% CI) ^b
Disease stage										
Asymptomatic	97	160.7	7	4.4	1	122	190.9	2	1.1	1
Symptomatic	37	61.1	9	14.7	3.4 (1.3-9.1)	39	75.2	1	1.3	1.2 (0.1-14.0)
Viral p24 antigen										
Negative	117	200.9	12	6.0	1	147	233.3	2	0.9	1
Positive	17	30.0	4	13.3	2.2 (0.7-6.9)	24	32.4	1	3.1	3.4 (0.4-40.0)
CD4 ⁺ per mm ³										
>400	47	72.1	2	2.7	1	77	120.6	3	2.5	1
≤400	87	149.8	14	9.4	3.4 (0.8-14.8)	94	145.5	0	0	0

^a Person years at risk of acquiring the infection.^b 95% confidence interval.

TABLE 5. Incidence rates (IR) and relative risks (RR) of seroconversion of female sexual partners of men with CD4⁺ counts <400 per mm³ not using condoms

Characteristics	N	py ^a	HIV ⁺	IR	RR (95% CI) ^b
Asymptomatic, p24 antigen negative	47	84.6	4	4.7	1
Symptomatic, p24 antigen negative	6	8.1	1	12.4	2.6 (0.3-23.3)
Asymptomatic, p24 antigen positive	25	45.2	6	13.3	2.8 (0.8-10.0)
Symptomatic, p24 antigen positive	9	11.9	3	25.2	5.4 (1.2-23.8)

^a Person years at risk of acquiring the infection.

^b 95% confidence interval.

women who always used them. In couples with inconsistent use of condoms we have found a high infectiousness of partners with symptomatic disease or those positive to p24 antigen. Furthermore, when the man had a CD4⁺ cell count <400 cells per mm³, the concurrent presence of symptoms of disease and of p24 antigen in serum carried an additive effect on incidence. Based on the incidence estimates of this study, one-quarter of the women not using condoms who are partners of symptomatic men positive to p24 antigen and with a CD4⁺ cell count of ≤400 are expected to seroconvert in 1 year of sexual exposure. This result suggests that counseling must be an ongoing process. In fact, the reduction of CD4⁺ cells, symptoms of AIDS, and p24 antigenemia are signs of disease progression, and over time all infected subjects are expected to increase their infectiousness in parallel with the evolution of the disease.

Women seronegative at the time of inclusion after long-standing relationships (>1 year) with an infected man had 70% less risk of seroconversion. Some women might carry latent infections that do not express antibodies (29); in this case, an imbalance in their number between the two groups with shorter and longer relationships could explain the difference in the risk observed in this study. However, asymptomatic carriers have been described to be rare, and even their existence has been questioned (30-32). On the other hand, women still seronegative after long-standing relationships with infected men might represent a subpopulation with less susceptibility to infection. A lower susceptibility might be due to genetic factors, which have been hypothesized on the basis of variations in CD4⁺ receptor molecules on the surface of T cells (33). Molecular variations in HIV might influence its capacity to infect a new host (34), and women remain-

ing seronegative after long-term relationships might be partners of men carrying viral strains with less of a sexual infectivity.

The practice of anal sex was associated with a risk increase only in women reporting that they never or rarely used condoms during sexual intercourse. This result confirms that this practice has to be discouraged in partners of seropositive men. However, it also suggests that the effect of high-risk practices can be lessened or completely prevented by the use of condoms.

Small and nonsignificant risk increases were observed among women reporting a higher frequency of sexual intercourse. This result does not agree with what we observed in the cross-sectional part of the study, where women reporting sexual intercourse more than two times weekly had a twofold risk increase (25). A lack of consistency of the risk of transmission per each single sexual act with an infected person (35,36) has been noted in other studies. The lack of association between seroconversion and frequency of intercourse in this study might stem from the small number of seroconversions, which prevents reliable estimates when the investigated variable is not strongly associated with the risk of seroconversion.

The results on oral contraceptives and IUDs, although somewhat anecdotal, agree with our previ-

TABLE 6. Relative risks (RR) of seroconversion estimated by multivariate analysis (Cox's proportional hazard model)

Variables	RR (95% CI) ^a
Relationship length	1
≤1 year	0.3 (0.1-0.8)
>1 year	
Condom use	1
Not always-never	0.1 (0.0-0.5)
Always	
Frequency of intercourse	1
<2 weeks	1.3 (0.5-3.7)
≤2 weeks	
Anal intercourse	1
No	1.1 (0.3-4.4)
Yes	
Vaginitis	1
No	0.8 (0.2-3.57)
Yes	
Partner's disease	1
Asymptomatic	2.6 (0.9-7.1)
Symptomatic	
Partner's p24 antigen	4.0 (1.2-13.3)
Negative	
Positive	
Partner's CD4 ⁺ count	1
≥400	1.2 (0.4-4.0)
<400	

^a 95% confidence interval.

ous findings in the cross-sectional part of the study (25,37). No seroconversion was observed among the 22 women using oral contraceptives, whereas one of the two women who used IUDs seroconverted. As condoms are not completely successful in preventing unwanted pregnancies, it is advisable to use oral contraceptives and not IUDs in association with condoms when maximal contraceptive efficacy is required in women sexually exposed to HIV.

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Commentary: Condoms and HIV/STD Prevention—Clarifying the Message

ABSTRACT

In the United States and throughout the world, the majority of human immunodeficiency virus (HIV) infections are sexually transmitted. An estimated 12 million other sexually transmitted diseases occur annually in the United States. Avoiding sexual intercourse altogether or restricting sex to partners known to be uninfected will prevent infection; this needs to be promoted as the most effective strategy. Studies show that correct and consistent use of latex condoms is highly effective in preventing sexually transmitted HIV infection and other sexually transmitted diseases. The effectiveness of condoms depends on individual behavior leading to correct and consistent use. Further studies are needed to maximize the use and effectiveness of condoms for those who choose to be sexually active as well as to develop and evaluate other methods, particularly those more under the control of women. In the interim, our prevention message should be clear: When used correctly and consistently, condoms are highly effective; when used otherwise, they are not. (*Am J Public Health*. 1993;83:501-503)

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More than 1 million Americans have been infected with the human immunodeficiency virus (HIV), and more than 250 000 have already been reported with acquired immunodeficiency syndrome (AIDS). In the United States and throughout the world, the majority of HIV infections are sexually transmitted. Furthermore, an estimated 12 million other sexually transmitted diseases occur each year in the United States, resulting in mortality and serious morbidity for many thousands of adults and children.

How can we reduce the sexual transmission of HIV and other diseases? Avoiding sexual intercourse altogether or restricting sex to partners known to be uninfected will prevent infection, and this needs to be widely and consistently promoted as the most effective strategy. However, many people at risk for HIV infection and other sexually transmitted diseases do not adopt these behaviors. Studies of sexually active persons show that correct and consistent use of latex condoms is highly effective in preventing HIV infection and other sexually transmitted diseases, including gonorrhea, chlamydia, genital ulcers, and herpes simplex virus infection.¹

Two issues generally surface in the debate over advocating condom use in the prevention of HIV infection: One concerns the concepts of efficacy and effectiveness, the other the fear that making condoms available will encourage early sexual activity among adolescents and extramarital sex among adults. We deal with each argument in turn.

Condoms are not 100% efficacious and a high degree of individual compliance is required for condoms to be effective in use. Critics of the role of condoms in prevention cite worst-case-scenario estimates of condom efficacy and focus on results from studies that include persons who are inconsistent condom users. The problems associated with insisting on providing information only about perfectly effective prevention techniques have been recently reviewed.² Assertions that minimize the potential efficacy of condoms may be self-fulfilling prophecies, because condoms may be used less consistently by those who

do not believe them to be effective. However, Fineberg has developed a mathematical model that predicts that consistent condom use could prevent nearly half of the sexually transmitted HIV infections in persons with one sexual partner and over half of HIV infections in persons with multiple partners.³ Such a reduction could help interrupt the propagation of the epidemic. Therefore, promoting more widespread understanding of condoms' efficacy and advocating their consistent use by those who choose to be sexually active is crucial to protecting people from HIV infection and to slowing the spread of the HIV and sexually transmitted disease epidemics.

The effectiveness of consistent condom use is evident from recent epidemiologic studies of couples in which one partner has HIV infection. In three such prospective studies, consistent condom use provided a 70% to 100% reduction in the risk of transmitting HIV infection.⁴⁻⁶ One of these studies⁶ makes the critical distinction between the benefits of consistent and inconsistent condom use. In that study, from the European Study Group on Heterosexual Transmission of HIV, 563 couples from nine European Community countries were evaluated. Overall, 12% of the male partners and 20% of the female partners of HIV-infected persons became infected. However, among the 24 couples who consistently used condoms, none of the partners became infected. By contrast, among the 44 couples who reported inconsistent use of condoms, six female partners became infected. For condoms to provide a high degree of protection against HIV infection, they must be used correctly and consistently; inconsistent condom use provides an unacceptably low rate of protection.

The importance of compliance is illuminated by an analogy with pregnancy

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Editor's Note. See related editorial by Hein (p 492) in this issue.

prevention programs. Although typical pregnancy rates for couples who use condoms are as high as 10% to 15%,^{7,8} rates are estimated to be as low as 2% for couples who use condoms correctly and consistently.⁷ This discrepancy makes clear that any condom strategy must rely on the continuing behavior of the condom user. It is necessary, therefore, to integrate consistent condom use into our HIV prevention strategies.

Despite the widespread understanding that HIV infection is transmitted sexually, most sexually active Americans at risk for acquiring HIV infection have intercourse without using condoms. For example, in San Francisco, only 6% of heterosexual males with multiple sex partners reported always using condoms; a much higher proportion (48%) of gay and bisexual men reported always using condoms.⁹ In another study, only about 20% of sexually active American women reported that their male partners used condoms.¹⁰ But even among these couples, condom use was inconsistent; only one in five who reported condom use said that they were used at last intercourse.¹⁰

The factors that contribute to the low use of condoms and the ready acceptance of risk of HIV infection or other sexually transmitted diseases are complex and not completely understood. Among heterosexual men and women and gay and bisexual men in San Francisco,⁹ sexual communication between partners and enjoyment of intercourse with condoms were the only statistically significant correlates of condom use. Although in that study Black and Hispanic women were less likely to report condom use by their partners than were White women,⁹ national data suggest that there are no significant differences in reports of condom use by partners of Black women, non-Hispanic White women, and Hispanic women once social and demographic variables are accounted for.¹⁰ This suggests that poverty and culture are important determinants of condom use.

After social and demographic factors are controlled for, women with multiple partners are less likely than those with one partner to report consistent condom use, perhaps because of the burden of negotiating condom use with many partners.¹⁰ Also, decisions regarding condom use may be complicated by strategies for pregnancy prevention. In Philadelphia¹¹ and Baltimore,¹² women who had undergone surgical sterilization were less likely than nonsterilized women to report condom use. It is possible that if the woman is

protected against pregnancy, the motivation of the woman or the man to use a condom may be reduced.

We turn now to the second issue often raised against advocacy of the condom. Many persons assert that those who promote condom use to prevent HIV infection appear to be condoning sexual intercourse outside of marriage among adolescents as well as among adults. Some information relevant to this possibility is now at hand. For example, recent data from Switzerland suggest that a public education campaign promoting condom use can be effective without increasing the proportion of adolescents who are sexually active.^{13,14} From January 1987 to October 1991, self-reported consistent condom use among persons aged 17 to 30 years increased from 8% to 52% in association with the campaign.¹³ By contrast, the proportion of adolescents (aged 16 to 19 years) who had sexual intercourse did not increase over that 3-year period.¹⁴

A clear message about condoms may in fact have been obscured by controversy over providing condoms for adolescents in schools while at the same time trying to discourage these same young people from initiating sexual activity. Sexual activity among adolescent women and men in the United States has increased steadily since the 1970s.¹⁵⁻¹⁷ The AIDS epidemic has brought new dimensions of complexity and urgency to the debate over adolescent sexual activity. Some have urged abstinence as the only solution; others champion condom use as the most practical public health approach.

There must be a common ground. We should all be able to agree that premature initiation of sexual activity carries health risks. Therefore, we must exercise leadership in encouraging young people to postpone sexual activity. Adolescents are bombarded with messages encouraging them to "do it." We need to strive for a climate supportive of young people who are not having sex and so help to create a new health-oriented social norm for adolescents and teenagers about sexuality.

As we proceed toward this objective, we must be mindful that many will continue to engage in sexual activity. It is essential that these youngsters receive the message that they must practice safer sex and use condoms. The message that those who initiate or continue sexual activity must reduce their risk through correct and consistent condom use needs to be delivered as strongly and persuasively as the message "Don't do it." Protection of the

individual and the public health will depend on our ability to effectively combine these messages.

Scientific studies are urgently needed to further understanding of how to maximize the use and effectiveness of condoms, to clarify the effectiveness of other barrier methods, and to develop and evaluate other preventive methods. In particular, studies should address the male, female, and couple determinants of consistent condom use, including the crucial role of peers and the need for a better understanding of economic and cultural variables. Because the male condom must be used by the man, a woman at risk must, in part, rely on her male partner(s) to protect her. Therefore, to enhance the ability of women to reduce their risks, further evaluation of mechanical and chemical barriers—including female condoms—is needed, as is the development of new methods over which women have greater control.¹⁸⁻²¹ Finally, studies should evaluate how condom use is related to the use of other methods to prevent unintended pregnancy so as to address the overall reproductive health needs of both partners.

For adolescents and adults alike who have multiple sex partners, partners who engage in high-risk behaviors, or partners whose infection status is unknown, the risk of HIV infection or other sexually transmitted diseases can be dramatically reduced by correct and consistent condom use. Our prevention message should be clear on this point: When used correctly and consistently, condoms are highly effective; when used otherwise, they are not. □

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ABSTRACT

HETEROSEXUAL TRANSMISSION OF HIV IN EUROPEAN COHORT OF COUPLES

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Objective: To determine risk factors and rates of HIV transmission in serologically discordant couples receiving regular safe-sex counselling.

Methods: From 1987 to 1991, 563 couples were recruited from 9 countries in a cross-sectional study. 378 HIV(-) partners recruited in settings where follow-up was achievable were included in the prospective study. At each interview, partners were tested, interviewed and counselled. Only partners presenting no risk factors for HIV infection other than sexual contacts with the index (HIV(+) partner) were included.

Results: The follow-up rate was 80.4% (304/378). 128 couples (42%) stopped sexual contacts (less than 3 months after inclusion for 59). Mostly because of death or severe disease of the index. 245 couples still having sexual contacts 3 months after inclusion were followed for a median of 22 months. 123 (50.2%) couples used condoms for each episode of vaginal or anal intercourse. No seroconversions occurred among these 123 partners (95% CI: 0-1.5/100 person-years). 12 seroconversions occurred among the remaining 122 partners (seroconversion rate = 5/100 person-years (95% CI: 2.6-8.8), or 1.2 per 1000 unprotected contacts (95% CI: 0.6-2.1). Cumulative rates of seroconversion at 24 months (SR) were compared using Kaplan-Meier survival analysis. Among irregular condoms users, SR were similar whatever the frequency of condom use, and the sex of the partner (12.5% for females versus 11.0% for males). For partners of symptomatic (or with $T4 < 200/\text{mm}^3$) index cases. SR was 36.7%, compared to 8.5% for partners of asymptomatic index cases with $T4 > 200/\text{mm}^3$ ($p < 0.01$). SR were different ($p = 0.05$) between partners reporting 1) no STD (9.5%), 2) non-ulcerative STD (25.0%), and 3) ulcerative STD (40.0%). The SR for female partners were different ($p = 0.02$) according to the frequency of sperm ejaculation by male index cases: no ejaculation (0%), ejaculation for about half of sexual contacts (6.7%) and nearly always ejaculation (29.7%).

Conclusion: 1. No seroconversion occurred in regular condom users. 2. The observed transmission rate of 1.2/1000 unprotected contacts should be interpreted with caution since it may greatly vary according to the presence or absence of risk factors: Advanced stage of infection for the index and partner's STD were found to increase the risk, whilst avoidance of sperm ejaculation showed some protective effect.

From the Surgeon General, US Public Health Service

Condom Use for Prevention of Sexual Transmission of HIV Infection: In 1989, a Public Health Service committee including representatives from the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA) reviewed with the Surgeon General the scientific data based on which condoms were recommended as part of a national strategy to prevent transmission of the human immunodeficiency virus (HIV). Although the committee concluded that only sexual abstinence or mutual monogamy between uninfected partners completely eliminate the risk of sexual transmission of HIV, it also concluded that latex condoms are highly effective barriers and should be used consistently by all persons who have multiple partners or have a primary partner who is infected or whose serostatus is unknown.

Recently, members of the committee met again with the Surgeon General to review data from the epidemic, new studies on condom efficacy, and statistical studies projecting the impact of condom use on the epidemic. The following updated data support the 1989 recommendation and indicate that proper use of latex condoms provides a high degree of protection against the sexual transmission of HIV.

Status of the Epidemic

Infection with HIV continues to increase in the United States and heterosexual transmission plays an increasingly important role. The proportion of cases of the acquired immunodeficiency syndrome (AIDS) attributable to heterosexual transmission increased by 21% during 1991, making heterosexual transmission the category with the largest percentage increase in AIDS cases from 1990 through 1991.

In Vitro Studies of Latex Condoms

One NIH study that evaluated latex condoms using scanning electronic microscopy found no holes even on magnification at $\times 2000$. Although the inability of this investigation to identify holes in latex condoms is reassuring, microscopic holes in latex condoms can occur. The FDA conducts periodic testing of condom lots using the water-leak test, which can identify holes as small as 10 μm . Recent FDA data indicate that the average batch of condoms has a water-leak rate of 0.3%.

Fortunately, there are obstacles to the passage of HIV through a microscopic hole. A free virus, which is non-motile, would pass through a hole only if it were associated with a cell that moves or if it were moved by hydrostatic pressure through the hole. Monocytes and lymphocytes that may carry HIV are 10 to 15 μm in diameter, too large to pass through the microscopic holes detected by routine testing. An FDA study simulated free HIV in fluid under pressure and found that most condoms leaked no fluid at all, and that even the worst-performing condom reduced estimated viral exposure by 10 000-fold. This evaluation was reassuring, especially since several extreme assumptions were made; for example, the titer of HIV-sized particles used was 100 million times the titer of HIV in semen.

Epidemiologic and Statistical Studies

Although laboratory data now demonstrate the barrier effectiveness to HIV of condoms, one must go beyond the laboratory to look at effectiveness during actual use. Studies of people who use condoms for contraception report failure rates ranging from less than one per 100 to 16 per 100 users per year. The importance of proper condom use is evident from a recent report of Great Britain's Oxford Family Planning Cohort study, in which condom-user failure rates for pregnancy among married, more experienced users were predicted to be as low as six per 1000 users per year.

Since 1989, both statistical modeling and prospective observational studies have provided evidence that the relative risk of HIV infection among condom users is equivalent to that for pregnancy, but that the absolute risk of acquiring HIV infection from condom failure is lower than the comparable risk for pregnancy. The results of two recent observational studies from the highest-risk group (discordant couples, in which one partner is HIV-seropositive and one is not) have now demonstrated a relative risk reduction for HIV of 80% or better. Based on an underlying seroconversion rate of 20 in 100 discordant couples and an 80% risk reduction, four seroconversions in 100 discordant couples using condoms are expected per year.

Consistent with this projection, a recently published prospective study from Zaire identified an annualized condom-

user HIV failure rate of 3.1 in 100 in discordant couples. Other studies in discordant couples have shown no seroconversions among consistent condom users, and condom-user HIV failure rates for the general population have been projected to be two to four seroconversions per 100 000 condom users. Not only are the failure rates for condom users low but, independent of the level of HIV in the general population, 20%, 40%, or 80% of all new HIV seroconversions in the United States will be avoided if 25%, 50%, or 100%, respectively, of persons use condoms consistently and correctly.

New Behavioral Studies

Because proper condom use is key to preventing the sexual transmission of HIV, it is imperative to better understand the determinants of correct condom use. Some studies are under way and more are planned. One early finding is that motivation plays a key role. It is unreasonable to expect that people at risk will be highly motivated to systematically use condoms unless they believe that condoms will be highly effective if they do so. We have a responsibility to let them know that a compelling case now exists for condom effectiveness—if condoms are used consistently and correctly.

Conclusion

Our message must be clear and simple. First, the only sure way to avoid the risk of sexual exposure to HIV is to have sex in a monogamous relationship with an uninfected partner or to abstain. Insertive sex with an infected partner or one of unknown serostatus is unsafe. If one engages in these unsafe practices, a latex condom should be used every time from start to finish. Doing so is a highly effective way to reduce the risk of sexual exposure to HIV. Instructions for proper condom use are contained in the FDA brochure *Condoms and Sexually Transmitted Diseases... Especially AIDS*, which is available through the National AIDS Hotline, (800) 342-AIDS.

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

- 586 Update: Barrier Protection Against HIV Infection and Other Sexually Transmitted Diseases
587 Nosocomial Enterococci Resistant to Vancomycin — United States, 1989–1993

Update: Barrier Protection Against HIV Infection and Other Sexually Transmitted Diseases

Although refraining from intercourse with infected partners remains the most effective strategy for preventing human immunodeficiency virus (HIV) infection and other sexually transmitted diseases (STDs), the Public Health Service also has recommended condom use as part of its strategy. Since CDC summarized the effectiveness of condom use in preventing HIV infection and other STDs in 1988 (1), additional information has become available, and the Food and Drug Administration has approved a polyurethane "female condom." This report updates laboratory and epidemiologic information regarding the effectiveness of condoms in preventing HIV infection and other STDs and the role of spermicides used adjunctively with condoms.*

Two reviews summarizing the use of latex condoms among serodiscordant heterosexual couples (i.e., in which one partner is HIV positive and the other HIV negative) indicated that using latex condoms substantially reduces the risk for HIV transmission (2,3). In addition, two subsequent studies of serodiscordant couples confirmed this finding and emphasized the importance of consistent (i.e., use of a condom with each act of intercourse) and correct condom use (4,5). In one study of serodiscordant couples, none of 123 partners who used condoms consistently seroconverted; in comparison, 12 (10%) of 122 seronegative partners who used condoms inconsistently became infected (4). In another study of serodiscordant couples (with seronegative female partners of HIV-infected men), three (2%) of 171 consistent condom users seroconverted, compared with eight (15%) of 55 inconsistent condom users. When person-years at risk were considered, the rate for HIV transmission among couples reporting consistent condom use was 1.1 per 100 person-years of observation, compared with 9.7 among inconsistent users (5).

Condom use reduces the risk for gonorrhea, herpes simplex virus (HSV) infection, genital ulcers, and pelvic inflammatory disease (2). In addition, intact latex condoms provide a continuous mechanical barrier to HIV, HSV, hepatitis B virus (HBV), *Chlamydia trachomatis*, and *Neisseria gonorrhoeae* (2). A recent laboratory study (6) indicated that latex condoms are an effective mechanical barrier to fluid containing HIV-sized particles.

Three prospective studies in developed countries indicated that condoms are unlikely to break or slip during proper use. Reported breakage rates in the studies were 2% or less for vaginal or anal intercourse (2). One study reported complete slippage

*Single copies of this report will be available free until August 6, 1994, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231.

Barrier Protection — Continued

off the penis during intercourse for one (0.4%) of 237 condoms and complete slippage off the penis during withdrawal for one (0.4%) of 237 condoms (7).

Laboratory studies indicate that the female condom (Reality™[†])—a lubricated polyurethane sheath with a ring on each end that is inserted into the vagina—is an effective mechanical barrier to viruses, including HIV. No clinical studies have been completed to define protection from HIV infection or other STDs. However, an evaluation of the female condom's effectiveness in pregnancy prevention was conducted during a 6-month period for 147 women in the United States. The estimated 12-month failure rate for pregnancy prevention among the 147 women was 26%. Of the 86 women who used this condom consistently and correctly, the estimated 12-month failure rate was 11%.

Laboratory studies indicate that nonoxynol-9, a nonionic surfactant used as a spermicide, inactivates HIV and other sexually transmitted pathogens. In a cohort study among women, vaginal use of nonoxynol-9 without condoms reduced risk for gonorrhea by 89%; in another cohort study among women, vaginal use of nonoxynol-9 without condoms reduced risk for gonorrhea by 24% and chlamydial infection by 22% (2). No reports indicate that nonoxynol-9 used alone without condoms is effective for preventing sexual transmission of HIV. Furthermore, one randomized controlled trial among prostitutes in Kenya found no protection against HIV infection with use of a vaginal sponge containing a high dose of nonoxynol-9 (2). No studies have shown that nonoxynol-9 used with a condom increases the protection provided by condom use alone against HIV infection.

Reported by: Food and Drug Administration, Center for Population Research, National Institute of Child Health and Human Development, National Institutes of Health, Office of the Associate Director for HIV/AIDS; Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion; Div of Sexually Transmitted Diseases and HIV Prevention, National Center for Prevention Svcs; Div of HIV/AIDS, National Center for Infectious Diseases, CDC.

Editorial Note: This report indicates that latex condoms are highly effective for preventing HIV infection and other STDs when used consistently and correctly. Condom availability is essential in assuring consistent use. Men and women relying on condoms for prevention of HIV infection or other STDs should carry condoms or have them readily available.

Correct use of a latex condom requires 1) using a new condom with each act of intercourse; 2) carefully handling the condom to avoid damaging it with fingernails, teeth, or other sharp objects; 3) putting on the condom after the penis is erect and before any genital contact with the partner; 4) ensuring no air is trapped in the tip of the condom; 5) ensuring adequate lubrication during intercourse, possibly requiring use of exogenous lubricants; 6) using only water-based lubricants (e.g., K-Y Jelly™ or glycerine) with latex condoms (oil-based lubricants [e.g., petroleum jelly, shortening, mineral oil, massage oils, body lotions, or cooking oil] that can weaken latex should never be used); and 7) holding the condom firmly against the base of the penis during withdrawal and withdrawing while the penis is still erect to prevent slippage.

Condoms should be stored in a cool, dry place out of direct sunlight and should not be used after the expiration date. Condoms in damaged packages or condoms that show obvious signs of deterioration (e.g., brittleness, stickiness, or discoloration) should not be used regardless of their expiration date.

[†] Use of trade names is for identification only and does not imply endorsement by the Public Health Service or the U.S. Department of Health and Human Services.

Barrier Protection — Continued

Natural-membrane condoms may not offer the same level of protection against sexually transmitted viruses as latex condoms. Unlike latex, natural-membrane condoms have naturally occurring pores that are small enough to prevent passage of sperm but large enough to allow passage of viruses in laboratory studies (2).

The effectiveness of spermicides in preventing HIV transmission is unknown. Spermicides used in the vagina may offer some protection against cervical gonorrhea and chlamydia. No data exist to indicate that condoms lubricated with spermicides are more effective than other lubricated condoms in protecting against the transmission of HIV infection and other STDs. Therefore, latex condoms with or without spermicides are recommended.

The most effective way to prevent sexual transmission of HIV infection and other STDs is to avoid sexual intercourse with an infected partner. If a person chooses to have sexual intercourse with a partner whose infection status is unknown or who is infected with HIV or other STDs, men should use a new latex condom with each act of intercourse. When a male condom cannot be used, couples should consider using a female condom.

Data from the 1988 National Survey of Family Growth underscore the importance of consistent and correct use of contraceptive methods in pregnancy prevention (8). For example, the typical failure rate during the first year of use was 8% for oral contraceptives, 15% for male condoms, and 26% for periodic abstinence. In comparison, persons who always abstain will have a zero failure rate, women who always use oral contraceptives will have a near-zero (0.1%) failure rate, and consistent male condom users will have a 2% failure rate (9). For prevention of HIV infection and STDs, as with pregnancy prevention, consistent and correct use is crucial.

The determinants of proper condom use are complex and incompletely understood. Better understanding of both individual and societal factors will contribute to prevention efforts that support persons in reducing their risks for infection. Prevention messages must highlight the importance of consistent and correct condom use (10).

References

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(Continued on page 597)

Barrier Protection — Continued

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Nosocomial Enterococci Resistant to Vancomycin — United States, 1989-1993

As part of continual surveillance for antibiotic resistance among pathogens associated with nosocomial infections, a recent analysis of data reported to CDC's National Nosocomial Infections Surveillance (NNIS) system demonstrated a 20-fold increase in the percentage of enterococci associated with nosocomial infections that are resistant to vancomycin from January 1, 1989, through March 31, 1993. Many of these strains are resistant to all available antimicrobial agents. This report summarizes that analysis.

The NNIS system began in 1970 when selected U.S. hospitals routinely reported nosocomial infection surveillance data for aggregation into a national data base; it is the only source of national data on the epidemiology of nosocomial infections in the United States. Isolates of *Enterococcus* sp. from nosocomial infections reported to the NNIS system from January 1, 1989, through March 31, 1993, were examined. Up to four pathogens could be reported for each episode of nosocomial infection. Multiple isolates of the same species from the same patient were not reported. Information on site of isolation (e.g., respiratory tract or urinary tract), place of acquisition of infection (intensive-care unit [ICU] or non-ICU), medical school affiliation of hospital (teaching or nonteaching), hospital size, and the hospital's susceptibility testing method was obtained for each infection and/or isolate.

Of 16,571 nosocomial *Enterococcus* isolates, 10,961 (66.2%) were tested for vancomycin susceptibility; 278 (2.5%) were resistant. The percentage of nosocomial enterococci resistant to vancomycin increased from 0.3% in 1989 to 7.9% in 1993 ($p < 0.0001$, chi-square test). Among patients in ICUs with nosocomial infections, the percentage of enterococcal isolates resistant to vancomycin increased from 0.4% in 1989 to 13.6% in 1993 ($p < 0.0001$) (Figure 1). Vancomycin resistance varied by site of infection: gastrointestinal (e.g., intraabdominal abscess), skin and soft tissue, and bloodstream sites had the highest percentage of resistant nosocomial enterococci (7.8%, 4.1%, and 3.8%, respectively).

Of the 10,961 nosocomial enterococcal isolates tested for vancomycin susceptibility and reported to the NNIS system, 1881 were from primary bloodstream infections; 323 (17.2%) patients died. Of the patients with primary bloodstream infection, mortality was significantly higher in those with vancomycin-resistant isolates compared with those with vancomycin-susceptible isolates (26 [36.6%] of 71 versus 287 [15.4%] of 1810; $p < 0.0001$, chi-square test). Insufficient data on comorbidity were obtained to determine the relation of the bloodstream infection to death in these patients.

Vancomycin-resistant nosocomial enterococci have been reported from nine of 33 states with NNIS hospitals; the highest percentages were from NNIS hospitals in New York, Pennsylvania, and Maryland (8.9%, 8.6%, and 3.6%, respectively). Vancomycin resistance also varied by teaching affiliation of hospital: 14 (0.6%) of 2154 nosocomial enterococci at nonteaching hospitals were resistant versus 264 (3.0%) of 8807 at teaching hospitals ($p < 0.0001$, chi-square test). The percentage of vancomycin resistance varied also by number of beds in the hospital: none of

Let me help you.

**If you want him to use a condom,
this is all you have to say.**

If you'd like information about condoms, HIV, and HIV prevention, call 1-800-342-AIDS.

AMERICA
RESPONDS
TO AIDS



CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

WAYS TO LOCALIZE THE MMWR

TIP SHEET

The MMWR provides a wonderful opportunity to work with local media to help frame support and awareness around your organization's HIV/AIDS public information efforts. The scientific findings outlined in the report can be used to generate local media attention and can be used to reinforce your agency's public information efforts.

Take advantage of media opportunities

Be proactive. Contact a local print or broadcast reporter to "pitch" a local story idea that incorporates the report's findings and features an agency program or service. Discuss the need for more education and prevention, cite local statistics reflecting an increase in the rate of HIV infection among different populations, such as young people. Convey how the report's findings have positive implications for the state and local HIV/AIDS education and prevention programs.

Make a statement. Develop a statement and release it along with the enclosed CDC statement to local media, AIDS service organizations and other interested constituencies outlining your agency's policy on condom efficacy.

Utilize experts. Develop a list of local experts that a reporter or journalist can use to generate story ideas and or quotes. Develop the list to include representatives from local AIDS service organizations, state and local health department spokespersons, and science and public health officials.

Use the MMWR materials to create tie-in opportunities

Release a local study. Use the findings to build support for education and prevention programs that link HIV/AIDS education and awareness with condom education. Develop and release a local report about the current status and success of HIV/AIDS programs with recommendations that call for condom education including information about condom efficacy and the need for providing the public with more information about condoms.

Make it known. Provide AIDS service organizations, state government offices and departments (e.g. public affairs), public interest groups, and other supportive constituencies with the MMWR update to make sure that they too can use it to bolster their HIV/AIDS communication efforts. Find out if there are upcoming events, health fairs, town meetings or conferences where the MMWR materials can be distributed.

FOR MORE INFORMATION

For media inquiries, please contact:

CDC Press Office (Media Only)
(404) 639-3286

**For additional information on the contents
of this kit, please contact:**

**National AIDS Information and
Education Program**
(404) 639-0956
(404) 639-0973 (fax)

**Centers for Disease Control
and Prevention**
Mail Stop E-25
1600 Clifton Road
Atlanta, GA 30333

**CDC National AIDS
Clearinghouse**
PO Box 6003
Rockville, MD 20849-6003
800-458-5231

**CDC National AIDS
Hotline**
800-342-AIDS
800-344-7432 (Spanish)
800-243-7889 (Deaf)



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CDC Prev. Mktg
Camp



HIV/AIDS PREVENTION

PHOTOCOPY
PRESERVATION

Ms. Kristine Gebbie



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control

**PHOTOCOPY
PRESERVATION**

Info for Mtg.
on July 26th

CDC HIV/AIDS PREVENTION

CENTERS FOR DISEASE CONTROL AND PREVENTION

Centers for Disease Control and Prevention
Office of HIV/AIDS (OHA)*
1600 Clifton Road, N.E.
Building 26, Executive Park
Atlanta, Georgia 30333

FACSIMILE TRANSMISSION

TO: Kristine Bebbie

Address: _____

Telephone No.: 202-690-5471

Facsimile No.: 202-690-7054

FROM: Connie Granoff

Address: _____

Telephone No.: 404-639-2918

Facsimile No.: 404-639-0943

Date: 7/16/93 Number of Pages: 4
(Excluding cover sheet)

Subject: Agenda and travel order for 7/26 mtg

Comments: _____

*Pending Approval

HIVVIC008 (2/93)

**Meeting of Subcommittee Chairs
and Lead Consultants
Executive Park, Building 26
July 26,1993**

8:30 - 9:00	Welcome and Discussion of Key Issues and Concerns	James W. Curran, M.D./ Kristine Gebbie
9:00 - 12:00	Reports From External Review Groups	
9:00	Monitoring the Epidemic	Julie Gerberding, M.D. Michael Osterholm, Ph.D.
9:30	Promoting Knowledge of Serostatus	Nell Schram, M.D. Jeffrey Kelly, Ph.D.
10:00	Break	
10:30	Developing Partnerships for HIV Prevention	Mark Magenheim, M.D. Belinda Rochelle
11:00	Improving Public Understanding of the HIV Epidemic	Norma Lopez Vicki Freimuth, Ph.D.
11:30	Preventing Risk Behaviors Among School Students	Steve Joseph, M.D. Gene Wilhoit
12:00 - 1:00	Lunch	
1:00 - 4:00	Mid-course Recommendations for Advisory Committee and CDC	

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. report	[Personally Identifiable Information] [partial] (1 page)	07/13/1993	b(6)

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 3772

FOLDER TITLE:

Briefing on CDC'S [Centers for Disease Control] Campaign, 12/21/93

2018-0756-F

ds471

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

HHS/PHS/CENTERS FOR DISEASE CONTROL
TRAVEL ORDER

TRAVEL ORDER #: 9321412
NAME OF TRAVELER: KRISTINE M. GEBBIE
ORGANIZATION: OD OPP (HCA4)
DUTY STATION: ATLANTA GA

DATE INITIATED: 07/13/93
(b)(6)

----- PURPOSE AND ITINERARY -----

PURPOSE: TRAVELER IS ATTENDING MEETING OF THE CHAIRS OF
THE SUBCOMMITTEES OF THE CDC ADVISORY COMMITTEE ON
THE PREVENTION OF HIV INFECTION AT CDC ON 7/26.

POINT OF ORIGIN: WASHINGTON, DC

DEPARTURE DATE: 07/25/93

DUTY POINTS

ARRIVAL DATES

ATLANTA, GA

07/25/93

WASHINGTON, DC

07/26/93

MODE OF TRAVEL: AIR

----- AUTHORIZATIONS -----

1. USE OF LOCAL TRANSPORTATION, INCLUDING TAXICABS, AUTHORIZED WHEN ADVANTAGEOUS TO THE GOVERNMENT AND JUSTIFIED ON THE VOUCHER.
2. TRAVEL AND PER DIEM IS AUTHORIZED IN ACCORDANCE WITH DHHS POLICY AND FTR.
3. HOTEL RECEIPTS REQUIRED.
4. THE FOLLOWING ARE AUTHORIZED:
MEETING ATTENDANCE

AUTHORITY IS HEREBY GRANTED TO PERFORM TRAVEL AND TO INCUR SUCH EXPENSES AS
MAY BE NECESSARY UNDER THE CONDITIONS SET FORTH ABOVE. (FUNDS ARE AVAILABLE)

APPROVED BY: JOSEPH M POSID,
CHIEF, OFC OF PROG RESOURCE SVCS (HCA71) ON 07/14/93

CDC-1 1/89 (COMPUTERIZED MODIFICATION OF TRAVEL ORDER HHS-1)

TRAVELER: K M GEBBIE

TRAVEL ORDER: 9321412

PAGE 2

----- ACCOUNTING DATA -----

	DHHS	REIMB	IN CASH/KIND
GTR TICKET(S)	260.00	0.00	0.00
PER DIEM	128.50	0.00	0.00
OTHER	50.00	0.00	0.00
REGISTRATION	0.00	0.00	0.00
TOTAL	438.50	0.00	0.00

ALLOW	CAN	OBJ	OBJ	OBJ
*****	*****	*****	*****	*****
A2AXB	39210225	21.21	260.00	0.00
A2AXB	39210225	21.21	178.50	0.00

RESERVATION INFORMATION

HOTEL: MARRIOTT COURTYARD, EXECUTIVE PARK

ACTUAL ITINERARY

TRAVEL ORDER 9321412 - KRISTINE M. GEBBIE

TICKET PICK-UP DATE - 07/22/93

DATE	TIME	DESTINATION	TRAVEL DETAILS
072593	06:00 PM	WASHINGTON, DC	TWA 747
072593	07:53 PM	ATLANTA, GA	MIE: 38 LDG: 81
072693	05:10 PM	ATLANTA, GA	TWA 796
072693	07:02 PM	WASHINGTON, DC	MIE: 38



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

JUL 20 1993

NOTE TO DR. DOWDLESUBJECT: CDC HIV/AIDS Prevention Marketing Program -- **ACTION**

I would like to express my appreciation for the June 22 briefing by CDC staff on the HIV/AIDS Prevention Marketing Program. I believe this program represents a formidable opportunity to strengthen our HIV prevention efforts for our vulnerable young people 25 years of age and under.

As I mentioned at the June meeting, the HIV/AIDS Prevention Marketing Program should be considered a major HIV prevention priority. For that reason I wish to be personally involved in this effort. Accordingly, I ask that you schedule periodic meetings with me to discuss the substantive elements of the program and the implementation actions planned. Key staff from my office and the Office of the Secretary should be included in these sessions.

Additionally, since Ms. Kristine Gebbie has been named as the National AIDS Policy Coordinator, I think it is appropriate for CDC to schedule a meeting as soon as possible to fully brief Ms. Gebbie and her staff on the program.

I look forward to our continuing discussions on this important prevention effort.

Phil
Philip R. Lee, M.D.
Assistant Secretary for Health

cc: Ms. Gebbie

HCA78824

The Role of the Project Officer in CDC's HIV/AIDS Program

Centers for Disease Control and Prevention (CDC) project officers have primary responsibility for providing technical assistance and other support to public health departments in planning, developing, implementing, and evaluating HIV prevention programs. Project officers review cooperative agreement applications and recommend funding levels. They monitor grantees' progress through quarterly reports, routine telephonic communications, and periodic site visits. Project officers also work with the CDC Procurement and Grants Office to ensure that applicable grant regulations are followed and with grantees to make sure that they receive appropriate services, guidance, and technical assistance. In addition, project officers coordinate and promote collaboration among health departments and other CDC-funded HIV prevention programs such as National Minority Organizations (NMOs) and community-based organizations (CBOs).

The Role of the Procurement and Grants Office in CDC's HIV/AIDS Program

The programmatic and business management performance of a grant are continuously reviewed by CDC throughout the life of the grant through the collection and assessment of information gathered from a variety of sources: (1) audits, (2) annual financial status reports, (3) progress reports, (4) continuation applications, (5) correspondence, (6) grantee board minutes, (7) newspaper articles, (8) site visits, and (9) other sources. Following the assessment of information, monitoring also includes taking whatever corrective action that may be necessary.

Should any monitoring activity uncover information which indicates that a grantee is in severe financial distress, the monitoring official first verifies that the information is reasonably accurate and then notifies other responsible monitoring officials for the grant and the monitoring officials for any other Public Health Service grant administered by the grantee. There are several indications of financial distress, e.g., reports of financial losses or pending bankruptcy, adverse audit findings, large amounts in the grantee's accrued expense account, delinquent payments for taxes. CDC will determine and initiate further action as indicated by the circumstances to help the grantee overcome financial distress or protect the financial interests of CDC if overcoming the problem is not possible. After resolution, CDC will follow-up to verify that the actions they recommend are taken. The monitoring official will continue to closely monitor the grantee until the problem is resolved.

The CDC Grants Management Officer (GMO) is responsible for maintaining all official grant records. All monitoring actions must be documented and placed in the official grant file. The GMO ensures that copies of the documentation are distributed to all persons who have an interest in the monitoring actions, especially the appropriate program officials.

CDC Administrative and Technical Assistance to the Washington, D.C.,

HIV/AIDS Program

The Division of STD/HIV Prevention conducted a program assessment of the Washington, D.C., HIV prevention program (the Office of AIDS Activities at

that time, currently the Agency for HIV/AIDS, or AHA) during February 3-7, 1992. The assessment documented weaknesses in the counseling and testing component of AHA. Among the findings was the concern that insufficient resources had been used to support Counseling, Testing, Referral and Partner Notification services for persons at increased risk outside STD clinics. Another significant weakness was found in the health education/risk reduction component, where no needs assessment had been conducted which could be used to target programs and focus resources. These problems were complicated by major administrative and management deficits within AHA and the Department of Human Services. A Technical Assistance Plan was developed and on-site technical assistance was provided to AHA later that month and repeatedly provided throughout the following months by Division personnel, totaling one full-time equivalent for approximately six months. The Technical Assistance Plan has been used to focus additional technical assistance and other support through temporary assignments, site visits, and telephone calls.

K:\DC3.716

7-21-93; 5:30 pm

**CENTERS FOR DISEASE CONTROL
HIV/AIDS
AWARDS TO THE DISTRICT OF COLUMBIA
FY 1993 (THOUGH 6/30/93)**

AWARDS DIRECTLY BENEFITTING THE DISTRICT OF COLUMBIA

<u>GRANTEE</u>	<u>PROJECT</u>	<u>AMOUNT</u>
Children's Hospital National Medical Center	Epidemiologic Research Studies-Surveillance of Pediatric AIDS	\$136,998
D. C. Women's Council on AIDS	Minority & Other Community Based HIV Prevention Project	\$280,741
District of Columbia Department of Human Services	Local Programs to Prevent HIV Infection for Youth	\$129,147
District of Columbia Department of Human Services	HIV/AIDS Surveillance & Seroprevalence	\$813,281
District of Columbia Department of Human Services	HIV Prevention	\$2,941,654
District of Columbia Department of Human Services	HIV Early Intervention Services Network Demonstration Program	\$388,249
Everyday Theatre, Inc.	Minority & Other Community Based HIV Prevention Project	\$232,418
SUBTOTAL 1, AWARDS DIRECTLY BENEFITTING THE DISTRICT OF COLUMBIA		\$4,922,488

AWARDS TO NATIONAL ORGANIZATIONS LOCATED IN THE DISTRICT OF COLUMBIA

GRANTEE	PROJECT	AMOUNT
American Federation of Fed., State, & Local Employees	National AIDS Education Information	\$121,069
American Federation of Teachers Education Foundation	National AIDS Education Program	\$160,398
American Red Cross	Development & Distribution of ARC AIDS Education Materials	\$6,055,477
Americans for a Sound AIDS Policy	National AIDS Education Information	\$167,765
Association of Black Psychologists	National AIDS Minority Information & Education Program	\$328,892
Association of State & Territorial Health Officials	HIV Related Policy, Regulation, and Legislative Tracking System	\$79,884
Center for Population Options	National AIDS Education Program	\$205,409
COSSMHO	National AIDS Minority Information & Education Program	\$327,028
Council of Chief State School Officers	National AIDS Education Program	\$624,501
Foundation of Pharmacists & Corporate America	National AIDS Education Information	\$100,000
Hispanic Designer, Inc.	National AIDS Minority Information & Education Program	\$224,485
Howard University	National AIDS Minority Information & Education Program	\$177,878
National Association for Equal Opportunity in Higher Education	National AIDS Minority Information & Education Program	\$357,728
National Association of Broadcasters	National AIDS Education Information	\$153,567
National Coalition of Hispanic Health	National AIDS Education Program	\$268,207
National Council of La Raza	National AIDS Minority Information & Education Program	\$365,298

AWARDS TO NATIONAL ORGANIZATIONS LOCATED IN THE DISTRICT OF COLUMBIA, CON'T

GRANTEE	PROJECT	AMOUNT
National Education Association	National AIDS Education Program	\$204,492
National Education Association	National AIDS Education Information	\$138,000
National Leadership Coalition on AIDS	National AIDS Education Information	\$298,834
National Minority AIDS Council	National AIDS Minority Information & Education Program	\$238,904
National Network for Runaway & Youth Svcs.	National AIDS Education Program	\$450,882
National Organization of Black County Officials	National AIDS Education Program	\$221,580
National Organization of Black County Officials	National AIDS Minority Information & Education Program	\$332,569
Service Employees International Union	National AIDS Education Information	\$91,470
United States Conference of Mayors	Info Interchange & Technical/Financial Assist for HIV Prevention	\$1,284,233
SUBTOTAL 2, AWARDS TO NATIONAL ORGANIZATIONS LOCATED IN THE DISTRICT OF COLUMBIA		\$12,978,550
TOTAL, ALL AWARDS (SUBTOTALS 1 + 2)		\$17,901,038

**Meeting of Subcommittee Chairs
and Lead Consultants
Executive Park, Building 26
July 26, 1993**

8:30 - 9:00	Welcome and Discussion of Key Issues and Concerns	James W. Curran, M.D./ Kristine Gebbie
9:00 - 12:00	Reports From External Review Groups	
9:00	Monitoring the Epidemic	Julie Gerberding, M.D. Michael Osterholm, Ph.D.
9:30	Promoting Knowledge of Serostatus	Neil Schram, M.D. Jeffrey Kelly, Ph.D.
10:00	Break	
10:30	Developing Partnerships for HIV Prevention	Mark Magenheimer, M.D. Belinda Rochelle
11:00	Improving Public Understanding of the HIV Epidemic	Norma Lopez Vicki Freimuth, Ph.D.
11:30	Preventing Risk Behaviors Among School Students	Steve Joseph, M.D. Gene Wilhoit
12:00 - 1:00	Lunch	
1:00 - 4:00	Mid-course Recommendations for Advisory Committee and CDC	

BILLING CODE: 4160-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

CDC ADVISORY COMMITTEE ON THE PREVENTION OF HIV INFECTION

SUBCOMMITTEE ON MONITORING THE HIV/AIDS EPIDEMIC

REQUEST FOR COMMENTS

AGENCY: Centers for Disease Control and Prevention (CDC), Public Health Service, HHS.

ACTION: Request for Comments.

SUMMARY: A subcommittee to the CDC Advisory Committee on the Prevention of HIV Infection (CDC ACPHI) has been established to conduct a review and evaluation of CDC's HIV surveillance activities. The Subcommittee on Monitoring the HIV/AIDS Epidemic has enlisted the assistance of a number of experts in identifying the areas to be addressed in the review process.

During meetings in April, July, and September 1993, the subcommittee is examining CDC efforts to assess 1) sexual and drug-use behavior associated with HIV transmission, 2) occupational exposures associated with HIV transmission, and 3) HIV infection and associated morbidity and mortality.

In order to assure the broadest possible input into this review process, the CDC ACPHI requests comments from interested parties on these surveillance elements. In considering these monitoring activities, the following questions should be addressed:

- 1) What are the critical information needs of public health agencies that can be met through surveillance systems, in order to:
 - a. Assess the HIV epidemic, including sexual and drug-use behaviors associated with HIV transmission, occupational exposures to HIV, and HIV infections and resulting diseases,
 - b. Target programs to improve services for at-risk and infected populations,
 - c. Link at-risk and infected persons to ongoing services,
 - d. Evaluate the effectiveness of prevention programs (including prevention of new infections and prevention of complications in infected persons)?
- 2) How do information needs differ for local, state, and national agencies? What is the most effective way for surveillance systems to meet these multiple needs, protect the confidentiality of at-risk or infected individuals, and promote the delivery of preventive health services?

DATES: Please provide written comments within 30 days of this notice.

ADDRESSES: Comments should be addressed to: Chair, CDC Advisory Committee on the Prevention of HIV Infection, c/o Centers for Disease Control and Prevention (CDC), 1600 Clifton Road, NE., Mailstop E-40, Atlanta, Georgia 30333.

FOR FURTHER INFORMATION CONTACT: Connie Granoff, Committee Assistant, Office of the Associate Director for HIV/AIDS, CDC, 1600 Clifton Road, NE., Mailstop E-40, Atlanta, Georgia 30333, telephone (404) 639-2918.

Dated:

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Acting Associate Director for Management
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Centers for Disease Control and Prevention (CDC)

BILLING CODE: 4160-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

CDC ADVISORY COMMITTEE ON THE PREVENTION OF HIV INFECTION

SUBCOMMITTEE ON PROMOTING KNOWLEDGE OF SEROSTATUS

(COUNSELING, TESTING, REFERRAL, PARTNER NOTIFICATION)

REQUEST FOR COMMENTS

AGENCY: Centers for Disease Control and Prevention (CDC), Public Health Service, HHS.

ACTION: Request for Comments.

SUMMARY: A subcommittee to the CDC Advisory Committee on the Prevention of HIV Infection (CDC ACPHI) has been established to conduct a review and evaluation of CDC's HIV counseling, testing, referral and partner notification (CTRPN) programs. The Subcommittee on Promoting Knowledge of Serostatus (Counseling, Testing, Referral, Partner Notification) has enlisted the assistance of a number of experts in identifying the areas to be addressed in the review process.

During meetings in May, June, July, and September 1993, the subcommittee is reviewing and evaluating CDC's HIV antibody counseling, testing, referral and partner notification programs

to determine how well these programs provide persons at risk a convenient opportunity to:

- a) Learn their HIV serostatus.
- b) Receive HIV prevention counseling.
- c) Obtain referrals for additional prevention and other services.
- d) Assist sex and needle-sharing partners in receiving prevention services and referrals.

In order to assure the broadest possible input into this process, the CDC ACPHI requests comments from interested parties on the following questions:

- 1) What should be the ideal goals for the CDC HIV CTRPN program as well as each component (counseling, testing, referral, and partner notification). What should be the relative emphasis of each component?
- 2) How should progress be measured?
- 3) How well does the current program meet the ideal goals?
- 4) How should the program be changed to meet the ideal goals?
- 5) What should be the relative investment and priority of CTRPN in relationship to other HIV prevention programs and activities?
- 6) What information and data do CDC, health departments, and service providers need to continually improve the program?

- 7) What are the impediments to improving the program and achieving the ideal goals?

DATES: Please provide written comments within 30 days of this notice.

ADDRESSES: Comments should be addressed to: Chair, CDC Advisory Committee on the Prevention of HIV Infection, c/o Centers for Disease Control and Prevention (CDC), 1600 Clifton Road, NE., Mailstop E-40, Atlanta, Georgia 30333.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

CDC ADVISORY COMMITTEE ON THE PREVENTION OF HIV INFECTION

SUBCOMMITTEE ON IMPROVING PUBLIC UNDERSTANDING

OF THE HIV EPIDEMIC

REQUEST FOR COMMENTS

AGENCY: Centers for Disease Control and Prevention (CDC), Public Health Service, HHS.

ACTION: Request for Comments.

SUMMARY: A subcommittee to the CDC Advisory Committee on the Prevention of HIV Infection (CDC ACPHI) has been established to conduct a review and evaluation of CDC's HIV public information activities. The Subcommittee on Improving Public Understanding of the HIV Epidemic has enlisted the assistance of a number of experts in identifying the areas to be addressed in the review process.

During public meetings held in May and June 1993, the subcommittee examined four issues that are central to the success of CDC's public information activities: vision, intended audiences, systems, and evaluation.

In order to assure the broadest possible input into this review process, the CDC ACPHI requests comments from interested parties on the following questions:

- 1) What role can communications play in the public's understanding of HIV?
- 2) What groups need to be reached through communications?
- 3) What infrastructure is needed to coordinate the activities of CDC, its grantees, and the larger community?
- 4) How will success be measured?

DATES: Please provide written comments within 30 days of this notice.

ADDRESSES: Comments should be addressed to: Chair, CDC Advisory Committee on the Prevention of HIV Infection, c/o Centers for Disease Control and Prevention (CDC), 1600 Clifton Road, NE., Mailstop E-40, Atlanta, Georgia 30333.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

CDC ADVISORY COMMITTEE ON THE PREVENTION OF HIV INFECTION

SUBCOMMITTEE ON DEVELOPING PARTNERSHIPS FOR HIV PREVENTION

REQUEST FOR COMMENTS

AGENCY: Centers for Disease Control and Prevention (CDC), Public Health Service, HHS.

ACTION: Request for Comments.

SUMMARY: A subcommittee to the CDC Advisory Committee on the Prevention of HIV Infection (CDC ACPHI) has been established to conduct a review and evaluation of CDC's HIV prevention partnerships. The Subcommittee on Developing Partnerships for HIV Prevention has enlisted the assistance of a number of experts in identifying the areas to be addressed in the review process.

During public meetings held in May, June, and July 1993, the subcommittee and consultants reviewed the type, extent, and quality of partnerships between CDC and nongovernmental organizations in planning and implementing comprehensive HIV prevention programs.

In order to assure the broadest possible input into this process, the CDC ACPHI requests comments from interested parties on the following questions:

- 1) What can CDC do to promote and/or enhance HIV prevention partnerships among CDC, targeted populations, NGOs, and state and local health departments?
- 2) What are the effective characteristics of these partnerships? (How are roles differentiated?)
- 3) What should CDC do to best assess and meet the diverse technical assistance needs of NGOs, and state and local health departments?
- 4) What should CDC do to further integrate HIV/STD/TB/Substance Abuse prevention activities?

DATES: Please provide written comments within 30 days of this notice.

ADDRESSES: Comments should be addressed to: Chair, CDC Advisory Committee on the Prevention of HIV Infection, c/o Centers for Disease Control and Prevention (CDC), 1600 Clifton Road, NE., Mailstop E-40, Atlanta, Georgia 30333.

FOR FURTHER INFORMATION CONTACT: Connie Granoff, Committee Assistant, Office of the Associate Director for HIV/AIDS, CDC, 1600 Clifton Road, NE., Mailstop E-40, Atlanta, Georgia 30333, telephone (404) 639-2918.

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BILLING CODE: 4160-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
CDC ADVISORY COMMITTEE ON THE PREVENTION OF HIV INFECTION
SUBCOMMITTEE ON PREVENTING RISK BEHAVIORS
AMONG SCHOOL STUDENTS
REQUEST FOR COMMENTS

AGENCY: Centers for Disease Control and Prevention (CDC), Public Health Service, HHS.

ACTION: Request for Comments.

SUMMARY: A subcommittee to the CDC Advisory Committee on the Prevention of HIV Infection (CDC ACPHI) has been established to conduct a review and evaluation of CDC's HIV prevention programs directed toward school students. The Subcommittee on Preventing Risk Behaviors Among School Students has enlisted the assistance of a number of experts in identifying the areas to be addressed in the review process.

During meetings in June, July, and September 1993, the subcommittee is examining CDC efforts to reduce behaviors among the school-aged population that place them at risk of HIV infection.

In order to assure the broadest possible input into this review process, the CDC ACPHI requests comments from interested parties on the following questions:

1. What are the best ways for CDC to maintain a particular focus on HIV prevention among young people while promoting comprehensive school-based and community-based prevention strategies?
2. What future strategies could CDC employ to forge stronger linkages between the fields of health and education at the state and local levels in both policy and practice?
3. Many Federal programs aim to prevent HIV infection and other important health problems among young people. What more, if anything, should CDC do to better coordinate these efforts within CDC as well as with other Federal agencies?
4. Are CDC resources to prevent risk behaviors among school-aged youth: (a) appropriately allocated among the various strategies being employed, (b) appropriately allocated based on geographic and demographic data, and (c) appropriately allocated for college-aged youth and youth in high-risk situations?
5. Schools are not the only institutions that influence adolescent behaviors. What more, if anything, should CDC do to reach out to various audiences such as families, non-governmental agencies, community-based

organizations that serve youth, universities, philanthropies, the media, and the general public to improve HIV prevention and other health promotion strategies aimed at young people?

6. Are CDC efforts to follow up, evaluate, and use evaluation data to improve its strategies to prevent HIV infection and other important health risks among young people appropriate?
7. Are CDC strategies to prevent HIV infection and other important health risks among young people appropriate with respect to public health research, state of the art practices, Federal policy, and diverse societal expectations?

DATES: Please provide written comments within 30 days of this notice.

ADDRESSES: Comments should be addressed to: Chair, CDC Advisory Committee on the Prevention of HIV Infection, c/o Centers for Disease Control and Prevention (CDC), 1600 Clifton Road, NE., Mailstop E-40, Atlanta, Georgia 30333.

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Dated:

Ladene H. Newton
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As of July 23

EXTERNAL REVIEW LIST

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IMPROVING PUBLIC UNDERSTANDING OF THE HIV EPIDEMIC

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July 12, 1993

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Dear Dr. Curran:

We are writing to continue our conversation regarding the External Review process. Thank you for your response to our letter and our continued communications.

As we stated in our initial letter to you, we were concerned that the process used to develop the External Review Committees might have resulted in gaps in representation of a variety of groups. In particular, there appeared to be an imbalance with regard to the participation of HIV-positive individuals, people of color, women, gays and lesbians, HIV-positive drug users and youth or advocates for these groups. We also had concerns regarding the mandates of the Committees which were not clear to us or to many others.

As you may be aware, we have been conducting extensive research and interviews to determine the extent to which people with HIV and their advocates were either satisfied with or concerned about the membership and mandate of the Committees. While we were very pleased to learn that many individuals are satisfied with large parts of the process, a number of concerns were expressed to us.

The following is a list of these concerns:

1. Committee Composition

A. Many of those to whom we spoke noted the general absence of advocates and other experts in the area of mental health from the Committees. This absence is particularly noteworthy because of the increasing importance of the triple track approach (HIV/substance abuse/mental health) in addressing most aspects of HIV/AIDS, especially HIV prevention efforts.

B. Although women, people of color and gays and lesbians serve on the Committees, some individuals also noted the absence, on the full range of Committees, of representatives of groups primarily composed of or advocating specifically on behalf of

P: 2 -- Dr. Curran

these communities. This issue appears to be a consistent problem, as we witnessed in the CDC redefinition process. The CTRPN Committee seems particularly lacking in this fully balanced representation.

C. Individuals also noted the absence of advocates and other experts in the area of HIV and substance abuse on the CTRPN and School Students Committees.

D. CTRPN also appears lacking in representation of HIV/AIDS legal advocates whose input is particularly pertinent to this issue in light of the serious confidentiality and other legal and legal policy concerns in this area.

E. We and many others were pleased to see that Mike Isbell of Lambda Legal Defense and Education Fund and Cornelius Baker of National Association of People with AIDS were added to the Committee on monitoring the epidemic, as numerous individuals had expressed strong reservations regarding the makeup of this Committee. These were very important additions.

We would be very interested to know your feelings on these specific observations and also to discuss ways to address these issues promptly and constructively.

2. Community Input and Corrective Mechanisms

We are very pleased to see that a public meeting and comment format is being followed by some of the Committees (e.g. CTRPN and Prevention). We see this as one way to mitigate problems with Committee composition, so we hope that each committee is following this approach systematically.

Assuming that this type of open meeting will be held by each Committee, we encourage the agency, CDC ACPHI and Ms. Gebbie to ensure that the meetings are targeted to achieve geographic diversity and are well-advertised to encourage wide-spread attendance. We and others would be happy to widely circulate a complete list of such meetings to our networks, especially to advocates for people with HIV/AIDS, women, people of color, gays and lesbians, substance abusers, youth and those in the mental health arena.

We strongly encourage the agency to publish Committee reports in draft form for public comment. of

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course, we expect that the reports will be available to the public when complete.

We look forward to discussing these issues and proposals in the near future.

3. Committee Mandates

Crucial to the work of the Committees is the need to have their mandates well-defined and well circulated. This appears to be problematic. Certainly, the degree of effective and appropriate public input may be seriously compromised by a failure of the External Review process to clearly articulate its mandate.

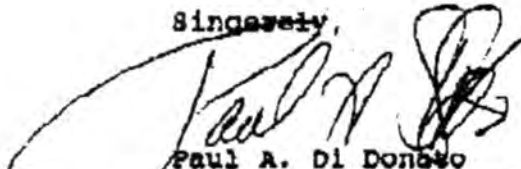
For example, several advocates on HIV prevention to whom we spoke expressed concern at the structure and scope of the External Review Committees. Some went so far as to suggest to us that the lack of a mandate to address prevention using the triple track model raised serious concerns. These advocates further suggested to us that, because of this, they feared it was possible that the review process would not produce a comprehensive review of the CDC's prevention efforts.

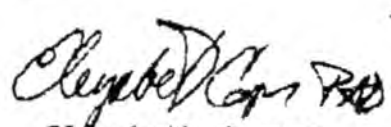
4. Status of Ms. Gebbie

In light of Ms. Gebbie's appointment as AIDS Coordinator, we are inquiring as to the status of her role in the Review Process.

We will call in the near future to follow-up on this letter. Thank you for your attention.

Sincerely,


Paul A. Di Donato
Public Policy Director, Esq.
AIDS Legal Referral Panel


Elizabeth Cooper
Gibbons Fellow
Crummy, Del Deo,
Dolan, Griffinger
& Vacchione

cc: Members External Review Committees
Ms. Kristine Gebbie

CRUMMY, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE

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July 16, 1993

James W. Curran, M.D., M.P.H.
Assistant Surgeon General
Associate Director for HIV/AIDS
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E.
Atlanta, GA 30333

Dear Dr. Curran:

I am writing to follow up on the letter that Paul DiDonato and I sent to you last week (a copy of which is enclosed). On Monday, July 12, 1993, I attended the hearing hosted by the CTRPN External Review Committee in New York City. I would like to pass along to you some of my observations regarding this meeting.

First, as attested to by many who presented testimony to the Committee, the meeting was not very well publicized. In fact, without the extraordinary efforts of the AIDS Institute and GMHC to notify organizations by fax and phone of the meeting, it would have been very sparsely attended. It was only through the work of these offices that an even moderate attendance was possible. In fact, many people who were at Monday's meeting became aware of it only the Friday before.

Moreover, although agendas were handed out, the benefit derived therefrom was grossly diminished by their not having been provided in advance, as part of the meeting announcement. Finally, it was particularly disturbing that there appeared to be no official note-taker or minutes-keeper (or mechanical recorder of testimony), whose sole responsibility it would have been to create an accurate record of public input.

CRUMMY, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE

Dr. James Curran
July 16, 1993
Page 2

Although the External Review process is an Advisory Panel initiative, its clear purpose is to enable the CDC to review and restructure the substance and administration of its HIV programming. Therefore, the failures described above highlight the Agency's strong and abiding responsibility to ensure that notice of all open meetings held by the External Review Committees is disseminated broadly and well in advance of scheduled meetings; such notice should include mention of the host Committee's mandate and its agenda for the day. Of course, both the agenda and the mandate of the Committee should be reiterated at the start of each meeting. Finally, a consistent means of maintaining a record of public input must be instituted for each External Review Committee meeting or hearing.

Quite frankly, the foregoing recommendations must be implemented immediately. Only by so doing will the Agency and the External Review Committees be executing a commitment to implement a process that truly involves the American public.

In light of the foregoing, we are particularly concerned with the mechanism that the External Review Committees will use to report their findings and the timing of the reporting process. The potential value and strength of the External Review program certainly will be diminished if public input to Committee draft reports is not appropriately sought and the reports are not timely issued.

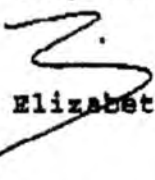
As a follow up, both to this letter and the letter we sent to you last week, Paul and I will call you in the late afternoon of July 21st. We wish to discuss with you the concerns addressed in our correspondence in the hope that they will be raised and discussed at the External Review Committee co-chairs meeting scheduled for July 26, 1993. If you do not expect to be available on the afternoon of the 21st, please have someone from your office call me to reschedule our discussion.

CRUMMY, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE

Dr. James Curran
July 16, 1993
Page 3

Once again, thank you for your cooperation. Paul and
I are looking forward to talking to you next week.

Very truly yours,



Elizabeth H. Cooper

EBC:gmw

Enclosure

cc: Members, External Review Committees
Ms. Kristine Gebbe
Mr. Paul DiDonato

JUL 21 1993

Elizabeth B. Cooper, Esq.
Crummy, Del Deo, Dolan,
Griffinger & Vecchione
Attorneys at Law
One Riverfront Plaza
Newark, New Jersey 07102-5497

Dear Ms. Cooper:

Thank you for your letters of July 12 and July 16 regarding the external review of CDC's HIV prevention programs. You have raised some very important issues, and we are providing copies to our advisory committee for their consideration.

Regarding the subcommittee meeting held in New York City on July 12, extensive attempts were made to publicize the event. A public notice was published in the Federal Register on June 18, 1993. In addition, staff from our National Center for Prevention Services, using mailing lists provided by the New York City Health Department, the New York State AIDS Institute and the National AIDS Clearinghouse, sent more than 500 notices of the meeting to agencies and organizations both in New York City and surrounding areas approximately 2 weeks before the meeting. The New York City Health Department also placed an announcement on several local radio stations with details of the meeting.

Unfortunately, we understand that many of the organizations failed to forward the information to their key staff members who should have been in attendance. In addition, some organizations were not on the mailing lists as no accurate, up-to-date address lists of these organizations exist. As you can appreciate, we do not have the resources to call each of these organizations prior to the meeting. Regardless, this meeting had the highest attendance to date, and our panel members commented on the diversity of the groups represented.

A recorder, whose sole purpose was to record the comments and testimony received at the meeting, was present throughout the meeting. In addition to extensive notes, the meeting was also recorded on audio tape. These minutes will be finalized within the next week, and we will be pleased to share a copy with you.

Fulla

Page 2 - Ms. Elizabeth B. Cooper

We appreciate your continued interest in HIV prevention and the efforts of the CDC Advisory Committee on the Prevention of HIV Infection.

An identical letter has been sent to Mr. Paul A. Di Donato.

Sincerely yours,

James W. Curran, M.D., M.P.H.
Assistant Surgeon General
Associate Director for HIV/AIDS

cc:
CDC/W
OHA
k:\DiDonato; HIV/HCA
prepared by: Gary Conrad
spelling verified by cg 7/21/93

Los Angeles Times Magazine

COURTING
DEATH

WHY A
GENERATION
OF YOUNG
GAY MALES
WON'T PLAY
IT SAFE

BY ROBERT A. JONES



Dangerous

YOUNG GAY MEN KNOW ALL ABOUT AIDS AND HIV, YET THEY PERSIST IN HAVING

Liaisons

UNPROTECTED SEX. HERE, SOME OF THEM SAY WHY. BY ROBERT A. JONES

Gabe, at 18, represents a kind of mystery. Not that Gabe, if you met him, would seem particularly mysterious. He lives at home with his parents, makes medium grades in high school, earns gas money bagging groceries at Safeway. On the surface, Gabe appears almost too ordinary to contain any sort of mystery.

But the questions arise when Gabe describes his recent past. For two years, Gabe has slipped into his car on weekend nights, and some school nights, to escape his parents' suburban world. Still nothing unusual about that, except that Gabe happens to be gay. On his forays from home, he heads for bars, parks, coffee shops, anywhere he can meet older men. And have sex.

In fairness, Gabe sees himself as searching for something besides sex; love perhaps, or, as he puts it, "a relationship where people fall for each other and

then stay together." But what he finds is sex. Gabe has had sex hundreds of times with dozens of men. Many dozens. And here's the mystery: During the two years in which Gabe has committed virtually every variety of sexual coupling with different men on different nights, he has never introduced the subject of safe sex with any of his older lovers. Nor, except on rare occasions, have they with him. In his search for love, Gabe can hardly remember stumbling across a condom.

Gabe knows about AIDS. He knew about it when he began his active sexual life at 16. He lives in a town on the San Francisco peninsula where AIDS is hardly kept a secret. Nor is Gabe mired in the kind of family that would create a kid bent on self-destruction. He views his life with good humor and often makes fine distinctions on points of personal behavior.

Yet he voluntarily and repeatedly engaged in unprotected sex with men whose chances of having HIV could be conservatively estimated at one in three. Gabe does not claim that his lovers forced him or even pressured him to forgo precautions. He just did it, willingly, and never thought about it afterward. In his words, "I didn't think about it."

What to make of Gabe? His behavior could be seen as an attempt at some subtle suicide, but Gabe does not believe it to be so. He enjoys life too much, he says, and has his own explanations that will be presented later. In truth, Gabe's behavior largely remains a puzzle.

For reasons that no one really understands, a generation of young gay men—not even men, really, but kids about to become men—seem to have turned away from the fundamentals of safe sex. They, like Gabe, appear to have abandoned caution, acting as if a decade of sexual education about AIDS had never taken place.

For several years, researchers have suspected that this rejection of safe sex was occurring. Then, a study by the San Francisco Department of Public Health in 1991 confirmed their fears. The study found that gay men between the ages of 17 and 25 consistently engaged in high-risk sex. And the younger the men, the riskier the behavior.

Among the men aged 23 to 25 in the survey, nearly 30% said they recently



Kurtis: The question isn't safe sex. It's what risks will you take under what circumstances?



Jason: I see people getting worn down by constantly being reminded that sex is associated with death. Young men ask themselves, "Do I want to be around when all my friends are dead?"

had unprotected anal intercourse. Among the men 17 to 19 years of age, the rate rose to roughly 43%. As for unprotected oral sex, about 82% of the older group said they had taken part, and the figure went up to a little more than 90% for the younger crowd.

Finally, the study showed that the rejection of safe sex was taking its toll. In the 23-to-25 crowd, 10.4% turned up HIV positive. Among the 17- to-19-year-olds, the HIV rate jumped to 14.3%. In other words, the younger kids, who had less time to get infected, produced an HIV rate almost 40% higher than

their older counterparts.

That study, which focused on young gay men in San Francisco, may reflect what's happening on the national front. Last month, in its final report, the National Commission on AIDS underscored the problem, stating that "while HIV transmission among older men who have sex with men is sharply reduced from the early '80s, transmission continues at high levels in younger gay men."

As of March, a total of 978 AIDS cases have been reported to the U.S. Centers for Disease Control among men age 13 to 24 who have sex with men.

While this may not be a number of epidemic proportions, officials are concerned that the number of cases will take off.

AIDS researchers have offered several explanations for the increase in unsafe sex. The young, they say, often see themselves as immortal and take terrible risks with their lives. And many have not developed the confidence or social skills to introduce the subject of safe sex with their partners.

While those theories offer some enlightenment, they assume that all generations of the young behave the same. But the San Francisco study has proven otherwise. It revealed that the youngest group of men are taking more risks than did the older groups when they were the same age. In other words, each group of young men is behaving more dangerously than the one before.

No answers have been offered by researchers for this acceleration. And so the mystery remains. In the following article, several young gay men try to explain what the experts cannot. They represent a variety of backgrounds and experiences. Some have confronted the worst news about their lives; some have gotten lucky. Each tells his story in his own words.

Jeff

Jeff is 19 and lives in West Hollywood. He grew up in Los Angeles and, until recently, lived with his parents. He plans to enroll in college.

My parents found out I was gay a few months ago. I had just turned 19 and was living with my mother in Bel-Air. I guess you could say they reacted, like, hostilely. What they did was kick me out of the house.

My mother found out on her own. One day she read through my diary while I was gone and she found some stuff in there about the experiences that I had been having. So when I came home, she didn't waste any time. She said she knew I was gay and then she looked at me and said, "I didn't raise my son to be gay. I want you out of the house." She gave me some money and then said I had to leave.

It was like, just get out of my life, you know?

Up to that point I had gotten along with my parents fine. They are divorced and I lived six months with one and then six months with the other. That was the arrangement spelled out in their (dissolution) contract. My parents are both pretty high-powered people. They have married each other three times. (He laughs.)

They both work in the industry and I had always figured it would be OK with them about being gay because they are surrounded by homosexuals all the time. They're both producers and they work with these people constantly, so I didn't think they—at least I didn't think my mother—would have a problem with it. In fact, I met some of my first lovers through my parents. They didn't know it at the time, of course. (He laughs.)

I would meet men who came to the house or when they were invited to one of their parties. I would just be there, you know, because I was their kid and I would end up talking to these guys and sometimes we would have a relationship.

Anyway, it turned out not to be OK. I was totally surprised. When my mom told me she had read my diary and knew I was gay, I said, "Well, you're friends with gay men. You work with them all the time and that doesn't seem to be a problem." She just gave me a look and said, "This is different. You're my son."

I left the house that same night. She had given me a thousand dollars and pretty much said she never wanted to see me again. So I left and the first night I spent at a hotel. That was a scary night because I didn't have any idea how I was going to live. It turned out I got lucky. I found a place at the (Los Angeles Gay and Lesbian Community Services) Center and that's still where I live.

Up to that point, I hadn't talked to my father so I called him one day at his office. I said, "Why don't we have lunch and talk about this?" But the way my parents are, they don't have the time. Everything is done at their convenience. My father said, "You know, I don't really have the time to discuss this right now."

And I said, "That's fine." That's not what I was feeling, but it's what I said.

I think a big part of the problem was the fact that my diary had described some of the men I met at their parties and the experiences I had. I think that really freaked them out, the idea that I was meeting these men through them. Also the fact that they were all older guys.

During that whole time, I almost never practiced safe sex. I knew about AIDS. I remember Rock Hudson dying when I was about 12. That's the same year I had my first sexual experience. (He laughs.) I knew AIDS was scary and I knew people were dying. I think I just never connected it to me. It didn't seem

to have anything to do with my life.

I remember there was this guy I met at (one of my parents' parties) that I really liked. I got to know this guy and pretty soon we had a relationship. I'm not the type of person who has sex on the first date but after a while we were doing everything. Everything that was unsafe.

Also I figured that this guy was older and he knew what was right. He never mentioned safe sex.

And that's how it always went. All through high school, AIDS was never an issue with me. In my junior year, I remember reading about AIDS in Newsweek and it described how bad it was. Even then I didn't change. I don't know why, really. I knew, and then I went out and did everything.

Not so long ago, I finally changed my ways. I met this guy who taught me about safe sex. Actually, he called it "safer sex." I met him through my father. As usual. (He laughs.) He's 34 and works in Washington on health-care issues. Anyway, he changed everything. He was the first person who said, "Look, you gotta be real careful about this stuff." He showed me how safe sex works, and we tried it his way.

I know I've been lucky. I'm still healthy and don't have HIV. Almost all my friends have done the same thing—exactly the same—and some won't be so lucky. I think it's possible that my generation could be wiped out. So many of them are going to die in their 20s.

And I think it's mostly because we think, "Hey, I'm young and I'm safe. I don't sleep with every person in the world so there's nothing to worry about." And we think that if we have a relationship, there's no problem. We don't realize that the relationships won't last and that people don't always care about you. It's so stupid, but that's what kids are. Stupid.

I don't know what's going to happen with my parents. It's possible my mom's starting to adjust to the situation. We are talking a little bit on the phone. So that's going better, and maybe in the fall I will start college. I want to study film history and, yeah, eventually work in the industry. In fact, I'd like to be a producer. My father's a producer, you know.

Alex

Alex grew up in Azusa with his mother and a succession of her boyfriends. In his early years at school, he was regarded as a budding athlete and a bright student. But at home, life became intolerable and he ran away at age 11. In the years that followed, he alternated between return visits to his home and life on the streets of Hollywood. Alex is now 18 and lives on his own in Los Angeles. He has AIDS.

I met the man who gave me AIDS in front of the gay and lesbian center (in Hollywood). A lot of people don't know how they got AIDS, or at least they don't know exactly who gave it to them. I do. I was standing outside the front door of the center around 7 in the morning. I had been up for two days straight.

This guy walked up and started talking to me. He was older and sort of good-looking and I knew he wanted sex. After a while, he invited me up to his apartment and I said OK because I was so tired I didn't care. I figured I would go there, give him what he wanted and then get some sleep.

And that's how it worked out, except I ended up staying there and we became lovers. Wayne had a really easygoing way about him and he seemed sincere. We got along real well. I liked Wayne. No, I loved him.

He let me live my life the way I wanted, except now I can see that he only had one purpose for me. I was like this young thing that he kept around so he could have his fun. At night he would buy me something to drink so I would get loaded. My favorites were vodka and schnapps. He would go buy it and I would get so drunk I forgot my own name. And then I'd let him do anything he wanted. I never asked him to use a condom because I was nearly passed out from the liquor.

I'm not saying I didn't like the life we had. At the time, I thought it was great. I told myself, "Hey, this means I'm really grown up. I can make my own decisions, get drunk when I want, have sex, everything." I was 15 and I really wanted to feel like I wasn't a kid anymore.

This had been going on for a few months when one day I was hanging out and talking to some of his friends. And they said, "Don't you know Wayne is HIV positive?"

Of course, he had never told me that. So I went out and got tested and the results came back positive. I mean, I knew before they told me. When I came in for my results, they told me I would be seeing a social worker rather than the doctor. And then I really knew.

After that, I made Wayne go get tested. It was stupid because he already knew and I knew he knew but I wanted to make sure. And he was positive.

I'm not in touch with Wayne anymore. (I turned him in and) got him charged for sodomizing a minor, contributing to the delinquency of a minor

Robert A. Jones is a Times columnist on leave to write a book on postwar Los Angeles and the invention of the modern world. His last article for this magazine was "California's Bitter Season," about the state budget crisis.



Alex: I just thought, "I'm so cute, and I'm so good in bed, nothing will happen to me." That's the way a 15-year-old thinks.

and statutory rape. I didn't even have to go to trial. He pled guilty. He did less than a year, and he's out now.

But even before Wayne, I never practiced safe sex. I didn't know condoms existed. I mean, I knew about condoms. I just didn't know what they were for. And even if I had known, it wouldn't have made any difference. I just thought, "I'm so cute, and I'm so good in bed, nothing will happen to me."

That's the way a 15-year-old thinks. They can't deal with a reality like AIDS. Death and dying is something that seems so far away, they can't connect it to themselves.

You would think the older gay men would let them know (about protecting themselves) but they don't. When I was 13 and 14, I was having sex with doctors and lawyers and stockbrokers, all these successful kinds of people in their 30s that I would meet in West Hollywood. And not once did any of them say anything about a condom.

Maybe they think it can't happen to them, either, because they're successful and drive around in BMWs. But they're gonna be next.

Jason

Jason works with homeless youths and counseled young gay men for an AIDS agency in San Francisco for a year. He is 24, an old man compared to the men he counseled. But Jason's history resembles those of his clients, and he believes he taught them valuable lessons.

One night, when I was 14, I was hanging out down on El Camino (a major thoroughfare south of San Francisco). A guy pulled up in a four-door Cadillac and asked if I wanted a ride. I said sure.

When I got inside, he offered me 60 bucks to give him head. You have to understand, I was pretty old for a 14-year-old. I remember thinking, "Sixty bucks for a blow job? Not bad."

Anyway, that's how it all started. A little later I decided to come up to San Francisco to make some money selling myself. The first night I got there, the

very first night, I turned a date with a cop. Two cops, actually. Undercover. So they busted me. At first they thought I was an adult and they were gonna let me go but then they found out I was only 14. So they made me call my mom to come get me. And she wouldn't.

They ended up keeping me for a month and a half at a guidance center and then transferred me to a juvenile detention center.

You could say that, for the next five years, I had no concept of safe sex. I did just about everything that should have gotten me infected. I was a prostitute off and on, and even when I wasn't doing that I was still having unprotected sex.

I knew about AIDS, of course, but at that time I couldn't conceive of worrying about something that would kill me in 10 years. I mean, 10 years seemed like forever. I had a bunch of other things that worried me a lot more, like where I was gonna get drugs and how was I gonna survive the next couple of weeks. There are times when I think about those years and I go, "Wow, there must have been a guardian angel behind me for a long time."

You know, I have friends who can tell you the one time they had unsafe sex. Somebody f— them without a condom just once and now they're (HIV) positive. And, of course, I am not infected. I see them and I can't, I just can't ask myself why that happens cause it makes me crazy.

I finally got myself straightened out around 1988. I quit drugs and started to get educated about HIV and then started wondering what I was going to do with my life. And a friend suggested I apply for a job as a counselor for homeless run-aways, so I did and I got it. Ever since, I have been dealing with young kids and the issues of HIV and AIDS. I can tell you there are problems out there.

A lot of times, younger gay men say things to me like, "Well, the older guys got to do the bathhouse stuff, where there was wall-to-wall men and just sex everywhere, and we don't get to do it." And you see them (young men) getting real tired of a situation where everything is no, no, no while their bodies are saying yes, yes.

Now they're being told that they should use condoms even for oral sex, that it's a possible route of transmission. And these young guys say, "OK, first you told me I couldn't f— and now you're telling me I can't do the one other thing I like."

We just tell them that the numbers suggest there is some risk from unprotected oral sex. But you know what? I don't know anybody—from my co-workers to my clients—who has safe oral sex, if that means always using a condom. People just aren't willing to do that, even though statistics show that some people have been infected through oral sex. There is just some kind of line that people draw (with safe sex) and they won't go beyond it, even though they know that they have increased their risk.

More than anything else, I see people getting worn down by constantly being reminded that sex is associated with death. Young men ask themselves, "Do I want to be around when all my friends are dead?" And part of me says that's a really rational and relevant question. I don't think necessarily that it's a healthy decision to go out and have unsafe sex. But I can understand how it happens.

You have to find some way to let people express themselves sexually without killing themselves. You know, there are still sex clubs around. There's a couple in this (Castro Street) neighborhood that replaced the old bathhouses that were shut down. I think in some ways the clubs are a good idea. They have posters about safe sex and condoms and referral cards, all the things you do not get exposed to if you go out in the bushes somewhere.

Like, we have a place called Eros (a safe-sex club). It has monitors who work there. These places get people to talk about the issues. Not talking about it is the worst thing you can do. And, you know, there are still parts of the community that don't talk about it. I have some friends who are very—have you heard the term *A-gay*?—it means very materialistic, very dressing nice all the time, brunch, that kind of stuff.

So one of the members of this group came to me and said, "You know, I have some concerns about my health." He had just tested positive. And we don't know each other very well, so I said to him, "Why don't you talk to your

Continued on Page 34

pared down. His fish tartare is a terrific dish—wonderfully rich tuna chopped and mixed with bits of shiso, some wasabi, some soy—served on rounds of cucumber. It relies on the quality of the fish.

There is a salad made of fried calamari, reminiscent of one once served at Chinois. What you notice here is the lightness of the frying, the crunch of squid rings against the crisp of slivered vegetables. This is a salad informed by the best tempura, and it is wonderful.

Vodka-cured salmon, which owes very little to Japan, is equally wonderful, the salmon served with a warm potato salad and studded with fresh pearls of salmon roe. And a salad of sautéed mushrooms and watercress is infused with the fresh intensity of the mushrooms.

But when Zenzero's food gets complicated, it sometimes gets lost. Sirloin steak is made into a salad: big pieces of thin steak, hard to pick up with chopsticks and inexplicably tossed with baby lettuces, dried cherries, lava beans and olive oil. The elements never quite seem as if they belong on the same plate. Stir-fried chicken—a variation on the minced squab of Chinese restaurant fame—is just too sweet. You make your own little packages, wrapping bits of chicken and julienned vegetables in radicchio, along with pale strips that look like cucumber but are really honeydew melon. Throw in sugary fried peanuts, and you end up with something that Matsusaka must have thought his customers would like.

The entrees, like the appetizers, are best when they are simple. Chinese air-dried duck is spectacular here, the skin as hard and shiny as glass, the flesh moist and tender. On the side is a tart plum chutney that cuts through the richness of the meat.

Whole fried fish is good, too. Matsusaka takes a pedestrian dish usually made with catfish and improves it by using sweeter, subtler, less forceful fish, such as New Zealand snapper, and frying it very, very well. Salmon is good, too, simply grilled and served with mushrooms and a *ponzu* sauce of soy, rice wine vinegar, sugar and lemon that tempers the fat in the fish.

But the fancier dishes lose their edge: Grilled skirt steak, an Asian take on fajitas, comes with a "grilled vegetable chutney" and doughy Chinese flat bread. Roasted lamb loin is served with a too-sweet curry sauce. And while the grilled squab and steamed lobster—a sort of Asian surf 'n' turf—is nice, its potato tart seems like an afterthought.

Desserts come with another lecture: "Resident chef Tony D'Onofrio," you will be told, "worked at Citrus." Perhaps, but these desserts are delicious in a way that owes little to Michel Richard. I haven't had one

that wasn't delicious, but I particularly recommend the raspberry brown-butter tart served with green-tea ice cream, which looks like a giddy sunset melted onto a plate. It is silly and seductive, and after the crisp severity of the best of Zenzero's dishes, the perfect ending.

Kazuto still knows fish. Now he knows dessert, too.

Zenzero, 1535 Ocean Ave., Santa Monica; (310) 451-4455. Open nightly for dinner. Full bar. Valet parking. All major credit cards accepted. Dinner for two, food only, \$50-\$85.

THE WINE LIST

The chef's name is always emblazoned in headlines when a flashy new restaurant comes along, but the guy who assembles a great wine list, one that helps make the food better, is usually ignored.

But food and wine lovers should pay attention to this name: Chris Schaefer, formerly of Ivy by the Shore, Brentwood Bar & Grill and Geoffrey's, now at Zenzero.

The list is small (60 wines) and well-edited. This means you won't find the same old war horses everyone else stocks, though Zenzero's all-California list has some of the top names in the game. What you do find is an array of wine styles.

Want a full-bodied Chardonnay? There's 1991 Edna Valley Vineyards, \$22. Lean? The attractive 1990 Trefethen, \$24. A full-bodied Cabernet Sauvignon? Look to 1986 Grgich Hills, \$34. More refined? There's 1989 Jordan, \$35.

Then, for the wine collectors, there is a host of rarely seen items that raise smiles: 1991 Pahlmeyer Chardonnay, \$32, an unfiltered, unfiltered, powerfully constructed wine with a load of oak and highly extracted flavors; 1990 Staglin Family Vineyards Cabernet, \$32, gorgeously fragrant, made of fruit from one of the finest vineyards in the Rutherford Bench area; 1991 Buttonwood Farm Sauvignon Blanc, \$15, herbal nuances from the Santa Ynez Valley that work wonders with Zenzero's spiced foods; 1991 Navarro Vineyards Gewürztraminer, \$14, annually one of the best Gewürztraminers in the nation and a perfect accompaniment to the Far East flavors in many of the dishes.

There's more, including elegant glassware, good service and a house white wine, 1991 Smith-Madrone Riesling, that I happen to love.

Pricing here is among the most reasonable in town, barely twice wholesale, which makes most wines just a corkage charge over retail.

—Dan Berger

Young Gay Men

Continued from Page 13

friends about this?" And he said, "Oh, no, we don't talk about that."

My reaction was, "How can you not talk about it? That's the only way you're going to stay alive." It was very startling to me at the time but those people are out there, right now, just pretending the epidemic doesn't exist.

Kurtis

Kurtis, 22, was born in Vietnam. When the war ended, his family migrated to the United States and prospered. Kurtis has lived in the Bay Area most of his life and last fall enrolled as a first-year student at a local law school.

About a year ago I went to Hawaii, and that changed a lot of things for me. I went there to set up an apartment for my mother. She asked me to go over first and it turned out I was there by myself for about four months. I had a lot of time on my hands and I got into the bar scene for the first time in my life.

Before I went to Hawaii, I had this belief that there was no way I could have sex with somebody I don't know very well. I had never done any one-night stands, ever, because I regarded it as very dangerous behavior. But in Hawaii I had a lot of time and I started going to dance clubs. Usually I went to this place called Hula's that was right near Waikiki.

In a gay bar, the most difficult thing is to make the connection with someone you're attracted to. That's the first thing I learned. Eight out of 10 of us are afraid to make the first move. The first thing you want to do is make eye contact and see what happens. If he looks at you too, then you know you've got semi-approval to move closer and maybe offer to buy him a drink.

That happened to me one night after I had been going to this bar for several weeks. I met this guy and we started talking. I was really interested in talking to him and at that point I knew I would go back to his hotel if he asked. That's when I realized that if the passion is strong enough, your standards about careful behavior will go out the window. When the attraction goes beyond a threshold level, you will ditch those standards.

It turned out the opportunity was missed that night because he didn't ask me. But eventually it happened. It wasn't a one-night stand; it was more a one-day stand with someone I had met the night before.

He was coming to my apartment, the one I had set up for my mother.

Before he got there, I kept wondering if I had the courage to ask him to use a condom. I didn't know this guy hardly at all, you know, and I didn't know how he would react. I kept saying to myself, "You've got to do this, you've got to do it."

Finally, after he had been there for a while and things got going, I told myself, "OK, it's now or never." So I said, "You know, we have to use a condom." And then I went to get it. It turned out—and I didn't realize this until afterward—that he thought that meant I wanted anal sex. And I didn't. So when I came back with the condom, there was this misunderstanding. I had to tell him, no, I didn't want to go that far. He was fine. He said all right, and we just had oral sex.

After that, the whole question of safe sex got more complicated for me. The question really isn't, do you practice safe sex? The question is, what risks will you take under what circumstances? Because everybody takes risks, no matter how small.

It's like, after he left my apartment that afternoon, I started worrying, "My God, I kissed him. Was I going to get AIDS? What if my gums had been bleeding?" I was going through all this agony and I finally told myself to relax, that the chances were slim, and that's how I rationalized it.

You can say, "Well, that wasn't much risk." But it was a risk to some degree and that's the kind of decision you are always making.

(Shortly thereafter, Kurtis returned to the Bay Area.)

I have a lover now and the same kind of thing came up with him. About a month after we met, he said he wanted to have unprotected anal sex. And he was really adamant about it.

At that point we had told each other our sexual histories and we had gone in for our tests but we hadn't gotten the results back. We really didn't know for certain that we were both negative.

Anyway, not with my best judgment, I gave in. The decision was made in the heat of the moment and I think I was curious, too. I had never done it without a condom and I figured, "Well, why don't I give it a try?" Also I told myself, "I probably won't like it and I'll make him stop real fast." You know, you always come up with a rationalization for what you do.

Afterward, I really worried. I told myself, "You shouldn't have done that, what if you get AIDS because you slipped up this one time?"

I realized that I did it partly because I wanted to make him happy. Also, I wanted to express the fact that I trusted him and that I believed he hadn't done anything risky in the past.

I don't know anyone who can say they never, ever take risks. Almost everyone does it at one time or another. But because we're young, we don't think we will die because of it. We think we will be lucky and dodge the bullets.

He arrived in Los Angeles 18 months ago from Denver with virtually no money in his pockets. He now lives at the gay and lesbian center in Hollywood. Angelo is smart, ironic and 21. He plans to go to college when he can save the money.

So far I've had sex with 10 or 12 men, a pretty small number. What I've found is, I can't have sex with anyone who is my friend. It's like it's

The funny thing is, her preaching started before I told her I was gay. I think she must have suspected.

He attends high school in a well-to-do community south of San Francisco. He is 18 and plans to go to college to study psychology.

Then one day another guy called me a faggot. I was thinking, "What's a faggot?" I knew it was bad, that's

I never even thought about safe sex. For me, AIDS wasn't an issue because I thought it was something that happened to older guys. From the very beginning, in all the stories about AIDS, the people with AIDS always seemed real old. So I just cat-

A lady gave me the results. She was very sympathetic and told me about some support groups. I remember thinking, "Gabe, you have f— up

—M[ARE] | M[ET] C[UT]TERS, *| The Compass in Your
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Dichaevelus | Fimbriable | Fimbriable
Gastaway | Huesated | Lefin | Joldest Knicks
I | Icaroths | M | The | N | Metamorphosis
Orating the clock | P | Punctum star | O | Outaway

big time. You are now going to die." After the lady finished talking, I walked out of the clinic and just went, "Whooo . . . 17 years old and you are going to die."

Since then, my life turned around 360 degrees. There was one night when my mother and my two older brothers found out I was gay. I told my mother and she told my brothers. Everyone cried and they said they still loved me. The only ones in my family who don't know are my 9-year-old brother and my father. My mother said my father would kick me out if he knew.

But so far I haven't told them about HIV yet. It just seems too much right now. I haven't been sick or anything.

Sometimes I think that if I hadn't been so alone when I was 15 and 16, none of this would have happened. I was so scared of letting anyone know I was gay that I didn't have anyone to talk to and tell me I was doing everything wrong. At the time, it felt like I was the only kid in the world like me.

Now, of course, I totally do safe sex. A little late for me,

but at least it means I won't be infecting anyone else.

At first, I thought I would be real depressed because I was HIV positive. I mean, I'm not going to be around for very many years, right? But it turns out, I'm not depressed at all. And the most interesting thing is, I've become very intrigued by death. I don't want to commit suicide or anything, it's just I'm so curious about what's out there after I die. I want to know what it's like to leave this world and go somewhere else. Somewhere new.

When I was a little kid I used to dream about heaven. Sometimes it was a real dream and sometimes a daydream. What I pictured was this golf course, this humongous country club, and all the men were dressed in tuxedos and the women were dressed in evening gowns. All day long everyone played golf and every once in a while they would sit down underneath a tree and sip tea.

And that was heaven, I guess. I loved it and always wanted to go there. And I don't even play golf. (He laughs.)

Light

Continued from Page 25

shapes the stones over and through which it flows. Had light not "seen" man, we should never have seen the light.

What Goethe pointed to at the concrete level of human physiology is likewise true for more subtle organs of soul. Cézanne's looking and working, the Buddhist in his meditations and Goethe through his ceaseless artistic and scientific undertakings, all aimed at birthing the "necessary organ, the inward instrument" needed to see more deeply into nature. And the opportunity for this practice is ever-present, for, as Goethe says, "Every object, well contemplated, opens up a new organ within us."

The artist and the monk both know that through a disciplined practice, one can realize new capacities of mind. Personal growth is not only a matter of memorizing sacred texts, or of academic artistic analysis, it also requires daily labor to fashion fresh, hard-won soul faculties. Every action of the hand and eye sculpts the soul.

IF EVERY CULTURE AND period has thought so variously about light, and if quantum theory has stripped light of its naively imagined attributes, then what of certainty is left to the nature of light at the end of this evolution? Everything. True artists and scientists are not searching to grasp knowledge as an object, but rather as event. The moment of critical importance is the moment pointed to by Goethe, the moment of insight. For millennia, one can see the sun rise and never notice the rotation of the earth. We can wake each morning for 60 years to the glow of the dawn and never see light. Why? Because one rushes past the immediate offerings of the senses to what we suppose to be the hidden, enduring primary objects of reality. The habits of our culture, the dogmas of our education constrain our sight.

Knowledge is not an object to be traded like chattel, but an epiphanous moment to be cherished. Too often we bypass epiphanies for a currency more ready to hand, for an abstract notion, an old insight in new dress, an equation whose characters could reveal, but which,

in fact, we allow to go unread. These are the stones of knowing instead of the bread, they are idols instead of gods. Epiphanous knowing presupposes organs for insight, inward instruments; new knowing requires new instruments. We each possess the rudiments of every organ, but we deny them the nurturing they need, we neglect the daily work in whose light they might grow and flourish.

Over millennia, cultures have embraced and discarded countless images of light. And in a single lifetime, we have lived within and shed successive understandings of light. Through research, artistic practices and quiet contemplation, light's elusive being constantly re-creates itself in our mind's eye, offering fresh epiphanies to every generation. When seen with a thousand eyes, light will finally rest with us in the haven we have made.

Seeing light is a metaphor for seeing the invisible in the visible, for detecting the fragile garment that holds our planet and all existence together. Once we have learned to see light, surely everything else will follow.

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July 12, 1993

James W. Curran, M.D., M.P.H.
Assistant Surgeon General
Associate Director for HIV/AIDS
Centers for Disease Control and Prevention
Department of Health and Human Services
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P: 2 -- Dr. Curran

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P: 3 -- Dr. Curran

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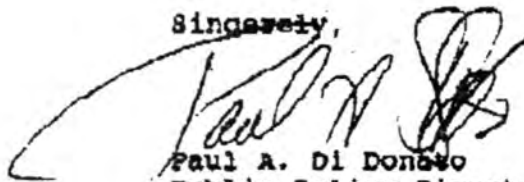
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We will call in the near future to follow-up on this letter. Thank you for your attention.

Sincerely,



Paul A. Di Donato
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AIDS Legal Referral Panel



Elizabeth Cooper
Gibbons Fellow
Crummy, Del Deo,
Dolan, Griffinger
& Vecchione

cc: Members External Review Committees
Ms. Kristine Gebbie

CRUMMY, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE

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ELIZABETH B. COOPER

July 16, 1993

James W. Curran, M.D., M.P.H.
Assistant Surgeon General
Associate Director for HIV/AIDS
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E.
Atlanta, GA 30333

Dear Dr. Curran:

I am writing to follow up on the letter that Paul DiDonato and I sent to you last week (a copy of which is enclosed). On Monday, July 12, 1993, I attended the hearing hosted by the CTRPN External Review Committee in New York City. I would like to pass along to you some of my observations regarding this meeting.

First, as attested to by many who presented testimony to the Committee, the meeting was not very well publicized. In fact, without the extraordinary efforts of the AIDS Institute and GMHC to notify organizations by fax and phone of the meeting, it would have been very sparsely attended. It was only through the work of these offices that an even moderate attendance was possible. In fact, many people who were at Monday's meeting became aware of it only the Friday before.

Moreover, although agendas were handed out, the benefit derived therefrom was grossly diminished by their not having been provided in advance, as part of the meeting announcement. Finally, it was particularly disturbing that there appeared to be no official note-taker or minutes-keeper (or mechanical recorder of testimony), whose sole responsibility it would have been to create an accurate record of public input.

CRUMMY, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE

Dr. James Curran
July 16, 1993
Page 2

Although the External Review process is an Advisory Panel initiative, its clear purpose is to enable the CDC to review and restructure the substance and administration of its HIV programming. Therefore, the failures described above highlight the Agency's strong and abiding responsibility to ensure that notice of all open meetings held by the External Review Committees is disseminated broadly and well in advance of scheduled meetings; such notice should include mention of the host Committee's mandate and its agenda for the day. Of course, both the agenda and the mandate of the Committee should be reiterated at the start of each meeting. Finally, a consistent means of maintaining a record of public input must be instituted for each External Review Committee meeting or hearing.

Quite frankly, the foregoing recommendations must be implemented immediately. Only by so doing will the Agency and the External Review Committees be executing a commitment to implement a process that truly involves the American public.

In light of the foregoing, we are particularly concerned with the mechanism that the External Review Committees will use to report their findings and the timing of the reporting process. The potential value and strength of the External Review program certainly will be diminished if public input to Committee draft reports is not appropriately sought and the reports are not timely issued.

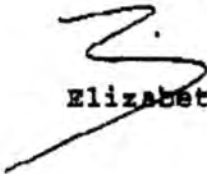
As a follow up, both to this letter and the letter we sent to you last week, Paul and I will call you in the late afternoon of July 21st. We wish to discuss with you the concerns addressed in our correspondence in the hope that they will be raised and discussed at the External Review Committee co-chairs meeting scheduled for July 26, 1993. If you do not expect to be available on the afternoon of the 21st, please have someone from your office call me to reschedule our discussion.

CRUMMY, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE

Dr. James Curran
July 16, 1993
Page 3

Once again, thank you for your cooperation. Paul and I are looking forward to talking to you next week.

Very truly yours,



Elizabeth B. Cooper

EBC:gmw

Enclosure

cc: Members, External Review Committees
Ms. Kristine Gebbe
Mr. Paul DiDonato

JUL 21 1993

Elizabeth B. Cooper, Esq.
Crummy, Del Deo, Dolan,
Griffinger & Vecchione
Attorneys at Law
One Riverfront Plaza
Newark, New Jersey 07102-5497

Dear Ms. Cooper:

Thank you for your letters of July 12 and July 16 regarding the external review of CDC's HIV prevention programs. You have raised some very important issues, and we are providing copies to our advisory committee for their consideration.

Regarding the subcommittee meeting held in New York City on July 12, extensive attempts were made to publicize the event. A public notice was published in the Federal Register on June 18, 1993. In addition, staff from our National Center for Prevention Services, using mailing lists provided by the New York City Health Department, the New York State AIDS Institute and the National AIDS Clearinghouse, sent more than 500 notices of the meeting to agencies and organizations both in New York City and surrounding areas approximately 2 weeks before the meeting. The New York City Health Department also placed an announcement on several local radio stations with details of the meeting.

Unfortunately, we understand that many of the organizations failed to forward the information to their key staff members who should have been in attendance. In addition, some organizations were not on the mailing lists as no accurate, up-to-date address lists of these organizations exist. As you can appreciate, we do not have the resources to call each of these organizations prior to the meeting. Regardless, this meeting had the highest attendance to date, and our panel members commented on the diversity of the groups represented.

A recorder, whose sole purpose was to record the comments and testimony received at the meeting, was present throughout the meeting. In addition to extensive notes, the meeting was also recorded on audio tape. These minutes will be finalized within the next week, and we will be pleased to share a copy with you.

Patricia

Page 2 - Ms. Elizabeth B. Cooper

We appreciate your continued interest in HIV prevention and the efforts of the CDC Advisory Committee on the Prevention of HIV Infection.

An identical letter has been sent to Mr. Paul A. Di Donato.

Sincerely yours,

James W. Curran, M.D., M.P.H.
Assistant Surgeon General
Associate Director for HIV/AIDS

cc:
CDC/W
OHA
k:\DiDonato; HIV/HCA
prepared by: Gary Conrad
spelling verified by cg 7/21/93

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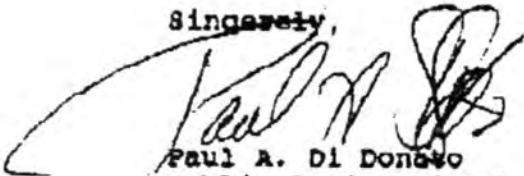
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Atlanta, GA 30333

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I am writing to follow up on the letter that Paul DiDonato and I sent to you last week (a copy of which is enclosed). On Monday, July 12, 1993, I attended the hearing hosted by the CTRPN External Review Committee in New York City. I would like to pass along to you some of my observations regarding this meeting.

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Moreover, although agendas were handed out, the benefit derived therefrom was grossly diminished by their not having been provided in advance, as part of the meeting announcement. Finally, it was particularly disturbing that there appeared to be no official note-taker or minutes-keeper (or mechanical recorder of testimony), whose sole responsibility it would have been to create an accurate record of public input.

CRUMMY, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE

Dr. James Curran
July 16, 1993
Page 2

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Quite frankly, the foregoing recommendations must be implemented immediately. Only by so doing will the Agency and the External Review Committees be executing a commitment to implement a process that truly involves the American public.

In light of the foregoing, we are particularly concerned with the mechanism that the External Review Committees will use to report their findings and the timing of the reporting process. The potential value and strength of the External Review program certainly will be diminished if public input to Committee draft reports is not appropriately sought and the reports are not timely issued.

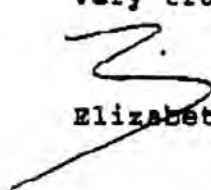
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CRUMMY, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE

Dr. James Curran
July 16, 1993
Page 3

Once again, thank you for your cooperation. Paul and I are looking forward to talking to you next week.

Very truly yours,



Elizabeth H. Cooper

EBC:gmw
Enclosure

cc: Members, External Review Committees
Ms. Kristine Gebbe
Mr. Paul DiDonato

JUL 21 1993

Elizabeth B. Cooper, Esq.
Crummy, Del Deo, Dolan,
Griffinger & Vecchione
Attorneys at Law
One Riverfront Plaza
Newark, New Jersey 07102-5497

Dear Ms. Cooper:

Thank you for your letters of July 12 and July 16 regarding the external review of CDC's HIV prevention programs. You have raised some very important issues, and we are providing copies to our advisory committee for their consideration.

Regarding the subcommittee meeting held in New York City on July 12, extensive attempts were made to publicize the event. A public notice was published in the Federal Register on June 18, 1993. In addition, staff from our National Center for Prevention Services, using mailing lists provided by the New York City Health Department, the New York State AIDS Institute and the National AIDS Clearinghouse, sent more than 500 notices of the meeting to agencies and organizations both in New York City and surrounding areas approximately 2 weeks before the meeting. The New York City Health Department also placed an announcement on several local radio stations with details of the meeting.

Unfortunately, we understand that many of the organizations failed to forward the information to their key staff members who should have been in attendance. In addition, some organizations were not on the mailing lists as no accurate, up-to-date address lists of these organizations exist. As you can appreciate, we do not have the resources to call each of these organizations prior to the meeting. Regardless, this meeting had the highest attendance to date, and our panel members commented on the diversity of the groups represented.

A recorder, whose sole purpose was to record the comments and testimony received at the meeting, was present throughout the meeting. In addition to extensive notes, the meeting was also recorded on audio tape. These minutes will be finalized within the next week, and we will be pleased to share a copy with you.

Furra

Page 2 - Ms. Elizabeth B. Cooper

We appreciate your continued interest in HIV prevention and the efforts of the CDC Advisory Committee on the Prevention of HIV Infection.

An identical letter has been sent to Mr. Paul A. Di Donato.

Sincerely yours,

James W. Curran, M.D., M.P.H.
Assistant Surgeon General
Associate Director for HIV/AIDS

CC:
CDC/W
OHA
k:\DiDonato; HIV/HCA
prepared by: Gary Conrad
spelling verified by cg 7/21/93

? evaluation of local programs

what is effective prevention?

which agency should fund prevention services?

resources for partner notification -

CDC relationships generally -
to state / local govt & to others

rural
corrections
Native American
Border issues

internal CDC coordination -
include strategic planning -
institutional credibility for CDC
"politization"

general vs. targeted approaches

Resource allocation

Health leadership - CDC backing + local

Themes -
many epidemics
evaluation
community planning.

Lopez/Freimuth

leadership role for CCR
evaluation

Joseph/Wilbert -

final draft in mid/late Sept -

little info from right side of spectrum

~~Mike~~

~~Jim~~

~~Norm~~

~~Mark~~

~~Steve~~

Julie Gerberding / Mike Osterholm - Surveillance
overlapping epidemics

Draft by ~~November~~? October / final November

? are purposes clear?

? cohorts → surveillance

Schramm / Kelly - CTRPN

relationship to pertinent services - are they there?

unlinking testing from prevention

Draft in October / final in November

Mazegenheim / Rochelle -

Draft report in August / final in October

"dysfunctional" families of organizations

? if federal cross-agency coordination

cooperative agreements -

clear goals? / outcomes

Belinda	Julie
Mark	Mike
Julie	Jeff
	Steve
	Norm
	Jim

**AIDS
LEGAL
REFERRAL
PANEL**

114 Sansome St.
Suite 1120
San Francisco,
CA 94104
(415) 291-5454

An independent
not-for-profit organization
sponsored by
San Area Lawyers
for Individual
Freedom (SALIF) and
Volunteer Legal
Services Program of
the Bar Association
of San Francisco
(VLS/BASF)

July 12, 1993

James W. Curran, M.D., M.P.H.
Assistant Surgeon General
Associate Director for HIV/AIDS
Centers for Disease Control and Prevention
Department of Health and Human Services
1600 Clifton Rd., NE
Atlanta, GA 30333

Dear Dr. Curran:

We are writing to continue our conversation regarding the External Review process. Thank you for your response to our letter and our continued communications.

As we stated in our initial letter to you, we were concerned that the process used to develop the External Review Committees might have resulted in gaps in representation of a variety of groups. In particular, there appeared to be an imbalance with regard to the participation of HIV-positive individuals, people of color, women, gays and lesbians, HIV-positive drug users and youth or advocates for these groups. We also had concerns regarding the mandates of the Committees which were not clear to us or to many others.

As you may be aware, we have been conducting extensive research and interviews to determine the extent to which people with HIV and their advocates were either satisfied with or concerned about the membership and mandate of the Committees. While we were very pleased to learn that many individuals are satisfied with large parts of the process, a number of concerns were expressed to us.

The following is a list of these concerns:

1. Committee Composition

A. Many of those to whom we spoke noted the general absence of advocates and other experts in the area of mental health from the Committees. This absence is particularly noteworthy because of the increasing importance of the triple track approach (HIV/substance abuse/mental health) in addressing most aspects of HIV/AIDS, especially HIV prevention efforts.

B. Although women, people of color and gays and lesbians serve on the Committees, some individuals also noted the absence, on the full range of Committees, of representatives of groups primarily composed of or advocating specifically on behalf of

P. 2 -- Dr. Curran

these communities. This issue appears to be a consistent problem, as we witnessed in the CDC redefinition process. The CTRPN Committee seems particularly lacking in this fully balanced representation.

C. Individuals also noted the absence of advocates and other experts in the area of HIV and substance abuse on the CTRPN and School Students Committees.

D. CTRPN also appears lacking in representation of HIV/AIDS legal advocates whose input is particularly pertinent to this issue in light of the serious confidentiality and other legal and legal policy concerns in this area.

E. We and many others were pleased to see that Mike Isbell of Lambda Legal Defense and Education Fund and Cornelius Baker of National Association of People with AIDS were added to the Committee on monitoring the epidemic, as numerous individuals had expressed strong reservations regarding the makeup of this Committee. These were very important additions.

We would be very interested to know your feelings on these specific observations and also to discuss ways to address these issues promptly and constructively.

2. Community Input and Corrective Mechanisms

We are very pleased to see that a public meeting and comment format is being followed by some of the Committees (e.g. CTRPN and Prevention). We see this as one way to mitigate problems with Committee composition, so we hope that each committee is following this approach systematically.

Assuming that this type of open meeting will be held by each Committee, we encourage the agency, CDC ACPHI and Ms. Gebbie to ensure that the meetings are targeted to achieve geographic diversity and are well-advertised to encourage wide-spread attendance. We and others would be happy to widely circulate a complete list of such meetings to our networks, especially to advocates for people with HIV/AIDS, women, people of color, gays and lesbians, substance abusers, youth and those in the mental health arena.

We strongly encourage the agency to publish Committee reports in draft form for public comment. Of

P: 3 -- Dr. Curran

course, we expect that the reports will be available to the public when complete.

We look forward to discussing these issues and proposals in the near future.

3. Committee Mandates

Crucial to the work of the Committees is the need to have their mandates well-defined and well circulated. This appears to be problematic. Certainly, the degree of effective and appropriate public input may be seriously compromised by a failure of the External Review process to clearly articulate its mandate.

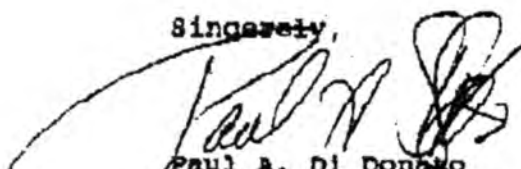
For example, several advocates on HIV prevention to whom we spoke expressed concern at the structure and scope of the External Review Committees. Some went so far as to suggest to us that the lack of a mandate to address prevention using the triple track model raised serious concerns. These advocates further suggested to us that, because of this, they feared it was possible that the review process would not produce a comprehensive review of the CDC's prevention efforts.

4. Status of Ms. Gebbie

In light of Ms. Gebbie's appointment as AIDS Coordinator, we are inquiring as to the status of her role in the Review Process.

We will call in the near future to follow-up on this letter. Thank you for your attention.

Sincerely,


Paul A. Di Donato
Public Policy Director, Esq.
AIDS Legal Referral Panel


Elizabeth Cooper
Gibbons Fellow
Crummy, Del Deo,
Dolan, Griffinger
& Vacchione

cc: Members External Review Committees
Ms. Kristine Gebbie

CRUMMY, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE

A PROFESSIONAL CORPORATION

GIBBONS FELLOWSHIP IN
PUBLIC INTEREST & CONSTITUTIONAL LAWJOHN J. GIBBONS
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201-596-0549CABLE-TELEX
36154LAWRENCE S. LUSTBERG
DIRECTORJOHN V. JACOBI
ELIZABETH S. COOPER

July 16, 1993

James W. Curran, M.D., M.P.H.
Assistant Surgeon General
Associate Director for HIV/AIDS
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E.
Atlanta, GA 30333

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CRUMMY, DEL DEO, DOLAN, GRIFFINGER & VECCHIONE

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July 16, 1993
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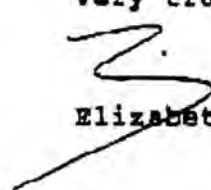
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Dr. James Curran
July 16, 1993
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Very truly yours,



Elizabeth B. Cooper

EBC:gmw
Enclosure

cc: Members, External Review Committees
Ms. Kristine Gebbe
Mr. Paul DiDonato

JUL 21 1993

Elizabeth B. Cooper, Esq.
Crummy, Del Deo, Dolan,
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Attorneys at Law
One Riverfront Plaza
Newark, New Jersey 07102-5497

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Page 2 - Ms. Elizabeth B. Cooper

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Assistant Surgeon General
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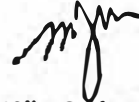
cc:
CDC/W
OHA
k:\DiDonato; HIV/HCA
prepared by: Gary Conrad
spelling verified by cg 7/21/93

MEMORANDUM for CDC REVIEW MEETING

July 26. 1993

TO: External Review Subcommittee Chairs and Lead Consultants.
CDC Advisory Committee on Prevention of HIV Infection

FROM: Mark J. Magenheim, Government Partner and
Belinda Rochelle, Non-Government Partner



"DEVELOPING PARTNERSHIPS FOR HIV PREVENTION" Subcommittee

RE: Summary of Process and Progress to date

=====

I. ISSUES delineated by HIV Prevention Partnerships Subcommittee:

An Orientation/Organizational Meeting of this Subcommittee was held in Atlanta May 11 at which time 4 questions were determined as the basis for external review in multiple city visits; (see attached).

II. DESCRIPTION of the Review Process:

The Subcommittee consisted of fourteen individuals (list attached), of whom at least six were present for each of the 7 cities visited:

1. Minneapolis, MN	May 21
2. Portland, OR	June 3
3. San Diego, CA	June 7
4. Chicago, IL	June 21
5. Gary, IN	June 22
6. Newark, NJ	July 7
7. Memphis, TN	July 12

The format for each city visit included "invited" and open public testimony focussing on the four questions in the morning and "workshop/focus group" discussions in the afternoon. In general, five minutes were allotted for each speaker in the morning, followed by five minutes for questions from the panel. In the afternoon, government representatives met separately with half of the review team and non-government representatives met with the other half of the review team in different locations. A CDC contract recorder/editor attended all city visits and compiled full synopses of testimony as well as condensed summaries of each city-visit.

On July 13, the full panel met in Memphis to organize its report of Findings and Recommendations. Over 40 issues and recommendations dealing with the four research questions were identified and 15-16 of these will be highlighted as Priorities in the final report. It is expected that the first draft of the Subcommittee's report will be available July 30 for circulation to the full panel. The Subcommittee has organized itself into "Section Editors" with a plan and schedule for specific review and second editing through August.

It is expected that a Conference Call may be needed before preparation of the final draft sometime in August. Text revisions, final panel review, and collation of appendices and supporting background material will be prepared by September. It is now anticipated that the Final Report will be finished by October 1, 1993.

III. PROGRAM AREAS or "GAPS" between the Sub-committees:

In addition to providing comments on the four focus questions, many speakers addressed overlapping issues of: public/community information (the "America Responds to AIDS"/ARTA Campaign in particular); HIV risk-reduction education needs and problems re: youth; funding for HIV prevention; the tension between HIV prevention and HIV care services; the perceived political process of funding decisions; and the intrusion of non-scientific factors in CDC program decisions. In addition, program gaps included issues of HIV prevention among the homeless, those in correctional settings, and those in rural areas, as well as bi-national HIV issues with Mexico especially.

IV. OTHER ISSUES or needs identified by the Subcommittee:

In city visit discussions among panel members and during the work session in Memphis on July 13, the Subcommittee discussed broader issues of CDC operations which emerged during the review process. Included are: internal and external roles and relationships of CDC Project Officers and staff; hierarchical barriers to CDC program integration; use of contractors; CDC assignees; logistical problems of notification, preparation, and timing; CDC resource allocation; prioritization process for grants; lack of federal policy and federal agency coordination; review and decision process for funding; CDC's visibility and credibility; distribution of the final Report and follow-up regarding outcomes of the external review process.

Enclosures: List of External Review Panel Members (fourteen)
 List of Advisory Subcommittee Questions (four)
 Criteria used to select cities for visits
 Cumulative AIDS Case Sheet for cities visited
 Sample of Meeting Announcement (Minneapolis)
 Sample of Site-Visit Fact Sheet (Newark, NJ)
 July 9 Memo to Panel re: preparation of final report

xc: Kristine Gebbie, Chair
 James W. Curran, M.D., CDC

DEVELOPING PARTNERSHIPS FOR HIV PREVENTION

CITY: Memphis

DATE: Monday, July 12, 1993

SUBCOMMITTEE MEMBERS AND CONSULTANTS:

Nancy Evans, M.P.H.
Program Director
Youth HIV Prevention Project
San Francisco, CA

Marta Flores, B.A.
Program Director
Logan Heights Family Health
Center
San Diego, CA

Aida Giachello, Ph.D.
Assistant Professor
Jane Addams College of Social
Work
University of Illinois
Chicago, IL

Jeremy Landau
Executive Director
National Rural AIDS Network
Santa Fe, NM

(*) Mark Magenheim, M.D., M.P.H.
Director and Health Officer
Sarasota County Public Health
Unit (HRS)
Sarasota, FL

(*) Sallie Perryman
Health Program Administrator
New York State Department of
Health
AIDS Institute
New York, NY

Belinda Rochelle
Program Director
AIDS Action Council
Washington, DC

Gail Tanaka, M.S.W.
Program Director of Health
Education
Comprehensive Health Education
Foundation
Seattle, WA

Dennis Whalen
Executive Deputy Director
New York State Department of
Health
AIDS Institute
Albany, NY

Renee Whiterabbit
AIDS Project Coordinator
Indian Health Board of
Minneapolis
Minneapolis, MN

Reggie Williams
Executive Director
National Task Force on AIDS
San Francisco, CA

James Credle, Asst. Dean
Rutgers University, Newark Campus

Susan Addiss, Health Commissioner
State of Connecticut (Hartford, CT)

Denise Webster
NGO Writer/Editor

(*) Lawrence Gostin, Exec. Director
American Society of Law and Medicine
Boston, Massachusetts

(*) CDC Advisory Committee on Preven-
tion of HIV Infection (ACPHI Member)

ADVISORY COMMITTEE ON THE PREVENTION OF HIV INFECTION

Developing Partnerships for HIV Prevention

Questions

1. **What could CDC do to promote and/or enhance HIV prevention partnerships among the CDC, targeted populations, NGOs, and state and local health departments?**
2. **What are the effective characteristics of these partnerships?
(How are roles differentiated?)**
3. **What can CDC do to assess and meet the diverse technical assistance needs of NGOs and state and local health departments?**
4. **What could CDC do to further integrate HIV/STD/TB/Substance Abuse prevention activities?**

Written comments to the above questions may be forwarded to Ms. Kristine Moore Gebbie, Chairman of the Advisory Committee on the Prevention of HIV Infection (ACPHI).

Please mail comments care of:

**Centers for Disease Control and Prevention
Attention: Ms. Connie Granoff
1600 Clifton Road, NE, MS E40
Atlanta, Georgia 30333**

Criteria Used in Identifying Metropolitan Statistical Areas (MSAs)

Cities selected according to the following criteria:

- high, medium and low prevalence areas;
- geographic representation (East, South, Midwest, West, Northwest, and/or Southwest;
- areas with directly funded CBOs and NMOs; and
- areas without directly funded CBOs and NMOs.

HIGH

MEDIUM

LOW

East

*Newark
Boston
Philadelphia
Baltimore

Hartford/New Haven

Buffalo

South

Atlanta
Miami
New Orleans
Dallas

San Antonio
Baton Rouge

Birmingham
*Memphis
Nashville

Midwest

*Chicago

*Gary
St. Louis
Cleveland
Kansas City
Detroit

*Minneapolis
Milwaukee
Indianapolis

West

Los Angeles
San Francisco
Denver
*San Diego

*Portland
Seattle

Phoenix

- * Indicates selected cities for site visits based on high, medium, and low prevalence areas, geographic regions, and areas with and without directly funded NGOs.

**ATTACHMENT 1
SELECTED DATA ON AIDS IN NEW JERSEY**

CUMULATIVE AIDS CASES REPORTED THROUGH DECEMBER, 1992

CITY / STATE	MSA	TOTAL AIDS CASES	%
CHICAGO, ILLINOIS 3.2% of all U.S. AIDS cases were reported by Illinois.	Chicago Lake County All Others TOTAL - ILLINOIS	6,885 142 1,202 8,229	83.7% 1.7% 14.6% 100.0%
GARY, INDIANA 0.7% of all U.S. AIDS cases were reported by Indiana.	Gary Indianapolis All Others TOTAL - INDIANA	173 790 781 1,744	9.9% 45.3% 44.8% 100.0%
MEMPHIS, TENNESSEE 0.7% of all U.S. AIDS cases were reported by Tennessee.	Knoxville Memphis Nashville All Others TOTAL - TENNESSEE	175 623 616 450 1,864	9.4% 33.4% 33.0% 24.2% 100.0%
MINNEAPOLIS, MINNESOTA 0.5% of all U.S. AIDS cases were reported by Minnesota.	Minneapolis/ St. Paul All Others TOTAL - MINNESOTA	1,118 184 1,264	88.4% 11.6% 100.0%
NEWARK, NEW JERSEY 5.8% of all U.S. AIDS cases were reported by New Jersey	Bergen/Passaic Jersey City Middlesex Monmouth/Ocean Newark All Others TOTAL - NEW JERSEY	1,865 2,467 1,239 965 6,073 2,093 14,702	12.7% 16.8% 8.4% 6.6% 41.3% 14.2% 100.0%
San Diego, CALIFORNIA PORTLAND 0.6% of all U.S. AIDS cases were reported by California OREGON	Portland All Others TOTAL - OREGON	1,231 334 1,565	78.7% 21.3% 100.0%
SAN DIEGO, CALIFORNIA 18.5% of all U.S. AIDS cases were reported by California.	Anaheim Bakersfield Fresno Los Angeles Oakland Oxnard/Ventura Riverside Sacramento San Diego San Francisco All Others TOTAL - CALIFORNIA	2,231 217 360 16,518 3,044 264 1,816 1,145 3,633 13,473 4,117 46,818	4.8% 0.5% 0.8% 35.3% 6.5% 0.6% 3.9% 2.4% 7.8% 28.8% 9.7% 100.0%

Source: Division of HIV/AIDS, Center for Infectious Disease, CDC. AIDS Cases Reported to CDC through December, 1992. CDC Public Use Microfiche Dataset.

MEETING ANNOUNCEMENT

The federally appointed Advisory Committee on the Prevention of HIV Infection (ACPHI) announces the following public meeting. Under terms of a United States Government Charter since 1988, the Advisory Committee on the Prevention of HIV Infection is authorized under 42 U.S.C. 217a, Section 222 of the United States Public Health Service Act "to advise the Director of the Centers for Disease Control and Prevention (CDC) regarding objectives, strategies, and priorities for HIV and AIDS prevention efforts."

The ACPHI consists of 16 members appointed for specific overlapping terms by the United States Secretary of Health and Human Services. No ACPHI members are federal employees and none have contracts with the CDC.

A series of meetings is being held by five ACPHI Subcommittees in 1993 as part of an expanded external review process. The ACPHI Subcommittee ("Developing Partnerships for HIV Prevention") convening this meeting consists of 3 ACPHI members plus external consultants. They will receive public comment on partnerships between governmental and nongovernmental organizations for planning and implementing comprehensive HIV prevention programs.

THIS PUBLIC MEETING IS BEING CONVENED AND CONDUCTED BY THE ADVISORY COMMITTEE FOR THE PREVENTION OF HIV INFECTION, NOT BY CDC.

DATE: Friday, May 21, 1993

TIME: 8 a.m.-5 p.m.

**PLACE: Marriott City Center
30 South Seventh Street
Minneapolis, Minnesota 55402**

STATUS: Open to the public, limited only by the space.

In the morning, subcommittee members and consultants will receive public comment from representatives of governmental and non-governmental organizations (NGOs) on the issue of enhancing partnerships for HIV prevention. The afternoon session will focus on discussions with NGO representatives who are current or past recipients of CDC funds, directly or indirectly (i.e., via health departments or USCM).

****over****

**NEWARK, NEW JERSEY SITE VISIT
FACT SHEET**

AIDS CASE REPORTING 5.8% of all U.S. AIDS cases were reported by the New Jersey State Department of Health.	CUMULATIVE AIDS CASES AS OF DECEMBER, 1992 <table><tr><td>Bergen/Passaic</td><td>1,865</td><td>12.7%</td></tr><tr><td>Jersey City</td><td>2,467</td><td>16.8%</td></tr><tr><td>Middlesex</td><td>1,239</td><td>8.4%</td></tr><tr><td>Monmouth/Ocean</td><td>965</td><td>6.6%</td></tr><tr><td>Newark</td><td>6,073</td><td>41.3%</td></tr><tr><td>All Others</td><td>2,093</td><td>14.2%</td></tr><tr><td>TOTAL - NEW JERSEY</td><td>14,702</td><td>100.0%</td></tr></table> See Attachment 1 for additional information.	Bergen/Passaic	1,865	12.7%	Jersey City	2,467	16.8%	Middlesex	1,239	8.4%	Monmouth/Ocean	965	6.6%	Newark	6,073	41.3%	All Others	2,093	14.2%	TOTAL - NEW JERSEY	14,702	100.0%
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SELECTED DATA REGARDING HIV SEROPREVALENCE:	Selected rates are shown below for the period January - March 1993: <table><tr><td>STD Clinic Patients:</td><td>97/3,269</td><td>3.0%</td></tr><tr><td>Correctional Facility Residents:</td><td>14/275</td><td>5.1%</td></tr><tr><td>Tuberculosis Clinic Patients:</td><td>8/177</td><td>4.5%</td></tr><tr><td>Women's Health Clinic Patients:</td><td>28/3,961</td><td>0.6%</td></tr><tr><td>Drug Treatment Program Clients:</td><td>85/1,486</td><td>5.7%</td></tr></table>	STD Clinic Patients:	97/3,269	3.0%	Correctional Facility Residents:	14/275	5.1%	Tuberculosis Clinic Patients:	8/177	4.5%	Women's Health Clinic Patients:	28/3,961	0.6%	Drug Treatment Program Clients:	85/1,486	5.7%						
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STATE FUNDING OF NGOs	NGOs may receive funds from the CDC HIV Prevention Cooperative Agreement with the Division of AIDS Prevention and Control (DOAPC), New Jersey State Department of Health (NJSDOH). Under the current CDC HIV Cooperative Agreement, the DOAPC administers HIV Prevention contracts with approximately thirteen (13) NGOs targeting racial/ethnic minorities, one (1) NGO providing public information services and four (4) NGOs providing HIV counseling and testing services. Other NGOs funded under the CDC Cooperative Agreement include drug treatment services providing HIV counseling, testing and other services to Injecting Drug Users. Contract awards under the Cooperative Agreement exceed \$1,473,850 for NGOs providing HIV Prevention Services (excluding funding for HIV Counseling and Testing and funding to drug treatment centers). NGOs funded by the NJSDOH under the CDC HIV Prevention Cooperative Agreement funds include, but are not limited to: Boys and Girls Club of Newark, Caribbean Haitian Council, Casa Prac, Check-Mate, Hispanic Association of Ocean County, Martin Luther King Academy, Morris County Urban League, Nigeria-America Institute, Planned Parenthood of Mercer, Puerto Rican Association for Community Organization, Urban League of Metropolitan Trenton, and Spanish Community Center.																					
CDC DIRECT FUNDING OF CBOs:	NGOs in several New Jersey MSAs were eligible to receive direct funding through CDC HIV Prevention Cooperative agreements. No NGOs in New Jersey currently receive direct funding through Program Announcement 202. However, at least eight NGOs have received awards under previous Program Announcements for direct funding of minority and other CBOs.																					

CDC NMO ACTIVITIES:	Puerto Rican Organization for Community Education and Economic Opportunity, Inc. (PROCEED) serves as lead agency for the Northeast Hispanic AIDS Consortium (NeHAC), a network of seven community-based organizations founded to create a regional response to HIV infection rates among Hispanic/Latinos. NeHAC serves communities in Connecticut, New York, New Jersey, Massachusetts, Puerto Rico. The affiliates of NeHAC completed HIV/AIDS needs assessments of their respective communities and developed culturally-sensitive and appropriate HIV/AIDS prevention models targeting men who have sex with men, injecting drug users and Latina women, and a training and resource manual. PROCEED is located in Elizabeth, New Jersey.												
ESTIMATED NUMBER OF NGOS:	Approximately 80 nongovernmental organizations are located in New Jersey. This estimate excludes public universities/hospitals, clinical trials units, medical societies, and hospice programs.												
SELECTED DEMOGRAPHICS:	1990 Census data for New Jersey: Population by race/ethnicity (Attachment 3 presents information on Newark): <table><tr><td>White, Not Hispanic:</td><td>6,370,411</td><td>(82.4%)</td></tr><tr><td>Black, Not Hispanic:</td><td>1,067,086</td><td>(13.8%)</td></tr><tr><td>Other:</td><td>292,691</td><td>(3.8%)</td></tr><tr><td>Total:</td><td>7,730,188</td><td>(100.0%)</td></tr></table>	White, Not Hispanic:	6,370,411	(82.4%)	Black, Not Hispanic:	1,067,086	(13.8%)	Other:	292,691	(3.8%)	Total:	7,730,188	(100.0%)
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OTHER RELEVANT INFORMATION:	The NJSDOH administers funds from the HIV Prevention Cooperative Agreement to support a number of Consortia to support HE/RR, Minority and Drug User Intervention Services. Lead agencies for the Consortias include: Camden Area Health Education Center, City of Trenton, Family Planning Program of Ocean County, and Paterson Counseling Center. The NJSDOH supports 25 free-standing HIV Counseling and Testing Sites. San Diego is the site of Project Action, a social marketing effort to promote condom utilization among teenagers at risk. The NJSDOH also collaborates with other Federally funded agencies and other organizations. This includes the N. J. Collegiate Consortium for Health in Higher Education (CDC), the New Jersey State Department of Education (CDC), the Regional AIDS Education Center at the University of Medicine and Dentistry of New Jersey (HRSA), and the National Pediatric HIV Resource Center at Children's Hospital, Newark (HRSA). The Division of AIDS Prevention and Control provides over 1.2 million dollars to drug treatment centers throughout the state to support HIV/AIDS prevention services. SOURCES: New Jersey HIV Prevention Cooperative Agreement Application (1992); New Jersey Quarterly Narrative (June 14, 1993).												
ATTACHMENTS:	1. Selected Data on AIDS in New Jersey. 2. 1990 Census Data - Selected Information 3. Partial Listing of Non-Governmental organizations involved in HIV prevention.												



STATE OF FLORIDA
DEPARTMENT OF HEALTH AND
REHABILITATIVE SERVICES

SARASOTA COUNTY
PUBLIC HEALTH UNIT

MARK J. MAGENHEIM, M.D., M.P.H.
DIRECTOR AND HEALTH OFFICER

(813) 954-2900
SUNCOM 552-7950

July 9, 1993

TO: CDC External Review Group on "HIV Prevention Partnerships"
FROM: Belinda Rochelle and Mark J. Magenheim, Co-Facilitators
RE: Ideas for July 13 preparation of final Review Panel Report

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We've been thinking about how we might organize all our notes and summaries of site-visit meetings for our report, and we'd like to propose the following format and plan for our July 13 work day.

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8:30-8:45 a.m.:	Overview of City-Visits	Mark and Belinda
8:45-9:00 a.m.:	Role of Professional Writer in today's Session with Panel	Mark, Belinda and Denise Webster
9:00-10:15 a.m.:	General Discussion of Visits	Full Panel
10:15-10:30 a.m.:	BREAK	
10:30-11:30 a.m.:	Agreement on Format and Work Plan	All (A)
11:30-12:15 a.m.:	Agreement on Findings re Question 1	All (B)
12:15-1:00 p.m.	LUNCH BREAK, etc.	
1:00-1:45 p.m.	Agreement on Findings re Question 2	All (C)
1:45-2:30 p.m.	Agreement on Findings re Question 3	All (D)
2:30-3:00 p.m.	BREAK	
3:00-3:30 p.m.	Agreement on Findings re Question 4	All (E)
3:30-4:45 p.m.	Priority Recommendations	All (F)
4:45-5:15 p.m.	Follow-up Work Assignments & TimeFrame for Preparation/Review of Drafts	Belinda and Mark

(LETTERS) after "ALL" denote different panel members serving as the facilitators for this section of the July 13 agenda. The proposed format and workplan for the Report is shown on the following page).

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 - o Names of advisory committee members, chair, co-author, external consultants
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- IV. FINDINGS AND RECOMMENDATIONS for Program Policies/Strategies
 - o Strengths and weaknesses
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Specific areas about which we will want to comment in our report:

- a) Perspectives on Current HIV Partnerships
 - a. NGO's with each other (local, state, regional, national)
 - b. NGO's with government (local, state, federal/CDC relations)
 - c. inter-governmental relations (local, state, federal/CDC)
- b) Problems identified among existing partnerships at all levels
 - a-c: as above
- c) Ideal Characteristics of partnerships: comments from the field
- d) Technical assistance interests and needs: views from the field
 - a-c: as above in (a), plus FROM the field TO CDC.
- e) Opportunities for integration of HIV/STD/TB/Hep. B programs

Appendices: Details about visits and the process in general, etc.

We propose that all panel members assign ourselves to take prime or shared responsibility for one section only and serve as the contact person to edit that section directly with Denise as she prepares the final document. All panel members would be invited to submit their comments and/or notes on a particular section to the panel member coordinator(s) for that section. The section coordinator(s) would act as editor(s) for collating panel comments on that section and would be the liaison for that part of the report with Denise.

xc: Jim Curran and Ron Valdiserri, CDC
Kristine Gebbie, Adv. Comm. Chair



**HIV/AIDS
PREVENTION**

FROM THE DESK OF
Dale Hubbard

Office of the Associate Director for HIV/AIDS

Phone: (404)639-0900

Fax: (404)639-0910

TO:

Connie Grant

Date:

7/12/93



Necessary Action



For Your Information

Comments

*FYI & please
send a copy to
R. Debbie.*

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND
REHABILITATIVE SERVICESMARK J. MAGENHEIM, M.D., M.P.H.
DIRECTOR AND HEALTH OFFICERSARASOTA COUNTY
PUBLIC HEALTH UNIT(813) 954-2900
SUNCOM 554-2900
FAX Numbers:
Ringling - 364-2837
Cattlemen - 378-6152
Venice - 492-3104
Laurel - 364-2834DATE: 7/12/93 FAX COVER

TO: DR. JAMES CURRAN
OFFICE: DEPUTY DIRECTOR (HIV) - CDC
PHONE #: (404) 639-0900 SUNCOM # _____
FAX #: (404) 639-0910 SUNCOM # _____
FROM: DR. MARK MAGENHEIM
OFFICE: SARASOTA COUNTY PUBLIC HEALTH UNIT -
PHONE #: (813) 954-2950 SUNCOM # _____
FAX #: (813) 364-2837

SUBJECT: "FYI" RE: OUR PLANS / PROGRESS -
PLEASE SEE THAT KRISTINE GEBBIE
ALSO RECEIVES A COPY OF THIS.

SPECIAL INSTRUCTIONS: WE LOOK FORWARD TO
SEEING YOU JULY 26. I'LL CALL
AFTER MEMPHIS TO UPDATE YOU -
Wk. OF JULY 19. THANKS!

IF THIS DOCUMENT IS NOT RECEIVED PROPERLY, PLEASE INFORM
SENDER AT THE ABOVE TELEPHONE NUMBER. THANK YOU.



STATE OF FLORIDA
DEPARTMENT OF HEALTH AND
REHABILITATIVE SERVICES

SARASOTA COUNTY
PUBLIC HEALTH UNIT

MARK J. MAGENHEIM, M.D., M.P.H.
DIRECTOR AND HEALTH OFFICER

(813) 954-2900
SUNCOM 552-7950

July 9, 1993

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FROM: Belinda Rochelle and Mark J. Magenheim, Co-Facilitators
RE: Ideas for July 13 preparation of final Review Panel Report

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xc: Jim Curran and Ron Valdiserri, CDC
Kristine Gebbie, Adv. Comm. Chair

July 6, 1993

The attached ideal goals were inadvertently omitted from the June 29, 1993 letter to you from the subcommittee on Promoting Knowledge of Serostatus (HIV counseling, testing, referral, and partner notification programs). Please add these additional ideal goals to those you have already received. We apologize for any inconvenience this may have caused you.

Thank you

Statement of Ideal Goal of Counseling, Testing, Referral, and
Partner Notification (CTRPN) Programs for HIV Prevention.

In regard to primary prevention of HIV infections, the major goal of the national CTRPN program should be to reduce high risk behaviors.

GOALS FOR PARTNER NOTIFICATION
JUNE 15, 1993

To notify people who might otherwise not be aware that they were exposed to HIV.

To encourage those exposed to be tested.

To bring into services and to obtain a reduction in high risk behaviors from sexual and needle-sharing partners of sero positive individuals.

Outreach programs in the context of CTRPN should be designed to reach three different populations:

- 1) People who are not at risk: to give them information about HIV, how it is and is not transmitted, and to reduce their demand for unneeded HIV prevention services.
- 2) People with HIV infection: to get them into counseling and other prevention, medical and social services.
- 3) People who engage in high-risk behavior: to get them into long-term counseling and other prevention services.



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

June 29, 1993

Charles S. Mahan, M.D.
State Health Officer
1317 Winewood Boulevard
Tallahassee, Florida 32399-0700

Dear Dr. Mahan:

As part of an external review process, the CDC Advisory Committee on the Prevention of HIV Infection (ACPHI) has established a subcommittee on HIV counseling, testing, referral and partner notification (CTRPN) and invited expert consultants to participate. None of the subcommittee members or consultants are federal employees.

Members of the subcommittee and consultants are planning to visit the following 5 cities: Dallas, Miami, New York, Raleigh, and Seattle. These visits are being made to help seek the broadest possible input into this process. The members and consultants will be visiting a number of counseling and testing sites and community-based organizations and holding small discussion groups with service providers as well as clients. CDC staff will accompany the external review teams at each site visit.

The subcommittee and consultants would like to observe CTRPN service delivery and discuss the goals and functions of CTRPN. These visits are not being held to evaluate your current program. The subcommittee is seeking your input to the recommendations that will be made to CDC for the future role of HIV CTRPN in an overall HIV Prevention strategy.

Enclosed are the subcommittee's current "Statement of the Ideal Goal of CTRPN Programs for HIV Prevention" and ideal goal for each component of CTRPN including outreach programs. Also enclosed is the most recent proposed language for the Federal Register notification requesting public comments for this review process. We expect publication of this notice shortly. Please review these materials before the visit by a team composed of subcommittee members. We look forward to talking with you and obtaining your advice and feedback about these important issues.

Sincerely yours,

Neil Schram
Neil Schram, M.D.
Subcommittee Chair

Jeffrey A. Kelly
Jeffrey A. Kelly, Ph.D.
Lead Consultant

Enclosures



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

June 29, 1993

Margaret A. Hamburg, M.D.
Commissioner
New York City Department of Health
125 Worth Street
Room 331, Box Number 28
New York, New York 10013

Dear Dr. Hamburg:

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Subcommittee Chair

Jeffrey A. Kelly
Jeffrey A. Kelly, Ph.D.
Lead Consultant

Enclosures



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

June 29, 1993

Bruce A. Miyahara, Secretary
Department of Health
1112 SE Quince Street
Post Office Box 47890
Olympia, Washington 98504-7890

Dear Mr. Miyahara:

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Neil Schramkau
Neil Schram, M.D.
Subcommittee Chair

Jeffrey A. Kelly
Jeffrey A. Kelly, Ph.D.
Lead Consultant

Enclosures



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

June 29, 1993

Charles E. Bell, M.D.
Chief, Bureau of HIV/STD Control
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199

Dear Dr. Bell:

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Jeffrey A. Kelly, Ph.D.
Lead Consultant

Enclosures



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

June 29, 1993

Ronald H. Levine, M.D., M.P.H.
State Health Director
State of North Carolina
Department of Environment, Health, and Natural Resources
Post Office Box 27687
Raleigh, North Carolina 27611-7687

Dear Dr. Levine:

As part of an external review process, the CDC Advisory Committee on the Prevention of HIV Infection (ACPHI) has established a subcommittee on HIV counseling, testing, referral and partner notification (CTRPN) and invited expert consultants to participate. None of the subcommittee members or consultants are federal employees.

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Sincerely yours,

Neil Schram, M.D.
Subcommittee Chair

Jeffrey A. Kelly, Ph.D.
Lead Consultant

Enclosures

The Ideal Goal of HIV testing

The ideal goal of HIV testing is to promote knowledge of HIV infection status in a reliable, convenient, timely way. Knowledge of the test results can then be used as a tool to provide access to prevention and appropriate health services.

The Ideal Goals of Referral

The ideal goals of referral are to:

1. Prevent transmission of HIV infection and
2. Ensure that all HIV-infected persons receive high quality medical care by:
 - 1) Linking HIV negative clients with high risk behavior to prevention counseling and
 - 2) Linking all HIV-infected clients to long term services which provide medical, behavioral, psychosocial, and case management services.

The Ideal Goals of Counseling

- 1) To help people assess their risk of HIV transmission.
- 2) To assist people with high risk behaviors reduce those behaviors
- 3) To assist people who are vulnerable to initiating high risk behaviors in preventing such behaviors.
- 4) To offer different quantities, intensities, and types of behavior change interventions based on the individual.

DRAFT

BILLING CODE: 4160-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

CDC ADVISORY COMMITTEE ON THE PREVENTION OF HIV INFECTION

SUBCOMMITTEE ON PROMOTING KNOWLEDGE OF SEROSTATUS

(COUNSELING, TESTING, REFERRAL, PARTNER NOTIFICATION)

REQUEST FOR COMMENTS

AGENCY: Centers for Disease Control and Prevention (CDC),
Public Health Service, HHS.

ACTION: Request for Comments.

SUMMARY: A subcommittee has been established to the CDC Advisory Committee on the Prevention of HIV Infection (CDC ACPHI) to conduct a review and evaluation of CDC's HIV counseling, testing, referral and partner notification programs. The Subcommittee on Promoting Knowledge of Serostatus (Counseling, Testing, Referral, Partner Notification) has enlisted the assistance of a number of experts in identifying the areas to be addressed in the review process.

During meetings over the next 3 or 4 months, the subcommittee will review and evaluate CDC's HIV antibody counseling, testing, referral and partner notification programs to determine how well these programs provide persons at risk a convenient opportunity to:

a). learn their HIV serostatus

DRAFT

- b). receive HIV prevention counseling
- c). obtain referrals for additional prevention and other services, and
- d). assist sex and needle-sharing partners in receiving prevention services and referrals.

In order to assure the broadest possible input into this process, the CDC ACPHI requests comments from interested parties on the following questions:

- 1). What should be the ideal goals for the CDC HIV prevention program as well as each component (counseling, testing, referral, and partner notification) of CTRPN programs? What should be the relative emphasis of each component? How should progress be measured?
- 2). How well does the current program meet the ideal goals?
- 3). How should the program be changed to meet the ideal goals?
 - a. What should be the relative investment and priority of CTRPN in relationship to other HIV prevention programs and activities?
 - b. What information and data do CDC, health departments, and service providers need to continually improve the program?
- 4). What are the impediments to improving the program and to better achieve the ideal goals?

DRAFT

DATES: Please provide written comments within 30 days of this notice.

ADDRESSES: Comments should be addressed to: Ms. Kristine Gebbie, Chair, CDC Advisory Committee on the Prevention of HIV Infection, c/o Centers for Disease Control and Prevention (CDC), 1600 Clifton Road (MS/E-40), Atlanta, Georgia 30333.

FOR FURTHER INFORMATION CONTACT: Connie Granoff, Committee Assistant, Office of the Associate Director for HIV/AIDS, CDC, 1600 Clifton Road, NE, Mailstop E-40, Atlanta, Georgia 30333, telephone (404) 639-2918.

Dated:

Signed by:

Arthur C. Jackson
Associate Director for Management
and Operations
Centers for Disease Control and
Prevention (CDC)



July 13, 1993

Ms. Kristine Moore Gebbie, Chairman
Advisory Committee on the Prevention
of HIV Infection
Centers for Disease Control and Prevention
Attention: Ms. Connie Granoff
1600 Clifton Road, NE, MS E40
Atlanta, GA 30333

Dear Ms. Gebbie:

As Chairman of the New Jersey Hospital Association/Medical Society of New Jersey Committee on Tuberculosis, I would like to thank you for the opportunity to comment on partnerships between government and non-governmental organizations for planning and implementing comprehensive HIV prevention. The Committee which I chair is focusing predominantly on the issue of TB, which, as you know, is disproportionately affecting the AIDS population.

Recently the New Jersey Hospital Association wrote to Secretary of Health and Human Services, Donna Shalala, requesting her support for TB initiatives in New Jersey, including financial support for New Jersey's hospitals. We received a response from Acting Assistant Secretary for Health, Audrey F. Manley, indicated that the CDC has awarded \$31,902,305 in prevention, control and elimination funds for continuing and expanding TB surveillance, outreach, improving laboratories and MDR TB controls efforts. New Jersey received \$2,924,649 in funding administered through the New Jersey State Health department.

While any source of financial support is of critical importance, \$3,000,000 is grossly inadequate to address the complex and costly consequences associated with Tuberculosis. Of the funding which is being provided, very little is filtering down to health care providers who are also assuming significant responsibility for providing care to patients with Tuberculosis; specifically, New Jersey's hospitals.

As you may know, the Occupational Safety and Health Administration (OSHA) has created enforcement guidelines for occupational tuberculosis exposure. Compliance with these guidelines, which only pertain to Region II, require expensive operational and environmental/facility changes.



K. Moore Gebbie

July 13, 1993

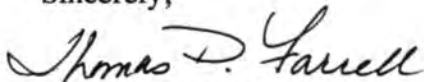
Page Two

With the current required changes to ventilation systems, hospitals are faced with the financial challenge of retrofitting their facilities with little guidance on effective interim control measures and no guidance on outpatient settings. As a result, New Jersey's hospitals are faced with enormous costs as they attempt to bring their facilities environmental controls into compliance. It is estimated that New Jersey's hospital will spend tens of millions of dollars attempting to develop isolation rooms with appropriate ventilation. One hospital in Newark is faced with a \$7 million dollar project to revamp their ventilation system to accommodate patients with TB. Such costs do not take into consideration the additional financing required for employee testing on at least an annual basis, employee education, and personal protection equipment for health care workers. It can be assumed that other congregate living facilities in New Jersey (prisons, jails, psychiatric hospitals, nursing homes, etc.,) will be encountering similar burdens.

If New Jersey's facilities are required to respond to the costly environmental controls and respiratory protection regulations imposed by OSHA, then financial resources must be provided to the facilities to assist them in these efforts. Facilities caring for disproportionate numbers of patients with AIDS, patients with TB and patients with both diseases are least able to carry the financial burdens associated with equipping their facilities to respond to TB. We are seeking your support for a federal block grant for retrofitting hospitals and other facilities, purchasing infection-control equipment and supplies, conducting demonstration projects aimed at finding the most effective ways to prevent TB transmission in inpatient and outpatient settings and, methods by which to get TB patients to comply with their treatment regimens.

We also ask for your support in making the OSHA guidelines truly guidelines, rather than regulations. We look forward to learning of the CDC's recommendations, which we hope will allow more flexibility to hospitals as they develop policies and procedures to respond to TB. Our committee is attempting to identify sources of private and state funds to assist hospitals and other health care facilities. In addition to our efforts, we ask for your assistance in locating the necessary financial support for New Jersey's health care facilities. Your support in this effort will be of tremendous help.

Sincerely,



Thomas D. Farrell, Chairman
New Jersey Hospital Association/Medical
Society of New Jersey Committee on TB

Health Services Supervisor,
New Jersey State Department of Corrections

HOWARD COUNTY BOARD OF HEALTH

120 EAST MULBERRY STREET

ROOM 206

KOKOMO, INDIANA 46901

PHONE (317) 456-2403

Center for Disease Control and Prevention
1600 Clifton Road, NE, MS E40
Atlanta, Georgia 30333

Dear Ms. Connie Granoff:

In response to review of planning and implementation of a comprehensive HIV prevention programs.

Our organization, The Howard County Board of Health, based in a rural and under 100,000 population urban area, has planned, organized, implemented and instructed programs in HIV/AIDS education since the early 1980's.

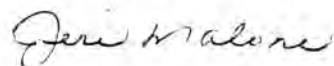
There is a need for support for rural, urban areas with continued funding for HIV/Aids education, HIV testing and the Community Aids Action Group.

The actual case rate for Aids infected persons is high for a rural urban area under 100,000 population. It totals out the same rate as Marion County.

We hope excellent programs will be rewarded by CDC'S continued support and funding.

All HIV/Aids services are a struggle for areas that are under-funded, but have significant HIV/Aids needs.

Sincerely Yours



Jeri Malone, R.N., M.S.N.

HOWARD COUNTY AIDS ACTIVITIES 1992

1992 Evaluation of HIV/AIDS Project

HOWARD COUNTY HIV/AIDS EDUCATION

277 Presentations given

8,901 persons attended

75 presentations to youth	1,698	
49 presentation to homeless	1,987	
25 presentations to women	470	
31 presentations to men	491	
2 Black churches	40	
5 jail inmate presentations	78	
28 presentations to high risk youth	203	(juvenile detention, etc)
8 Jail staff	31	
3 AIDS Councils	28	
12 Health Professionals	249	
5 Support groups	43	
12 Bona Vista Clients	245	
2 Chronic mentally ill adults	49	
<u>Support Group Meetings</u>	20	
<u>Community Action Group Meetings</u> (Community Group Started 3/92)	15	
<u>HIV Testing</u> (Anonymus at Health Dept.)	196	
<u>AIDS Couseling</u> for Health & Resources	5	
<u>AIDS Helpline Training</u>	2	

CAG funds were spent for AIDS brochures, Helpline installation, supplies, education and travel.

OVER

H. I. V. COUNSELING AND TESTING DATA
 YEAR 1992
 ACTIVITIES BY SITE

TESTING SITE TYPE	NUMBER OF SITES	NUMBER OF PATIENT VISITS	# PATIENTS PRETEST COUNSELED	TOTAL TIME SPENT	NUMBER OF PATIENTS TESTED	# PATIENTS POSTTEST COUNSELED	TOTAL TIME SPENT	NUMBER OF PATIENTS POSITIVE
March		36	24	8.45	1 decline 23	12	1.05	
April		40	21	6.05	21	19	3.30	
May		16	13	1.30	3	13	1.25	
June		39	22	15.05	22	17	2.50	
July		46	24	6.25	24	22	6.25	
August		49	25	12.	25	24	4.25	
September		28	13	4.	13	15	2.	
October		33	17	5.10	17	16	2.	
November		46	25	8.45	25	21	2.30	
December		40	19	8.10	1 decline 18	21	2.05	
Totals		373	203	75.15	166	180	24.45	

PSYCHARD CO. BOARD OF HEALTH
 120 E. MULBERRY STREET
 KOKOMO, IN 46901
 317-456-2408

Form Completed by: P. Harrison, R.N.
 Title: _____

CTS Site

Howard County Community AIDS Action Group

The Howard County Community AIDS Action Group (HCAG) is a group of concerned citizens with a goal of helping persons with HIV/AIDS in the community of Howard County.

The activities of the group is funded by a grant from the Indiana Community AIDS Action Network (ICAAAN) and the Indiana Department of Health.

The HCAG plans to reach individuals in the community through the distribution of this brochure to encourage them to seek the services of HIV/AIDS testing and support. The group will also be hosting a help line for the community.

Anyone, regardless of whether or not he/she has HIV/AIDS, who is interested in volunteering time or services for the Howard County Community AIDS

This brochure is dedicated to all who are living suffering, and have died of AIDS and of hopes of bringing a better quality of life to those in the community.

J.F.S.



Help Line



456-AIDS

And other
Howard County
HIV/AIDS Services

**NATIONAL and STATE
HIV/AIDS
HELP LINES**

National AIDS Hotline - 1-800-342-AIDS

Indiana HIV/AIDS Hotline - 1-800-848-AIDS

ICAAAN HIV/AIDS Helpline - 1-800-659-7580

HIV/AIDS-TEEN- Hotline - 1-800-347-8336

Damien Center, AIDS Support - 1-317-632-0123
1350 North Pennsylvania, Indianapolis, IN 46202

AIDS Discrimination - 1-800-775-AIDS

HIV/AIDS Testing in KOKOMO

*HIV/AIDS Testing, FREE and ANONYMOUS,
Mondays by Appointment at Health Department
120 E. Mulberry St. Rm 206 -456-2408*

Planned Parenthood

404 B Arnold Ct. - 455-2400

Howard Community Hospital

3500 S. Lefountain St. - 453-8437

Indiana Health Center

1940 S. Elizabeth - 459-0662

AIDS Education for Community - 456-2408

**HIV/AIDS Support Group for persons with
HIV/AIDS and Caregivers - 456-2408**

**Referral to Community on HIV/AIDS
Resources - 456-2408**

All HIV/AIDS services in Howard County are Confidential

AIDS educator making progress

By Trisha Guthrie
Tribune staff writer

Howard County has 30 reported cases of AIDS for every 100,000 residents. In Indiana, only Marion County can match this ratio.

Registered nurse Sharon Vincent wants to do something about that statistic.



Sharon Vincent
AIDS educator

The Howard County Board of Health's AIDS educator, Vincent said her quest is to "educate people in making positive choices to change their behavior."

In 1987, board of health nursing coordinator Jeri Malone began teaching the area about AIDS without funding from the state. "I tried to do as much as I could, quietly, as a part of the healing process after the Ryan White case," she said.

In 1990, using a state board of health AIDS program grant, she created Vincent's position. Since January, Vincent has spoken to more than 6,000 area residents, including students, jail inmates, dental hygienists and dentists —

She crafts each presentation around her audience's unique AIDS risks. Before her talks, she gives "pretests," to gather AIDS facts they already know. "Post-tests" help her determine what each group has learned.

Although out of her audiences, health care professionals score highest on the pretests, Vincent said many high school students also receive high marks. Least knowledgeable about AIDS are jail inmates, who are a high-risk group.

The most common misconception Howard County has about the AIDS virus, she said, is that it can be transmitted through giving blood.

"I tell them this is not and never has been the case. You only have contact with your own blood, and sterilized instruments are used," Vincent said.

Area schools' curriculums concerning teaching students about AIDS are good, Vincent said, but some teachers do not feel knowledgeable enough or are too uncomfortable about the topic to discuss it. But she feels educating people about the illness is the only way to overcome it.

Another benefit of education, she said, is ending prejudice against those afflicted with the disease.

"I've seen it, and it surprises me. Among the high-risk groups are people who are sexually active. From my post-test results I calculated that 61 percent of an audience of Kokomo High School juniors were sexually active," she said.

Vincent admits she has come a long way from her first days on the job, which included endless hours of making connections in the area and asking permission to make her presentations. Now she not only receives many calls from people wanting her to speak, she also heads an on-going program at Howard County Jail, leads a county support group and offers AIDS information to county, private and parochial schools, to name a few of her duties.

"Instead of knocking on doors and saying, 'Here I am,' I have people realizing that what I do is

Howard, Marion counties have highest AIDS rates

By Kris Kinkade
Tribune assistant local editor

A recently released study on reported cases of HIV-AIDS in Indiana shows two counties, Howard and Marion, as having the highest incident rates in the state.

According to Howard County Board of Health Nursing Coordinator Jeri Malone, Howard County and Marion County had reported case rates of Acquired Immune Deficiency Syndrome and Human Immunological Virus at 30-plus per 100,000 population. She said those are the highest reported levels in the state.

Malone said the latest monthly report for Howard County shows 27 cases of AIDS reported, with 20 deaths. She said the county is seventh in the state as far as total numbers of cases but second in terms of the population level.

Malone could only speculate as to the reasons for the high levels. She said part of the reason may be the fact that Howard County is reporting

more cases than other counties in the state. She said she knows of at least one area physician that started reporting cases this year for the first time and increased the rate.

There is little regulation in the state governing the reporting of patients who test positive for HIV or AIDS.

Malone also said that the higher income levels and the corresponding levels of recreational drug use may be a factor. The number of single parent households may also be a factor, she added.

Malone said the county hopes that the AIDS educator currently on staff in the county will help curb that rate in future years by educating high risk groups on the dangers of the disease and the means to prevent it.

She said the county is in the process of reapplying for the grant to fund that program and thinks the state will base a possible continuance of the program, in part, on the study just released by the State Board of Health.

Tuesday, Sept. 10, 1991

Kokomo (Ind.) Tribune

6/30/92

Howard County AIDS case rate 39.59/ 100,000 population

Howard County HIV case rate 23.51/100,000 population



STATE OF CONNECTICUT

DEPARTMENT OF HEALTH SERVICES

July 12, 1993

Ms. Kristine Gebbie, Chair
CDC Advisory Committee on the
Prevention of HIV Infection
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, MS/E-40
Atlanta, Georgia 30333

Dear Ms. Gebbie:

Thank you for the opportunity to comment on the questions posed by the CDC Advisory Committee's Subcommittee on Promoting Knowledge of Serostatus. My comments to the questions you have raised are as follows:

1. I see counseling, testing, referral and partner notification as having two goals: prevention and identification of people who are HIV infected. I believe that prevention should have slightly more weight as a focus than promoting knowledge of serostatus. Data from across the country show that most people are not identified as seropositive through HIV counseling and testing sites funded by CDC. Our own data in Connecticut show that 60 percent of AIDS cases that we interviewed were tested only when they were symptomatic. While it is important to promote earlier detection through the HIV counseling and testing sites, I think we must recognize that, at present, given who they serve, their greatest value can be in prevention.

Progress should be measured by a number of factors, including the percentage of people who identify a significant risk of HIV infection, post-test return rates, the ability of sites to do additional prevention education sessions with both high risk seronegatives and seropositives, and success in referring people at risk for services.

2. The current program does not meet the ideal goals well for a variety of reasons, some inherent to the program, and others not. The traditional structure of counseling and testing (pre-test counseling, testing and post-test counseling) is insufficient to really engage people in behavior change. CDC has prepared a revised model for counseling and testing to address this issue, but, not being entirely familiar with it, it is difficult for me to say whether the new model will address prevention needs sufficiently. With regard to the goal of promoting the knowledge of serostatus, the data described above

Phone:

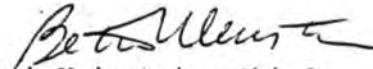
150 Washington Street — Hartford, Connecticut 06106
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indicate that in Connecticut, at least, we are not succeeding at promoting early knowledge of serostatus. I believe that this can be remedied by two actions: increasing accessibility of counseling and testing, and making a concerted effort to encourage people to get tested. The problem with the second factor is that we always succeed in encouraging those we call the "worried well" to come in for counseling and testing, and they overwhelm the resources available and make it difficult for those at high risk to get services. We are trying to address that in Connecticut through group pre-test counseling and are also investigating a relationship with Planned Parenthood of Connecticut, which is willing to accept referrals of people at low risk in return for lab services and counselor training. This would free up the CDC-funded sites to concentrate more of their efforts on people with significant risk behaviors.

3. Some suggestions on meeting the ideal goals are in the answer to question 2 above. Specifically:
 - a. Relative investment and priority: In looking at this, the committee should consider the fact that many states have state funds which they use for education, counseling and testing. The balance of CTRPN versus other prevention activities (education and outreach) can only be judged by taking those state funds into account. In Connecticut, where we spend more of our CDC funds on CTRPN than on HERR, we do the reverse with state funds. While it is difficult for me to say what the balance should be on a nationwide basis (because that depends significantly on a number of local factors), in Connecticut, my sense is that we should be spending a maximum of 40 percent of our combined state and federal funds on CTRPN. However, if we succeed in improving the ability of counseling and testing to effect behavior change under the revised CDC model, then the proportion for CTRPN might be greater.
 - b. Information and data: The difficulty with all HIV prevention programs is determining the amount of behavior change to be credited to particular interventions. While it is clear that we have succeeded in making remarkable changes in risk behaviors nationwide, we don't know the relative contribution of different programs. This can never be determined in actuality, since human behavior changes in response to a variety of messages over time. However, it would be helpful to understand better the role of CTRPN in changing behavior in those who have accessed it as an intervention. In addition, we should try to determine whether there are differences in impacts based on whether the person sought the service or whether the person was offered the service.
4. Impediments to improving the program include the following:
 - a. The large number of "worried well" who use CTRPN services.
 - b. The fact that many HIV counselors do not have adequate counseling and behavior change skills. Many of the counselors in CDC funded programs are in their positions because of their interest in AIDS. Often, they have insufficient training and experience in counseling and behavior change.

- c. Lack of a clearly articulated set of goals for counseling and testing.
- d. Difficulty in ensuring medical care for those referred, and difficulty in documenting referrals, especially in cities, because clients may choose to go to providers others than those recommended by counselors.

I hope that these thoughts are helpful to you in your deliberations.
Sincerely,


Beth Weinstein, Chief
AIDS Section

BW/sm

c: Margaret Skelley, ASTHO
Julie Scofield, NASTAD

5772J



St. Joseph's Hospital and Medical Center

703 Main Street ■ Paterson ■ New Jersey 07503 ■ (201) 977-2000

Continuing Commitment to Care

To: Ms. Connie Granoff
Centers for Disease Control and Prevention

From: Sister Fran Demarest, Director
Comprehensive Care Center for HIV Services

Priority: Adolescents Objective: Prevention of HIV

Strategies: It is a common belief that 10% of the population is homosexual. Homosexual boys have sex with older men and lesbian transmission of HIV is very rare. Stratagem for intervention with this population should come from those agencies who deal primarily with Gay persons.

The remaining 90% of the adolescent population can be approached by aggressive HIV counseling and testing. We recommend testing every three months because our experience has told us that testing adolescents once will result in less than a .01% positive outcome. St. Joseph's Hospital and Medical Center provides prenatal care to 300 adolescents a year. More than 50% test positive for an STD. However, after three years of testing, none have tested positive for HIV. After much review we have come to the conclusion that adolescents need to be tested very frequently if we are going to be able to identify those who are HIV positive.

The State Counseling and Testing Sites should be responsible for setting up an Adolescent Counseling and Testing Program in partnership with local school boards and health departments. As a part of School base health programs, testing can be anonymous and/or confidential. Since the State Counseling and Testing Sites would be implementing this program the infrastructure is already in place. The legal issues are familiar to these sites, the clients can be assured of proper handling of information and access for treatment has already been structured. Implementation should be efficient and effective.

Outcome: You will raise the consciousnesses of the reality of HIV to a population who thinks it is immortal. For those testing positive early treatment intervention will result. It is the belief in some medical circles that aggressive treatment weakens the virus thus lessening transmission.

Increase in funding for outreach services for Counseling and Testing Sites would be necessary. Success in prevention will take years to measure but it is our only hope.



7/7/93

Ms Kristine Moore Gebbie
Chairman
Advisory Committee on HIV
c/o CDCP
Att: Ms Connie Granoff
1600 Clifton Road NE, MS E40
Atlanta Georgia 30333

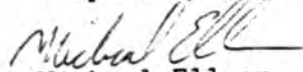
Dear Ms Gebbie:

In regards to federal government HIV prevention efforts:

Recent findings indicate that the entire HIV emphasis should now be reconsidered.

1. The June 11 issue of Bio/Technology points out the total unreliability of any HIV test now available.
2. Knowing one's sero-status does not prevent the spread of AIDS, in some cases it fosters unsafe behavior.
3. Early AZT treatment^e is of no benefit in preventing AIDS.
4. The test has no predictive value

Very truly yours,


Michael Ellner
President



AIDS • TASK • FORCE • INC

Serving Fort Wayne and Northeast Indiana Since 1985

2124 Fairfield / Fort Wayne, IN 46802-5158 / (219) 744-1144

June 21, 1993

Ms. Kristine Moore Gebbie
Chairman, ACPHI
Centers for Disease Control and Prevention
ATTN: Ms. Connie Granoff
1600 Clifton Rd. NE, MS E40
Atlanta, Georgia 30333

Dear Ms. Granoff:

"COMMENTS ON PARTNERSHIPS BETWEEN GOVERNMENTAL AND NONGOVERNMENTAL ORGANIZATIONS FOR PLANNING AND IMPLEMENTING COMPREHENSIVE HIV PREVENTION PROGRAMS"

in response to announcement of meeting June 22, 1993, Merrillville, Indiana

1. What could CDC do to promote and/or enhance HIV prevention partnerships among the CDC, targeted populations, NGOs, and state and local health departments?

A. Separate "promote" which is for beginners and "enhance" which is for NGOs with experience and a track record. Many of us have been doing this for eight years or more. We know what we're doing.

B. Eliminate layers of expensive bureaucracy. Our state health department gets your funds, pays another agency to administer them, adds their own regulations and reporting paperwork and passes on the money to local service providers in their own good time.

C. Make availability of funds consistent with time frames of local activity such as hiring, program planning, budget years. It is very difficult to plan and implement a program, especially when we need to hire staff, when we have no idea exactly when the funds will actually become available. In 1991 the first check came in November.

D. Most NGOs are non-profits who do not have the money to support a program or staff for several months until the state administering agency decides to send checks.

2. What are the effective characteristics of these partnerships? (How are roles differentiated?)

A. Often they lose their effectiveness because the administering agency assumes that the service provider knows nothing about how to implement projects.

B. Roles seem to be differentiated in the "big brother (State)" and "little brother (provider)" mode. This happens even when staff in state offices or contracted administrators has been there many years less than staff in providing agencies.

C. State seems to say: "Our way is the only way. Do it our way or we won't pay you." This often happens only when State gets reports after work has been done at provider's expense.

D. Each grant requires unique record keeping and reporting system. This frequently forces providers to hire additional staff for paperwork (which grants do not pay for) or to buy more computers (which state owns if paid for with grant funds.)

4. What can CDC do to assess and meet the diverse technical assistance needs of NGOs and state and local health departments?

A. Send out lists of what you can offer, what you consider "technical assistance."

B. Accept the fact that some of us out in the field can provide you with technical assistance.

C. ASK us what we need.

4. What could CDC do to further integrate HIV/STD/TB and Substance Abuse prevention activities?

A. Show us a united front at the national level among the various federal agencies involved. Substance Abuse Agencies (NIAAA, NIDA) are notoriously independent and non-cooperative, even with each other.

B. Put together some shared funding from all of you for programs that overlap and let constituent agencies know it's better to cooperate.

C. Develop common record keeping and reporting systems for funds and services.

D. Tell state agencies to cooperate.

I have worked in Ohio and Indiana under federal funds administered by state agencies. It has always seemed that the relationship between the service provider and the state funding source is adversarial and based on the state's suspicion of the provider. I hear the state feels somewhat the same way about the federal agencies.

The little guy we intend to help gets hurt.

But thanks for asking.

Yours truly

A handwritten signature in black ink, appearing to be "Jack E. Ryan", with a long horizontal flourish extending to the right.

Jack E. Ryan
Executive Director



Gary Neighborhood Services, Inc.

300 West 21st Avenue
Gary, Indiana 46407

ALL PHONES
(219) 883-0431

IRWIN LEWIS, JR., ACSW
Executive Director

June 28, 1993

Centers for Disease Control and Prevention
Attention: Ms. Connie Granoff
1600 Clifton Road, NE, MS E40
Atlanta, Georgia 30333

For: Advisory Committee on the Prevention of
HIV Infection

1. Appropriate funding for street outreach into communities which have not been extensively focused upon such as: Hispanic Community, I.V.D.U. Community, and the African-American Community.

Provide more grant availability for programs which may benefit the forementioned communities. Provide funding to non-government organizations' and local health departments so they may outreach into these target areas. Also, make legislation approve the dispersal of bleach kits and needle exchange program in all areas.

2. Each organization or entity has, in the past, concentrated on a relatively smaller catchment area which, in itself, is very useful. But, it is essential that those same agencies expand into areas which a neighborhood organization/agency may provide a certain amount of expertise or experience in outreach or service provision. This will effectively create a partnership between these two agencies that previously had not worked together, and which may provide a larger outreach or educational area.



--providing equal opportunity employment and services--

3. Create a needs assessment tool to be distributed to agencies providing HIV/AIDS services and outreach. Encourage separate agencies to conglomerate or network and create a larger more technically capable agency or organization which can further provide service and/or outreach to some of the less informed communities.

Irwin Lewis, Jr.
Executive Director

For: Advisory Comm. on the Prevention of
HIV Infection (ACPHI)
Radisson Star Hotel
Tuesday, June 22, 1993

6/17/93

1. Develop more funding, with more flexibility in program design. Proposals should be designed for better quality of service, rather than quantity (in number of individuals served, units delivered, etc.).

Caseloads shouldn't be so heavy (i.e., quantity) that you can't invest enough time in each case.

More outreach work needs to be performed with doctors, hospitals, community groups, school systems, neighborhood 'watch' groups, etc.

Program design needs to be integrated with local in-home homemaker services, general social services, etc. and training/educational services provided for professionals at the undergraduate level.

2. The CDC should develop more Federal funds made available, and continue to disseminate informational materials in bulk. Local health departments and health systems should gear up for more testing and follow-up.

NGO social service agencies should become more aggressive in providing case management, general social services, and utilizing all resources available to the client population.

3. CDC should develop a more simplified way of putting proposals together for NGOs, state agencies and health departments. Goals, objectives, program systems, and evaluation instruments should be simplified.
4. Accept program designs that integrate all these client populations (HIV/STD/TB/Subst. Abuse). NGOs are working with client populations where these problem areas are usually interrelated.

June 29, 1993

Ms. Kristine Moore Gebbie
Chairman of the Advisory Committee on the Prevention of HIV Infection
Centers for Disease Control and Prevention
Attention: Ms. Connie Granoff
1600 Clifton Road, NE, MS E40
Atlanta, Georgia 30333

Dear Ms. Gebbie:

We appreciate the opportunity to submit comments to the ACPHI subcommittee on "Developing Partnerships for HIV Prevention." Nancy Bringman, Assistant Administrator of the AIDS Activity Section, attended the public meeting held on June 21, 1993 in Chicago, but due to the limited time available for comments at that meeting, we are electing to also submit written comments. We would like to offer the following comments in response to the four questions posed by the committee.

- 1) To facilitate and enhance HIV prevention programs, it is essential that CDC continue to enter into cooperative agreements with state health departments. The state health department is the most capable entity to fulfill the unique role of monitoring and coordinating HIV prevention programs within that state. If funding is awarded by the CDC directly to other units of governments or NGOs, the state health department is hindered in its coordination role, and duplicated and/or overlapping programs/services can result. Duplication and overlapping do not facilitate maximizing available resources.
- 2) The CDC needs to recognize that in many rural areas, the local health department is the entity that is in the best position to conduct HIV prevention programs. In many areas, NGOs do not exist or exist in very limited numbers with limited capacity. Where NGOs do exist, it is important that funding be coordinated through the local health department because at the local level they should be serving as the "clearinghouse" for prevention programs, similar to the role of the state health department for the entire state.
- 3) The CDC needs to clarify the expected relationship between states and directed funded cities. If the intent of funds awarded to the state is to support prevention

programs in areas other than a directly funded city, then the notice of grant award should clearly state that intent, and the state should be able to target its programs to the remainder of the state without an expectation that a significant portion of the funding will support programs in the directly funded city.

4) In order to provide effective technical assistance to any funded entity, the CDC needs to recruit and hire individuals with technical knowledge and interest in HIV prevention programs. We have been consistently frustrated by the inability of project officers assigned to Illinois to provide meaningful programmatic or technical assistance. In the review of our most recent cooperative agreement application, there appeared to be little relation between the expert reviewer's comments and funding decisions made by CDC program staff. The project officer system needs to be developed so that project officers serve as true programmatic resources, or it should be eliminated.

Again, we appreciate this opportunity to provide comments. Please do not hesitate to call me at 312/814-4846 if you have any questions or need additional information.

Sincerely,

A handwritten signature in cursive script that reads "Chet Kelly".

Chet Kelly, M.S., M.P.H.
Administrator

cc: Russell J. Martin

ADVISORY COMMITTEE ON THE PREVENTION OF HIV INFECTION

Developing Partnerships for HIV Prevention

Questions

1. What could CDC do to promote and/or enhance HIV prevention partnerships among the CDC, targeted populations, NGOs, and state and local health departments?
2. What are the effective characteristics of these partnerships?
(How are roles differentiated?)
3. What can CDC do to assess and meet the diverse technical assistance needs of NGOs and state and local health departments?
4. What could CDC do to further integrate HIV/STD/TB/Substance Abuse prevention activities?

Written comments to the above questions may be forwarded to Ms. Kristine Moore Gebbie, Chairman of the Advisory Committee on the Prevention of HIV Infection (ACPHI).

Please mail comments care of:

Centers for Disease Control and Prevention
Attention: Ms. Connie Granoff
1600 Clifton Road, NE, MS E40
Atlanta, Georgia 30333

Question #1

What could the CDC do to promote and/or enhance HIV prevention partnerships among the CDC, targeted populations, NGO's and state and local health departments?

- Encourage the non-governmental and governmental organizations at the state and local levels to work together to better meet the needs of the targeted individuals in the area.

- Help the state and local areas develop an AIDS Advisory Council with representatives from public health, community-based organizations, and people affected by HIV to implement HIV prevention programming and administer funding for programs.

- Any disbursement of funds from the CDC to state and local areas must be in a timely manner.

- The particular needs of an area would then dictate the amount of funds needed for prevention activities and direct service to clients.

Question #2

What are the effective characteristics of these partnerships? (How are roles differentiated)?

- The benefit of partnerships would eliminate duplication of services, thereby making better use of time, funds, and increase the number of clients served.

- Partnerships on a local and state level would keep key players informed about what is being done, so a better referral network could be set up, thereby eliminating the clients wasting their time calling from agency to agency for services and being referred to someone else.

- A care coordination system should be set up in all areas of the state so a client can meet their needs and get assistance in one location. The case manager could then make appropriate referrals to the agencies that would benefit a particular client.

Question #3

- What can CDC do to assess and meet the diverse technical assistance needs of NGO's and state and local health departments?

- Provide funding to better meet the needs of NGO's at a grass roots level who are already out there providing services on a volunteer basis to those affected by HIV/AIDS.

- Assist NGO's and LHD's with needs assessments and surveillance data. Also assist with outcome evaluation of programs and provide funding to meet above needs.

- Continue funding for anonymous and confidential HIV testing for the general public as well as those at high risk for HIV.

Question #4 What could CDC do to further integrate HIV/STD/TB and substance abuse prevention activities?

- Encourage agencies dealing with HIV/STD/TB to work closely with agencies dealing with substance abuse to keep each other informed.

- ~~Hepatitis~~ substance abusers get treatment on request - then evaluate them to find out what risks they have been taking that could have exposed them to HIV/STD so they can be tested and counseled.

- Develop programs that realistically deal with the behaviors of youth including lesbian and gay youth, through school-based health promotion and sexuality education as well as out-of-school youth. There are too many AIDS curriculum councils that are non-functioning, or are bending under pressure from small groups of people from the general public who want little or no information given to youth in the schools. Our youth need the facts about HIV/AIDS and other STD's to reduce their risks of infection.

*From: Janet Garvey, Nursing Supervisor
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Testimony before the Advisory Committee on the Prevention of HIV Infection (ACPHI)

July 7, 1993

Good Morning. I am Bobbie Feuerlicht, a Social Worker and supervisor at MCOSS. MCOSS is a voluntary, non-profit home health agency with an 81 year old history of providing a comprehensive program of community based services. As the largest home health agency in New Jersey, and one of the five largest in the nation, MCOSS is privileged to care for clients in Middlesex County, Monmouth County, Northern Ocean County and parts of Somerset County.

MCOSS is dedicated to the promotion, restoration and maintenance of the health status of individuals and of the community at large. MCOSS is concerned with amelioration of human suffering and is committed to meeting the multi-dimensional needs of clients through the provision of care in the home and in the community.

As a community-based agency, MCOSS provides care for clients with HIV disease or AIDS through eight different programs, and is a member of two consortia. This has been a very positive experience. As the lead agency of the Monmouth-Ocean HIV Care Consortium, MCOSS is additionally responsible for overseeing the services funded by the Department of Health, Division of AIDS through that Consortium. Over 25 agencies participate in this active network.

MCOSS also received funding from the Department of Health, Division of AIDS to establish and maintain two Information and Referral lines and Resource Centers for the areas served by the Consortia. One is located in Red Bank and serves clients in Monmouth and Ocean Counties, and I supervise the center in Woodbridge which provides for clients in Middlesex County.

I would like to take this opportunity to thank the Department of Health, Division of AIDS for their advise and support of the Consortia. Bringing together very diverse agencies, as well as clients with AIDS, has been a wonderful opportunity for all to come together and to learn to work collectively. The Consortia had to identify needs in the community and then decide, with a limited budget, what to provide and what not to provide. I also would like to say that agencies in all counties have continued to participate actively even when it was not possible to fund their

agencies. This ability to work together and to see the "big picture" is testimony to the commitment of all Consortia members.

The needs of clients with AIDS will continue to escalate. As we see more and more clients able to live with this terrible disease, many diverse services are going to be required. Community-based Consortia are in a very unique position to provide this care because of the richness of experience brought to the group.

Case in point is Mike, a young man with AIDS on the Monmouth-Ocean Consortium. During one discussion, representatives from all the agencies agreed that transportation for clients to get to their treatment programs was necessary. But when Mike spoke of his walking miles every day to get to a methadone clinic, of sitting on the curb to rest because he was too weak to go on ... the need for transportation came to life. Before his death, Mike was an eloquent spokesman for clients with AIDS.

The linkage between the Consortia and the Department of Health, Division of AIDS is excellent. It enables diverse groups to be effective. As a member of two Consortia, MCOSS sees the need for linkage at the federal level as well. The creation of a regional liaison would enhance communication between the Center for Disease Control (CDC) and the HIV service agencies. It would allow for program identification of need by region because local site visits to the Consortia would be feasible. It would be possible to highlight the complexity of need, and the uniqueness of need by area.

The CDC has the capacity and the information necessary to meet the diverse technical assistance needs of non-governmental agencies, as well as state and local health departments. Increased federal visibility via the liaison/community representative would enable sharing of information and insights in a "clearinghouse" manner. Agencies with similar technical needs could then be "hooked up" to share experiences and to monitor results.

I want to thank the Advisory Committee for the opportunity to testify today. The Consortia have made significant strides in providing for clients in their communities. MCOSS looks forward to working with the federal government as we work to facilitate and continually improve the provision of care for local residents.

MISSISSIPPI
STATE DEPARTMENT OF
HEALTH

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July 7, 1993

CDC Advisory Committee on the Prevention of HIV Infection
c/o Centers for Disease Control and Prevention
1600 Clifton Rd., N.E., Mailstop E-40
Atlanta, GA 30333

Gentlemen:

Dr. Pat Nolan has asked the members of the ASTHO/HIV Committee to provide input to your group on the issue of counseling, testing, referral and partner notification for HIV. I'd like to offer a few thoughts.

The ideal goals for counseling, testing, referral and partner notification should be primarily: (1) to make HIV serological testing available to persons concerned about their serostatus, and (2) to provide education on risk reduction. It is the second of these that is best addressed by both counseling and partner notification. Counseling provided to an individual who has presented for HIV testing is targeted, since the individual has at least some reason to perceive himself or herself as being at risk. In a similar way, the counseling provided through provider referral partner notification is directed toward an individual who has some perception of risk, since that individual has just been advised that they have been exposed. This may be the most effective of all risk reduction education, since the element of denial of risk is removed. Thus, the principal goal of partner notification is targeted risk reduction education.

The current program meets the ideal goals fairly well, since states have the flexibility to emphasize the risk reduction aspects of the process. A critical element of the current program is that it allows for confidential as opposed to anonymous testing where states choose that policy. This is critical if partner notification is to be carried out on individuals tested outside the health department's own system. To permit anonymous testing precludes this. It would be a serious error to require that states allow anonymous testing.

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The program does not need to be materially changed in order to meet its ideal goals and I would recommend no major alterations in it. The relative investment in CTRPN should be large, since this is probably the most concretely targeted of our prevention activities. CTRPN activities should have a very high priority in regard to other HIV prevention programs and activities.

I hope these thoughts are of some help. I appreciate the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "F.E. Thompson, Jr. M.D.", written in a cursive style.

F.E. Thompson, Jr., M.D., M.P.H.
State Health Officer

FET:aru

cc: Pat Nolan, M.D.
Margaret Skelley