

SOCIAL AND POLITICAL OBSTACLES TO AIDS EDUCATION

Nicholas Freudenberg, DrPH

Professor, Community Health Education
Director, Center for Community Action to Prevent AIDS
Hunter College School of Health Sciences, City University of New York

Prevention through education remains the single most important strategy for containing the epidemic of HIV infection. Yet powerful social and political obstacles block the implementation of effective AIDS education intervention. Among these barriers are a confusion between moral and public health agendas, widespread distrust of scientists and public health authorities, and struggles for the control of AIDS prevention programs.

Strategies to reduce these obstacles include acknowledging the political dimensions of AIDS; linking AIDS prevention programs to other needed health and social services; raising the costs of inaction for public officials; building new constituencies for AIDS prevention; helping people understand the limits of scientific understanding of AIDS; and articulating a broader vision of the role of morality in AIDS prevention.

As the HIV/AIDS epidemic in the United States moves towards the end of its first decade, it is appropriate to take stock of what public health authorities have accomplished so far in regard to controlling its spread. While new drugs have improved the longevity and quality of life for some people with AIDS, and researchers have continued to work on developing new vaccines, few scientists are optimistic that there will be, in the near future, any dramatic breakthroughs that will significantly reduce morbidity or mortality from AIDS.

Prevention through AIDS education, therefore, remains the single most important strategy for containing the epidemic at this time. Several expert panels have recently reaffirmed this priority.¹⁻³ The Institute of Medicine of the National Academy of Sciences, for example, concluded in its 1988 report that "educational efforts to foster and sustain behavioral change are the only means now available to stem the spread of HIV infection."²

Indeed, AIDS information and education campaigns have reported some success. According to national public opinion polls and a variety of surveys, by the late 1980s such disparate populations as gay and bisexual men, intravenous drug users, adolescents, and minorities reported generally accurate knowledge of AIDS transmission and preventive actions.⁴⁻¹⁰ In one population — men in large urban gay communities — transmission of new cases of HIV infection dropped precipitously.^{3,11,12} While it is unclear how much of this decline is due to saturation of the vulnerable population, at least some part can be attributed to AIDS prevention campaigns in the gay community. Intravenous drug users, while slower to change their behaviors than gay men, have also shown reductions in risky behaviors.^{2,3}

Despite these rays of hope, however, the overall impact of AIDS education is less clear. Providing accurate information has proved to be far easier than changing risky behaviors. Significant proportions of sexually active young adults still do not use condoms; needle-sharing, though somewhat less prevalent than earlier, is still common among intravenous drug users; and the growing understanding of the links between cocaine/crack use, sexual behavior, and HIV infection suggest continued high transmission rates in some populations.¹³⁻¹⁶

In part, the limited impact of AIDS education is due to the inherent difficulty of changing those deeply seated patterns of sexual and drug behaviors that contribute to the risk of HIV infection.³ Other contributing factors are the social and political obstacles that AIDS educators encounter in developing and implementing effective interventions. Harvey Fineberg, dean of Harvard University School of Public Health, has observed that "the best we can do in AIDS education offers no guarantee of success. To do less invites failure."¹⁷

Improving the quality of AIDS education — the one fragile tool available for the prevention of HIV infection

— requires both improving the effectiveness of specific interventions and reducing the social and political obstacles that block the implementation of such programs. This report describes the broader obstacles, discusses their impact on the practice of AIDS education, and suggests strategies for overcoming them.

The Broader Obstacles

1. The use of a public health issue to advance a moral agenda. Perhaps the single most important obstacle to AIDS education is the difficulty in distinguishing a public health agenda from a moral agenda. This problem shapes every aspect of HIV/AIDS prevention.

Because HIV infection and AIDS first appeared among homosexual men and intravenous drug users in this country, public response has been inextricably linked with public feelings about homosexuality and illicit drug use. As Congressman Henry Waxman, a leader in mobilizing the federal response to AIDS, observed in 1982, "There is no doubt in my mind that if the same disease had appeared among Americans of Norwegian descent or among tennis players, rather than among gay males, the response of the government would have been different."¹⁸

For some, AIDS has also become a vehicle to advance a social agenda. Gary Bauer, former President Reagan's domestic policy adviser, asserted that the AIDS crisis provided the President with "the ideal opportunity to establish forgotten verities of moral behavior."¹⁹

This conflation of public health and moral goals has had direct consequences for AIDS educators. In 1988, for example, the U.S. Centers for Disease Control, based on directives from the U.S. Congress, issued guidelines for the AIDS education programs that it would fund. They said, "Messages must...emphasize the ways by which individuals can fully protect themselves from acquiring the virus," and asserted, "They include abstinence from the illegal use of IV drugs and from sexual intercourse except in a mutually monogamous relationship."²⁰ The CDC went on to say that the education programs that it would fund "shall not be designed to promote or encourage, directly, intravenous drug abuse or sexual activity, homosexual or heterosexual, and...shall provide information on the health risks of promiscuous sexual activity and intravenous drug abuse."²⁰

However, those individuals whose behavior has put them at highest risk of HIV infection — gay and bisexual men and intravenous drug users — are not likely to be reached by moralistic campaigns that communicate social disapproval of their values and lifestyles. Because of this, AIDS educators are confronted with the dilemma of either meeting funding guidelines, thereby diminishing the likelihood of reaching their target populations, or of offering programs that include explicit language and avoid condemnation of homosexuality or drug use, but jeopardize their continued funding.

Another consequence of making no distinction between public health and moral objectives is that some programs and educators are choosing not to acknow-

ledge and/or convey current scientific understanding of HIV/AIDS prevention. The AIDS curriculum of the New York State Education Department, for example, states that "the New York Board of Regents views the use of condoms as extremely risky behavior. The view that condoms should or can be used as a way to reduce the risk of AIDS transmission should not be supported."²¹ The Presidential Commission on HIV, the National Academy of Science, and the U.S. Surgeon General have all endorsed condoms as an effective way to reduce (although not eliminate) the risk of HIV transmission.^{1,2,22}

Why would some educators take positions that contradict or ignore the opinions of experts in HIV/AIDS prevention? Some honestly believe that their job is to instill social values of chastity, abstinence, and monogamy, if adherence to these values will reduce the risk of HIV infection. However, there are several problems with this approach. *First*, it underestimates the powerful

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SIECUS
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biological, social, and psychological forces that lead people to engage in sexual intercourse or to use drugs. *Second*, it ignores the large proportion of young people who have already chosen to be sexually active. (According to recent studies, nearly half of U.S. teenagers, aged 15 to 19, are already sexually active.)³ And *third*, it tends to undermine the credibility of public health authorities, who believe that specific preventive measures are important in curtailing the growth of this health epidemic. If health educators act as agents of the prevailing or dominant culture, rather than as communicators of accurate information, the likelihood of their being able to reach populations with varying values on this issue, or any other issue, may be seriously compromised.

“All people, no matter what their values, lifestyle, or behaviors, have the right to receive the information and skills that will protect them against HIV infection.”

The response of health educators to the moral debates that surround AIDS may compromise quality preventive efforts in other ways as well. To minimize political interference in their work, some AIDS educators avoid all political conflict and controversy: if explicit language in a pamphlet offends someone, they take it out; if teaching IV drug users how to clean their needles or works offends some law enforcement officials, they drop it.

Any disease involving sex, drugs, and death creates controversy, and almost anything that can be said about AIDS may offend someone. The danger of education that offends no one is that it may fail in its effort to communicate anything at all to those most in need of the information and resources at the time. Recently, a major medical center, in a high prevalence area of AIDS, made a film aimed at Black and Latino women on the perinatal transmission of AIDS. The film, which was well-produced and culturally appropriate, made not a single mention of the option of abortion for seropositive women, yet it encouraged them to consider HIV antibody testing. The group producing the film believed that *any* discussion of abortion would be offensive to some section of the community. Yet, this decision could deprive women viewers of the information that might help them to make informed reproductive choices.

The most disturbing aspect of using a public health issue to advance a moral agenda, however, emerges from the efforts of some to use AIDS to further isolate and stigmatize particular groups of people, such as gay men, IV drug users, and Blacks and Latinos. Public opinion polls during the mid-1980s show that 25-35% of the U.S. public strongly, or somewhat, agrees with statements such as, “AIDS is a punishment God has given homosexuals for the way they live.”⁹ Attitudes like

this are a major deterrent to effective public education campaigns on HIV infection.

2. Widespread distrust of scientists, public health authorities, and government, by significant sectors of the population, particularly in the communities most affected by the epidemic.

AIDS educators working in gay and minority communities frequently report encountering the belief that the AIDS epidemic was initially caused by a biological warfare experiment of the U. S. military. It is not surprising that those who hold this belief would be unwilling to trust the educational campaigns sponsored by the same government. In addition, the persistence of the belief that HIV can be contracted by donating blood or by insect bites, in spite of information to the contrary, provides another measure of distrust of official reassurances. This distrust can further be seen in a comment made by a New York City council member in 1986 at a public meeting held to protest the decision to open an ambulatory care facility for people with AIDS in New York City: “First, the experts told us it was safe to watch the atomic bomb explosion, then they told us Agent Orange posed no danger and the toxic chemicals at Love Canal were harmless. Now they tell us having AIDS victims use a clinic in our neighborhood presents no risk. How long will it take us to learn?” Such profound distrust, often encountered by AIDS educators, limits their ability to be heard, much less to be listened to, understood, and accepted as a source of credible information.

This distrust may be enhanced if the receiver of the information finds the information and terminology presented unfamiliar, confusing, and/or difficult to understand. Many people have had minimal education in health or science (a recent survey, for example, found that only 6% of the American population is “scientifically literate”), which may make it difficult to sort out fact from fiction. Sensational and inaccurate coverage of AIDS in the mass media also contributes to the problem. In addition, the specific behavior of AIDS researchers and health officials may serve to reinforce the public’s doubts and uneasiness. The debate over credit and patent rights to the HIV antibody test among French and American scientists; Secretary of Health and Human Services Margaret Heckler’s 1984 claim that an AIDS vaccine was “around the corner”; and the government’s characterization of Haitians as a risk group (later withdrawn as unjustified) are examples of cases where political expedience clouded scientific caution.

Too often, health authorities have attributed this distrust solely to ignorance or prejudice. However, a more plausible explanation is that this distrust is based on people’s perceptions of their own experiences. Unless AIDS educators are willing to address those perceptions, they may have trouble communicating effectively.

3. Debates over the control of AIDS prevention programs.

In the early years of the epidemic, most AIDS education was sponsored by gay organizations with privately raised funds. Indeed, one of the most

remarkable aspects of the epidemic was the rapid mobilization of the gay community. Those concerned about AIDS discussed various issues, including the role of gay bathhouses in spreading infection and their potential as sites for AIDS education, the advantages and disadvantages of HIV antibody testing, and the content and appropriateness of safer sex guidelines. However, what was most unusual was that a community was openly discussing and debating its values around health and disease, sexuality, and the role of social norms.

As concern about AIDS and HIV arose in other populations, and as government funding for AIDS prevention increased, new questions began to emerge around state and community responsibility and control of the content of AIDS prevention programs. These discussions inevitably became entangled in larger social divisions based on race, gender, class, and sexual orientation.

“Every time I see the words ‘hard to reach population’ in the RFPs [requests for proposals] I know they mean Blacks and Latinos, and I have to ask, ‘Hard to reach for whom?’”

In Black communities, unlike the gay community, AIDS most often was raised initially as a community issue by an outside group — a government agency or a mostly white AIDS organization. It should not come as a surprise, then, that the message that their community was at risk for a fatal illness, related to drug use and sexual behavior, was often met with skepticism or denial.

Once this obstacle was overcome, the question of the control of AIDS prevention programs, in Black and other minority communities, began to arise. To have health authorities tell them how to have sex, whether to have children, and how to control drug abuse seemed to them to be yet another attempt to impose the dominant culture and its values on a vulnerable population. In some Black communities, community leaders insisted that funding should go directly to local community-based organizations and not to AIDS organizations outside of the community: “We deserve the same health care and education that the white community is already getting,” the executive director of the Minority AIDS Project in Los Angeles, Reverend Carl Bean, explained. “So, we have to have *our* money.”

Black and Latino community leaders also began to insist on “culturally” appropriate educational programs, a term that usually meant choosing the language and the images that their target population would understand, and developing interventions that respected the values and belief systems of the intended audiences. Deciding how to produce culturally appropriate interventions, however, led to further conflicts. Some programs hired a minority staff member, or pretested

their materials with a focus group that included members of the target population, and felt that this was sufficient to ensure cultural appropriateness. Other minority AIDS educators took the position that minorities must control the prevention programs in their communities if they are to be effective. Rashidah Hassan, founder of BEBASHI (Blacks Educating Blacks About Sexual Health Issues) in Philadelphia, stated: “People in the Black community must recognize AIDS is not a white disease and Black community organizations are most capable of getting that message out.”

The prevailing view among foundations and government agencies, that minorities are a group not yet reached by existing AIDS prevention programs, reinforces the view that those (mostly white) experts in AIDS have to convince minorities to be worried about the epidemic. As one Black AIDS educator, working for a large city health department, observed: “Every time I see the words ‘hard to reach population’ in the RFPs [requests for proposals] I know they mean Blacks and Latinos, and I have to ask, ‘Hard to reach for whom?’”

While the question of who should control HIV prevention has emerged most contentiously in Black and Latino communities, the same issues have come up in rural areas, schools, and other settings. Acknowledging the experience of the gay organizations that have been working hardest and longest to contain the AIDS epidemic, while at the same time giving each new population in need of AIDS education the right to shape its own educational programs, has proved to be an elusive goal.

Strategies for Reducing Obstacles to AIDS Education

Together the obstacles described above have the potential to block the implementation of effective AIDS education programs or to prevent them from reaching populations at risk of HIV infection. Given the singular importance of education in controlling the spread of the epidemic, the success of public health professionals in reducing these barriers will have a decisive impact on the future of the AIDS epidemic. No discovery in research laboratories, or in hospital wards, will be more important in reducing mortality from HIV infection than the development of effective strategies for minimizing the obstacles to AIDS education.

What recommendations can be made to those responsible for planning and implementing AIDS prevention programs? **First, we need to acknowledge that AIDS is a political issue and that AIDS educators must be able to operate effectively in the political arena.** To claim, as some AIDS educators do, that they cannot afford to get involved in politics makes as much sense as saying that they cannot afford to get involved in science or medicine. The skills of proponents of effective AIDS education in legislatures, in courtrooms, and in the streets of our communities will determine the shape of interventions in the years to come. Acknowledging the political dimensions of their work may help AIDS educators directly address the stress that comes from fighting an undeclared war against opponents of open discussions of sexual and drug behaviors. Understanding

the causes of this stress is a first step toward reducing it.

Second, AIDS education interventions need to be more closely linked with a variety of health and social services, such as school health and sex education, primary health care, sexually transmitted disease control programs, substance abuse treatment and prevention programs, family planning, and teen pregnancy prevention. The almost exclusive reliance on categorical funding for "AIDS prevention" by government and private funders has created a number of problems. It has isolated AIDS education programs from related services that have already established some support and credibility among the target populations. Such isolation emphasizes the unique moral and social questions raised by AIDS, rather than its commonalities with other public health and social problems, and makes the programs politically vulnerable to those conservative forces wishing to use AIDS to advance their moral agenda. Moreover, categorical AIDS programs tend to reinforce the view, often encountered in Black and Latino communities, that AIDS is a problem that is in competition with other pressing and important problems such as poverty, infant mortality, employment, housing, and education. There is yet another problem. As elected officials' interest in AIDS wanes — as it inevitably will — categorical programs will become likely targets for budget cuts.

Both funders and programs planners have helped to create and reinforce the categorical approach to AIDS; both need to search for alternatives. A more comprehensive approach must be taken — one that emphasizes the links between HIV/AIDS and other social problems and one that will engender broader political support and more secure and lasting funding commitments. By providing resources for HIV/AIDS prevention to existing community-based organizations and to health and social service agencies, funding agencies will help to ensure that AIDS prevention messages reach new audiences; and, by integrating AIDS programs into other services, program planners will help to reduce the barriers that people face in receiving these messages.

It should be noted that the first organizations that developed categorical AIDS education programs were often the only institutions that were willing to talk about AIDS. Any reorganization of services should acknowledge the important role that such AIDS organizations have played and utilize the experience and wisdom they have accumulated.

Third, the costs of inaction on AIDS, for public health and other officials, must be raised. While some opposition to AIDS education comes from those who have genuine moral objectives to explicit discussions of sexual behavior or drug use, most public opinion polls show that only a small minority of the population of the United States opposes frank AIDS education. For example, a 1985 national poll by the *Los Angeles Times* found that 74% of the respondents would support production and distribution of explicit safer sex material.⁹

In many cases, school authorities or public health agencies are reluctant to become involved in AIDS

education, not because they object to it, but because they fear opposition from vocal minorities. In such cases, providing them with the support they need can play an important role in extending the reach of AIDS education programs. Among the techniques that AIDS educators have employed are: educating officials about the importance of AIDS for their constituency and about the benefits of AIDS education, mobilizing the silent majority to make their voices heard, and warning officials about the potential costs of inaction. One might point to the large damages awarded to HIV-infected individuals whose confidentiality has been violated, for example, or to the intense political controversy that has surrounded AIDS, where prior education was not carried out.

"There has never been a society in which the patterns of sexual behavior were restricted solely to monogamy or chastity, and America in the 1980s is surely not going to be the first."

Fourth, we must build new constituencies for AIDS prevention. Gay organizations have borne too much of the responsibility of advocating for more prevention resources for too long. Defining the issue in new ways could help to bring in new groups. Parents and teachers, for example, want help in talking to children about drugs and sex. Communities are desperate for help in solving the problems caused by drug abuse. Health care providers want help in learning how to counsel their patients about AIDS, sexual behavior, drugs, and other issues. And, women are looking for ways to talk to their partners about sexuality and contraception. Each of these urgent needs can be met, in part, by AIDS prevention programs. However, AIDS educators must also do a better job in developing programs that address these needs. Then, they must convince their constituencies that the programs they have developed have something to offer.

Fifth, we must help people to understand the limits of our scientific understanding of AIDS and must address the distrust of scientists and public health authorities that hampers effective communication on AIDS. Two strategies may help to reduce these problems. By helping learners understand the process of scientific inquiry into AIDS, educators can assist them to interpret new findings for themselves. As this happens, information might be used as a tool for self-protection, rather than be perceived as a bludgeon to exact compliance with the dominant social norms related to sexual and drug behavior. The success of urban gay communities in understanding and critiquing basic questions in AIDS research demonstrates that those without formal scientific training can, when informed and motivated, master complicated scientific or applicable bodies of knowledge. Replicating this experience, in populations with varying levels of education, poses a formidable challenge to AIDS educators. Another way to reduce the mistrust is

to distinguish clearly between moral and political agendas and public health goals. If AIDS educators want to initiate a community dialogue on sexual and drug behavior — a necessary condition for behavioral change — they will need to listen to their constituency as well as transmit messages to them. If they simply want to persuade their constituencies to the benefits of abstinence, chastity, and/or monogamy, it is not likely that they will find a receptive audience. As newly appointed Chair of the National AIDS Commission June Osborn noted, "There has never been a society in which the patterns of sexual behavior were restricted solely to monogamy or chastity, and America in the 1980s is surely not going to be the first."²⁴

"The AIDS epidemic provides the opportunity to fight for, and win, the right to know about sexuality, drugs, and AIDS, and the right to protect one's health."

Finally, AIDS educators need to articulate a vision of a different approach to AIDS education — one that brings people together rather than separates them. It may not be possible to convince those who think that gay men and drug users are expendable to believe differently, but it is possible to show the majority of people, who are open to new perspectives, a different approach to morality.

It was noted previously that public health professionals should not confuse public health agendas with moral agendas. But that does not mean morality should be conceded to the religious right or conservatives. One of the cornerstones of an alternative morality around AIDS might be that all people, no matter what their values, lifestyle, or behaviors, have the right to receive the information and skills that will protect them against HIV infection. Just as the labor and environmental movements established a new "right to know" about occupational and environmental exposures, the AIDS epidemic provides the opportunity to fight for and win the right to know about sexuality, drugs, and AIDS, and the right to protect one's health. What could be more moral than to use this terrible epidemic as an opportunity to win this new right?

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AIDS EDUCATION

What Can Be Learned From Teenage Pregnancy Prevention Programs

Debra W. Haffner, MPH

Executive Director, SIECUS

More than a decade of evaluations of teenage pregnancy prevention programs have provided clear lessons about what is needed to motivate teenagers to change their sexual behaviors. Yet, as I review HIV prevention programs from throughout the United States, I am struck by how few programs have actually incorporated the basic findings of these evaluations. In fact, it appears that some program planners may not yet be aware of this important theoretical base and others may feel some pressure, due to political constraints, to ignore it. Clearly, the knowledge already gained from teenage pregnancy prevention programs should be applied now to HIV prevention efforts if we are to be successful in helping teens avoid infection.

Lesson One: Information Alone Is Not Enough.

Research indicates that programs that offer information *only* are, in general, not changing behavior. Initial surveys of teenagers have found that although teens are knowledgeable about AIDS, very few are adopting new prevention behaviors.¹ Those of us who have offered one-time contraceptive lectures in classes know that our single lecture changed very few teenagers' behaviors. Most often, we accomplish no more than to let students know that there are adults in clinics in their communities who are willing to talk with them about sexual issues. Single school assemblies on the facts about AIDS may be no more successful in changing teens' complex intimate behaviors. In addition, most existing AIDS curricula concentrate on epidemiology, virology, and biology. Facts about HIV and its transmission provide an important knowledge base for young people and may be effective in helping to reduce their irrational fears about casual transmission, but, too often, these programs skip the information about HIV/AIDS that concerns teens most: "Can I still French kiss?" "Am I the only virgin left in the senior class?" "Where can I buy condoms in my town?" and "Do I need parental permission to be tested?" Such questions as these indicate that education programs about HIV/AIDS must also address young people's personal concerns — their attitudes and their feelings about AIDS.

In the beginning of my career as a sexuality educator, I had to "relearn" the different effects of progester-

one and estrogen before each presentation I gave on menstruation to fifth graders. After several presentations, I realized, that if I, myself, could not remember such facts between lectures, how could I expect the students in these classes to remember them. It was also clear that what young girls really wanted to know was whether menstruation is painful, if people can tell when a woman is menstruating, how to use a tampon, and how to deal with possible accidents. Today, as I educate teens about HIV, I find that they, too, are often more concerned with their feelings than they are with the facts. They frequently ask: "How can I tell if I am really in love?" "How do I say 'no' when we are going steady?" and "How does a person know if he or she is gay or straight?"

Didactic, knowledge-based programs have often been criticized because they have been ineffective in changing immediate behaviors.² Sex education programs based only on information do not reduce teen pregnancies, neither will they reduce HIV infection. It is clear that only behaviorally-based programs can expect behavioral outcomes. Behaviorally-based HIV prevention programs should provide ample opportunities to develop and practice skills in communication, decision-making, assertiveness training, peer refusal, and to develop an individual's ability to seek and obtain further information and resources.

Lesson Two: Services Alone Are Not Enough.

In the early 1970s, many of us simplistically believed that if there were enough family planning clinics, sexually active teens would frequent them and teen pregnancy rates would automatically decrease. Now we know that although these services are essential for pregnancy prevention, they must also be linked to education programs. Evaluations of teen pregnancy prevention programs demonstrate that education programs and health services must be integrated, or at a minimum coordinated, to be successful.³ An outstanding education program will not change birth rates if teenagers who are having sexual intercourse do not have access to contraception; conversely, a school-based clinic that distributes contraceptives will not change birth rates if there is no education on how and why one should use contraception.

The above observations should be applied when initiating and developing HIV prevention programs. For example, education efforts should be linked with helping young, sexually active people obtain condoms. Moreover, schools, institutions, and community organizations might want to distribute condoms as part of their education programs and/or advocate for their availability in their communities. AIDS educators could assure that local pharmacies and convenience stores sell latex condoms and nonoxynol-9 products at reasonable prices, that they train their clerks to be helpful to teens who are looking for contraceptives, and that they have signs indicating the locations of contraceptive methods in their stores. Further, education programs are most likely to be effective if there are linkages between schools, community programs, AIDS service networks, and medical services.

Lesson Three: Motivation Is Critical.

Many studies on teenage pregnancy prevention have concluded that teenagers have to be motivated to avoid premature childbearing.⁴ Taking this into account, many programs have wisely adopted a "life options" approach — one that includes counseling young people in the setting of future education and employment goals as well as providing them with sexuality education.

As with teenage pregnancy prevention programs, HIV/AIDS education must address the importance of young people preparing for their futures. For, if it is true that young people are less likely to be successful as adults if they have children as teenagers, it is an even starker truth for those who become infected with HIV during their teen years. Due to drugs, violence, homelessness, and untreated illnesses, too many of our young people are now living in situations where dying by their mid-twenties is a real possibility. HIV prevention programs must directly address these larger issues and help young people obtain the education, employment, and housing necessary for them to have successful adult lives.

Lesson Four: Programs Must Address Teens' Feelings of Immortality and Invincibility.

A hallmark of adolescence is the perception of invincibility and immortality. Pregnant teenagers often report, "I didn't think it could happen to me." Indeed, this is the third most frequent answer given by teenagers when asked why they did not use contraceptives.⁵ Yet, teenagers in almost every school in America know someone their age who is or has been pregnant. However, because of the long incubation for HIV infection, few will know while teenagers someone their own age who will be diagnosed with AIDS.

Focus group studies corroborate the observation that teens do not believe that AIDS has much to do with their lives: white teenagers report that AIDS is a problem for Black, gay, older adults; Black teenagers report that it is a problem for white, gay, older adults.⁶ In fact, recent studies have indicated that teenagers are more concerned about pregnancy than they are about HIV/AIDS.⁷ Yet, the striking evidence is that teens are not protecting themselves against pregnancy either. How, then, can we make teenagers understand their vulnerability to this critical infection so that they will adopt preventative behaviors?

Programs must help young people understand how they could be at risk of pregnancy, HIV, and other STDs. Several curricula have begun to incorporate exercises that focus on risk assessment.⁸ In addition, although there have been no formal evaluations, educators have found some efforts highly effective in changing young people's attitudes toward AIDS and in promoting safer behaviors. Successful approaches have been programs that employ young people with AIDS as lecturers in their education efforts, and meetings (held across the country in Massachusetts, San Francisco, Kansas City, and the District of Columbia) where young people in their 20s discuss their personal lives and their

illness (HIV/AIDS) with teenagers, exhorting them to protect themselves so that they will not become infected.

Lesson Five: Teenagers Should Be Involved in the Design and Implementation of HIV/AIDS Programs.

Many successful teen pregnancy education programs are now taught by peer leaders. Such programs appear to be beneficial for both the peer educators and the participants. Teen pregnancy prevention projects have successfully used teen life theater, peer educators, peer hotlines, older students mentoring younger students, and other teen activities to reduce teen pregnancy. Other health promotion efforts targeted toward teenagers, such as anti-smoking/drinking/drug campaigns, also have demonstrated the efficacy of using peer education to change adolescent norms around unhealthy behaviors.⁹ Many HIV prevention efforts throughout the country also are successfully employing the peer education approach. Among such projects are AIDS hotlines run by teens, teen theater productions on AIDS, and peer counseling programs. Teenagers also can play an important role in community efforts. They are very effective on advisory committees, in planning efforts, in promoting programs for teens, and in providing testimony at community hearings.

Lesson Six: Parents Should Be Involved.

Parents should be an integral part of any teen pregnancy prevention or HIV prevention effort. Studies have shown that sexuality education program for parents and children can increase communication about these important topics.¹⁰ Further, in homes where children and parents are able to talk about sexuality issues, teens are less likely to have sexual intercourse and are more likely to use contraception if they do.¹¹ However, as with other sexuality-related topics, many parents report difficulty in talking to their children about HIV and its prevention. A recent survey indicated that the vast majority of parents did not discuss last year's household mailing of the Centers for Disease Control AIDS pamphlet. Almost 40% of parents say they have not discussed AIDS with their children. Moreover, recent surveys indicate that many adults remain confused about the facts of HIV transmission.¹²

Parents need to receive information about AIDS and HIV. They also need to have the opportunity to be involved with program planning, to review curricula and resources, and to meet with the teachers or leaders who are, or will be, presenting this education. Programs for parents and children together and/or homework assignments for the student that involve parents at home may also encourage parent/child communication about HIV/AIDS.

Lesson Seven: The Entire Community Must Be Involved in the Preventive Efforts.

As I noted in a recent (January/February 1989)

SIECUS Report editorial, "Sexuality Education: Whose Job Is It Anyway?," an issue that frequently comes up is whose job should it be to teach sexuality education...to prevent teenage pregnancies...and now, to prevent HIV/AIDS.

The lessons from teenage pregnancy prevention programs are clear. Efforts are most successful when they are community-wide and include parents, churches and synagogues, youth-serving agencies, schools, local governments, and businesses.¹³ HIV prevention requires a similar community-wide response. Young people should receive information and support about HIV prevention in their homes, schools, youth groups, places of employment, and churches. All segments of the community should work together to assure that teenagers will have the information and services needed.

Lesson Eight: Programs Must Address Males As Well As Females.

Teenage pregnancy prevention efforts were first directed almost exclusively toward young women. It was not until the late 1970s that programs aimed at young men became more common. Although past programs most often have reinforced the double standard — boys try to "get sex," it is the girls' job to say "no" — research clearly indicates that both partners are critically involved in decisions related to sexual and contraceptive behaviors. Existing HIV prevention programs for teens now appear to be making the same mistake. A recent poster, for example, which depicts a young woman sitting with her jean-clad legs tightly crossed with the caption "the best way to avoid AIDS," reinforces this double standard. The implied message is: it is a girl's job to say "no." Indeed, I have heard professionals lament that HIV prevention will be more difficult than teen pregnancy prevention, because boys must be involved with condom use.

These messages do not help teenagers who are struggling to develop their capacity for intimate relationships. Programs need to address both young men and young women. They must address not only the responsibilities of relationships but also young people's rights in relationships as well. They must directly address the double standard that still seems to permeate many high schools, and they must address the concept of equality in sexual limit setting as well as in sexual relationships.

Lesson Nine: Programs Must Focus on the Behavior to Be Avoided.

I have participated in several national meetings on teenage pregnancy where debate centered on defining the problem we were meeting to address. Is the problem that teenagers are having sexual intercourse? Or, is the problem that teenagers are involved in any sexual behavior at all? Are we concerned about teenage pregnancy or teenage childbearing? Is it possible to focus on teen sexuality, pregnancy, and childbearing simultaneously and still be effective? These types of

questions permeate discussions of HIV prevention as well. Are we trying to prevent HIV or teenagers' sexual involvement?

Many teenagers believe that adults are using the AIDS epidemic to scare them away from sex.¹⁴ To paraphrase one teenager, quoted in a New York student newspaper, "I think adults are more concerned with teens having sex than they are with preventing us from becoming infected with HIV." She may be right. One-half of the state mandates for AIDS education require that abstinence be stressed in all programs.¹⁵

However, HIV prevention activities must recognize that the vast majority of teenagers are experimenting with sexual behaviors and that many of these behaviors are placing them at risk of HIV infection. More than half of all late teens are having sexual intercourse. It is therefore important to place abstinence in the context of delaying intercourse until the partners have the capacity for mature emotional relationships. While all programs should clearly state that abstinence from all types of sexual intercourse is the only completely effective prevention against HIV, because few people can guarantee that they are involved in mutually monogamous relationships with an uninfected partner, programs must also provide practical information about how teenagers who are having sexual relationships can avoid infection.

Conclusion

The HIV epidemic should compel us to develop quickly effective AIDS education programs for our young people. The rapid response of state legislatures across the country to pass mandates for AIDS education indicates general public consensus in regard to this need. Yet, it is not enough to pass mandates and implement quickly conceived programs. Programs must be designed to be effective in changing young people's behaviors. Program designers and educators must heed the lessons learned from prior health promotion programs aimed at teens. The history of teenage pregnancy prevention programs is an important place to begin.

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Patterns and Trends In United States HIV/AIDS Surveillance

Highlights from the Latest Supplement (May 12, 1989) and the June 23, 1989 issue of the Centers for Disease Control's *MMWR (Mortality and Morbidity Weekly Report)*

General HIV/AIDS Statistics

To date, AIDS cases have been reported in each of the 50 states, the District of Columbia, and four U.S. territories. However, the distribution of cases remains uneven.

The Centers for Disease Control's (CDC) working estimate of total HIV infections is 1.0-1.5 million, which corresponds to a 0.4-0.6% infection rate in the U.S. population of 245 million. Most HIV-infected persons are between 17 and 55 years of age, an age span that constitutes about 55% of the population. With a male-to-female predominance in prevalence typically of at least 4 to 1, the prevalence rate might be expected to range from 1.2% to 1.8% for men and from 0.3% to 0.4% for women.

- Although **homosexual and bisexual men** still account for the majority of AIDS cases, case surveillance has documented an increasing role of IV drug use in the transmission of HIV. **IV drug users:** seroprevalence in the western cities appears to be remaining at the low levels previously seen. In Washington, DC, the 28% seroprevalence rate in hospitalized IV drug users without AIDS-like conditions is similar in magnitude to earlier data from nearby Baltimore. Cohort data from New York City showed an annual rate of new HIV infection of 7% in previously uninfected persons through 1987. By the end of 1988, 3,589 **heterosexually acquired AIDS cases** had been reported to CDC.

- The cumulative incidence of AIDS per 100,000 persons was highest in **Black and Hispanic communities**, (83.8 and 73.0 respectively). The ratio of AIDS case incidence is 3.2 to 1 for Blacks and 2.8 to 1 for Hispanics compared with whites. Even among homosexual and bisexual men and among IV drug users, where race/ethnicity-specific data are available, Blacks appear to have higher seroprevalence rates than whites.

- The proportion of **adult cases in women** increased from 7% before 1984 to 10% in 1988. **HIV infection in women of reproductive age:** results of 13 new or updated surveys and studies from clinical settings in eight areas became available in 1988. The observed

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seroprevalence ranged from less than 1% to approximately 4.3% in female clients who were screened without knowledge of risk status. The prevalence of HIV infection in childbearing women is determined by anonymously testing blood that is routinely collected from their newborn infants. This method measures the seroprevalence in childbearing women because sample selection is relatively unbiased and blood specimens are available for over 90% of births.

- **Heterosexual partners of persons at risk:** new and updated studies continue to show varied but appreciable levels of transmission risk. Female partners of HIV-infected men appeared to have higher prevalence rates than did male partners of HIV-infected women in the same study populations.

- CDC is collaborating with the American College Health Association in an assessment of HIV infection in **college students**. For the first 12,000 specimens tested, comprising various number of specimens from 17 of the participating campuses, the crude overall seroprevalence is 0.2%.

- Patients with AIDS in 82% of **adolescent cases** and in 55% of **pediatric cases** were male. These proportions have remained relatively stable since 1982.

- **Prisons:** Most routine screening programs have yielded seroprevalence rates higher than those estimated for the general population but much lower than those seen in groups composed of persons at increased risk.

- **Migrant & Seasonal Farm Workers:** Researchers conducted a study at a health clinic serving approximately 4,500 workers in North Carolina. Of 426 samples, 11 (2.6%) were positive for HIV antibody.

Heterosexual Transmission Of HIV Infection In the U.S.

By March 31, 1989, 89,501 AIDS cases in persons older than 13 years of age had been reported to CDC; 3,962 (4%) of these were attributed to heterosexual transmission. While the number of heterosexually acquired AIDS cases reported each year has increased, the overall proportion has remained relatively stable. However, the composition of the group has changed over time. Since 1986, persons reporting sexual contact with a partner at risk have outnumbered HIV-infected persons born in countries with predominantly heterosexual transmission.

Facts about heterosexuals with AIDS:

- Of the 2,625 heterosexual persons with AIDS with an "at-risk" partner, 672 (26%) were men and 1,953 (74%) were women.
- Men were older than women (mean age 40, compared with 34 years, respectively).

- Forty-seven percent were Black, 29% white, 23% Hispanic, 0.6% Asian Pacific Islander and 0.2% American Indian/Alaskan Native.

- In a multi-city study, HIV antibody was detected in 180 (13%) of 1,378 female prostitutes; 80% of the infected prostitutes reported using IV drugs.

It was noted in the *MMWR* that surveillance data for heterosexual transmission of HIV infection need to be interpreted cautiously. The actual number of AIDS cases reported to be associated with heterosexual transmission probably underestimates the role of this mode of spread. Nearly 3,000 persons classified as bisexual men, IV drug users, or persons with hemophilia also reported heterosexual contact with a person at risk. Therefore, some of these persons may have acquired HIV through heterosexual contact rather than through other routes.

Trends in HIV Infection Over Time

The risk of new infection in persons with hemophilia and in persons receiving blood transfusions has been reduced dramatically as a result of the screening of donated blood and the heat treatment of clotting factor concentrates. There is also evidence that shows an appreciable decline in the incidence of new infection in homosexual men. However, the risk of new infection appears to remain high in IV drug abusers.

Mortality

Fifty-six percent of all AIDS patients (56% of adults and adolescents and 55% of children) and 85% of those diagnosed before 1986 are reported to have died. In 1987, AIDS deaths accounted for 11% of all deaths in men 25-34 years of age and 9% of all deaths in men 35-44 years of age.

Projections of AIDS Cases And Mortality Through 1992

Current data indicate that more cases were actually diagnosed in 1986 and 1987 than were predicted. Projections made in May 1988 estimate that 365,000 AIDS cases will have been diagnosed in the United States by the end of 1992. The number of cases is expected to increase by about 10,000 per year, from 39,000 cases in 1988 to 80,000 in 1992. The actual number of deaths may be lower because these figures do not reflect the effect of new therapies.

NEWS...

AIDS Epidemic Demands Better Data, More Behavioral Research, and Expanded Intervention States Report

A report issued recently by a committee of the National Research Council has indicated that the enormous difficulties posed by efforts to stem the AIDS epidemic will require that the federal government expand its current programs for monitoring the spread of the human immunodeficiency virus (HIV) infection, begin an unprecedented effort to collect data on intimate sexual behavior and drug use, and better support programs to change risky behaviors.

The National Research Council, an agent of the National Academy of Sciences and the National Academy of Engineering, conducts studies and investigations in the public interest and examines questions of science and technology at the request of the federal government. The Council received funding from the John D. Rockefeller Foundation, the Russell Sage Foundation, and the U.S. Public Health Service to report on what is known about the spread of HIV infection in the U.S., to identify groups at risk of infection and ways to reach them, to describe and evaluate current behavioral and social research that might be relevant, and to recommend new research efforts to stem HIV transmission through behavior change.

The committee has advised the Centers for Disease Control (CDC) to continue feasibility studies of a national probability survey of the entire U.S. population to track the spread of infection. To understand better the spread of HIV in different segments of the population, they have urged that the CDC augment their infant surveys by anonymously testing every U.S. newborn for the presence of AIDS antibodies and conduct national surveys of abortion clinic clients.

Regarding the behaviors that help to spread AIDS, the committee emphasized that scientific evidence from other health campaigns has shown that messages based on moral dictates do not work. AIDS prevention messages are most effective, they said,

if they are stated in "clear, explicit language" that offers a choice of behaviors to reduce the risk of HIV infection rather than prescribing "one appropriate behavior." Other actions recommended by the committee include expanding needle-exchange and needle-sterilization programs for IV drug users and placing more public service announcements about AIDS on television. They urged television networks to accept commercial advertising for condoms.

HIV Statistics

There exist at present "no reliable data on the current prevalence of HIV," the committee concluded. Counts of AIDS cases, for example, are "out-of-date indicators" of HIV prevalence. The most reliable estimates put the total number of persons now infected with HIV at about one million, but the committee said that the range of plausible estimates spans 500,000 to two million.

CDC has launched a program to survey HIV prevalence among several population groups, including clients of drug treatment centers, clinics for sexually transmitted diseases, tuberculosis clinics, and clinics serving women of reproductive age, patients at general hospitals, and some newborn infants. The committee noted that while such data will be valuable for many public health purposes, with the exception of the newborns survey, the "purposive selection" of survey sites "compromises the usefulness of the data for estimating prevalence and incidence" in the populations of interest. The surveys, they advised, should be augmented to provide probability samples of these populations.

To maintain confidentiality of an individual's HIV status, the committee said that the federal government should "vigorously pursue" three safeguards: legal penalties in the event that confidentiality is breached; legal protection against discrimination based on HIV status; and anonymous testing so that the identity of the donor is neither known nor traceable to the blood specimen.

Sexual Behavior

The committee found that information about sexual habits is "fragmentary and the underlying research data are often unreliable." For example, while gay men comprise nearly three-quarters of the AIDS cases to date, the most widely cited information on male homosexuality dates from the 1940s, was collected by flawed sampling schemes, and is "not an adequate base" for current predictions. Newer information from 1970 and 1988, they said, indicates that at least 6.7% of American men have sex with other men at some point in their adult lives, and that at least

2-3% of these men engage in such behavior with some frequency. The committee stressed that, because of underreporting, even this newer data represent the "lower bounds" of the actual number of men who have such experiences. Data are also lacking on frequency of monogamous relationships; on the number and frequency of sexual contacts among divorced persons; and on the incidence of prostitution. The committee urged that the federal government support greatly expanded research efforts to obtain such data.

Existing evidence, they indicated, does suggest that the number of youths in their very early teen years who have sexual intercourse is increasing. The committee warned that these young people "are not particularly skilled in managing their sexual lives." It recommended that education about HIV transmission be taught in schools and include "explicit information relevant to the prevention of HIV infection." In addition, they suggested that condoms be freely available to all sexually active persons.

IV Drug Use

One of the fastest-growing components of the HIV epidemic is IV drug users, their sexual partners, and their children. The committee recommended that a portfolio of research and intervention activities be undertaken on the part of local, state, and federal governments to control the spread of AIDS through drug use. They stressed that "drug treatment programs should be available to everyone" wanting them and recommended "expanding and sustaining" safer-injection programs — generally needle exchanges or distribution of bleach for sterilizing needles. "None of the current studies on safer-injection programs has shown increased IV drug use," they said. Among the programs currently in use, "mobile vans," they noted, "and a cadre of outreach workers" who can go out on the street and reach drug abusers susceptible to HIV infection, "have proven helpful in bringing services to people who have not been reached by other services or agencies."

Changing AIDS-Related Behaviors

While providing people with accurate information is the logical starting point for any health campaign, information alone is unlikely to be sufficient to change behaviors that involve strong and fundamental urges and addictions. In order for people to change, the committee concluded, they

"must be motivated, they must believe that the changes being proposed will do some good, and they must believe they have a reasonable chance of successfully accomplishing those changes." Incremental change is a more realistic goal than global lifestyle change, the committee stressed, and choice among a range of acceptable behaviors will be more effective than messages that prescribe a single, acceptable behavior.

The committee pointed out the need to provide long-term support for programs that foster both the initiation and continuation of appropriate behaviors. "Most people need assistance and support to change unhealthy behaviors" and many individuals need to make lifelong commitments to new behaviors. In recommending further development of a portfolio of programs to address the needs of diverse populations needing assistance, the committee recommended that such programs target both individuals and the communities in which they live. Furthermore, government policies and programs at all levels, they said, must provide easy access to treatment for drug dependency and sexually transmitted diseases.

Nutritional Guidelines for AIDS Issued

The Task Force on Nutrition Support in AIDS, a group of 11 researchers and practitioners who specialize in nutrition and/or AIDS treatment, has issued the first comprehensive and practical "Guidelines for Nutrition Support in AIDS." The guidelines are designed to provide specific, appropriate direction to physicians and health care professionals who are involved in the management of AIDS. Practical recommendations are aimed at mitigating the signs and symptoms of the disease. "To date, the lack of clinical research on nutrition and AIDS has impeded efforts to provide the most appropriate nutritional care for these individuals," said Myron Winick, MD, chairman of the Task Force, professor of nutrition at Columbia University, and author/editor of 22 books on nutrition for adults and children. "We believe these guidelines offer positive direction to health professionals."

The results of a telephone survey commissioned by the Task Force — of 150 physicians and dietitians from institutions in the top 10 metropolitan AIDS areas across the country —

found that, although more than 90% of caregivers at the major AIDS treatment centers in the United States consider nutrition important, fewer than 20% of the institutions have a standard nutrition protocol for people with AIDS. According to the journal *Nutritional Support Services*, "Of those institutions acknowledging a nutrition protocol for AIDS patients, the only consistent element is a dietary assessment, though follow-up is not necessarily provided." The journal indicated that 44% of persons with AIDS receive no nutrition support when hospitalized and 52% are discharged without nutrition support. In addition, many people with AIDS are following unsound dietary practices that may be jeopardizing their already compromised health. Experts believe that people with AIDS can benefit from legitimate nutritional intervention, particularly if it is initiated early in the process. The guidelines are designed for appropriate intervention at each stage of AIDS and address the entire course of the disease. Initiation of nutrition support, they said, can make the difference between an individual who continues to function independently and one who is bedridden and totally dependent on others.

"Malnutrition is common among people hospitalized for AIDS or ARC (AIDS-related complex)," said Kristin Weaver, RN, nursing director of nutritional support services for San Francisco General Hospital. "The exact cause of malnutrition in this particular population is unknown. Patients with AIDS or ARC may not be getting enough calories and protein for a variety of reasons. They simply may not be eating enough, their nutritional needs may be greater, or they may be unable to absorb the nutrients they are getting." She added, "Malnutrition can seriously impair immune function. This is particularly dangerous for people with AIDS, whose already damaged immune system is unable to mount an effective defense against opportunistic infections....aggressive nutritional intervention during high stress periods will prevent malnutrition, which may help them fight infection, improve their response to drug therapy, and shorten their hospitalization." In people with AIDS, nutritional problems such as Protein-Calorie Malnutrition, where intestinal damage, severe weight loss, and diarrhea are often experienced, or in those with specific nutrient deficiencies, there may be a further compromising of an already weakened immune system and an aggravation of the effects of opportunistic infections.

Significant weight loss is common in the AIDS disease process. It is not unusual for individuals to lose 20-30% of their usual body weight. A drop in weight of more than 30% can be fatal. Many factors con-

tribute to weight loss, including oral/esophageal complications (thrush afflicts 95% of PWAs). Mouth sores can make chewing painful. Ulcers and oral herpes can make swallowing difficult and cause nausea and vomiting. Diarrhea and malabsorption can result in weight loss, dehydration, and imbalances of electrolytes — critical elements in the circulating blood. Anorexia, often the result of malaise, depression, or drug therapy, may also develop in response to a primary infection or due to fear of uncontrollable diarrhea or incontinence and psychosocial factors — including emotional distress brought on by rapid physical breakdown, economic hardship, realization of being terminally ill, and social changes caused by reactions from coworkers, family, and friends.

The guidelines suggest:

Nutritional support should be given *before* the individual becomes malnourished to protect against nutritional complications.

When an individual is having difficulty chewing or swallowing due to painful mouth sores, simple changes in the texture, temperature, consistency, and flavoring of foods and the time of meals may help to improve one's diet and ability to eat.

If the digestive tract works, use it. The gastrointestinal tract is the preferred route of feeding to maintain its structure and function.

Diarrhea, a common and often severe consequence of AIDS (about 60% experience it), is often caused by drug therapy, the presence of infectious organisms, or is of unknown origin (AIDS enteropathy). Elemental enteral diet formulas (commercially available nutritional products that provide complete nutrition) often are indicated to relieve the symptoms and to replace the critical nutrients lost due to diarrhea and/or malabsorption, but they should be used under medical or dietary supervision to insure that each individual's needs are adequately met.

Drug therapy, infection, or malignancy can cause lengthy bouts of nausea and vomiting, leading to weight loss, electrolyte imbalances, and dehydration. Fluids should be encouraged between meals. Good choices are broth, water, ginger ale, and clear fruit juice, such as apple juice. Greasy, high-fat, spicy foods should be avoided; dry cereal, crackers, and toast can be offered to relieve nausea.

Total Parenteral Nutrition (TPN), delivered intravenously, increases risk of catheter-related infection, and should only be used with a totally nonfunctional gastrointestinal tract.

(Continued on Page17)

AIDS

Looking Forward/Looking Back

A SIECUS Annotated Bibliography
Of AIDS-Related Resources
For the General Public

In consideration of the far-reaching ramifications that the AIDS crisis has had on our nation as a whole, the resources (books, audiovisuals, and directories) listed in this bibliography — compiled for the general public — cover a wide range of topics that reflect the complexity of this subject. The bibliography covers general facts about HIV/AIDS; personal perspectives on AIDS; safer sex; resources for young adults, parents, and caregivers; directories; and organizations and hotlines that can be contacted for further information.

Because there are so many new resources constantly being produced on this subject, people are often confused as to where to begin their search for information. This bibliography is designed to highlight the resources that will facilitate an easy introduction to HIV/AIDS.

If these resources are not in your local bookstore, they

often can be ordered by the bookstore for you. If they are unable to do this, contact the publisher, whose address and telephone number is provided after each listing, and order directly. Although SIECUS does not distribute any of the materials listed in this bibliography, other than our own publications, they are available for use within our reference library.

Funding for this bibliography, prepared by Carolyn Patierno, SIECUS' AIDS associate, was made possible through a cooperative agreement with the Centers for Disease Control. Permission is granted for reproduction of this bibliography as long as SIECUS is acknowledged. A single copy can be obtained, free upon request with a self-addressed, stamped business envelope by writing to Publications, SIECUS, 32 Washington Place, Room 52, New York, NY 10003 or by calling 212 673-3850.

AIDS: THE FACTS

AND THE BAND PLAYED ON: POLITICS, PEOPLE AND THE AIDS EPIDEMIC

Randy Shilts

By the time America woke up to the dangers of the AIDS epidemic, the disease had spread to every corner of the nation. Although not without factual errors, this book will astound and enrage. 1987, 630 pp., \$24.95.

St. Martin's Press, 175 Fifth Avenue, New York, NY 10010; 212/674-5151.

CONFRONTING AIDS: UPDATE 88

Institute of Medicine, National Academy of Sciences

This compendium updates the October 1986 Institute of Medicine

report, *Confronting AIDS: Directions for Public Health, Health Care, and Research*.

The two books together provide definitive information on what we now know about HIV infection and its epidemiology, education, care of people infected with HIV, drugs and the international aspects of the AIDS epidemic. 1988, 239 pp., \$15.95.

National Academy Press, 2101 Constitution Avenue NW, Washington, DC 20418; 202/334-2665.

SURGEON GENERAL'S REPORT ON AIDS

C. Everett Koop

This booklet provides information about AIDS, how it is transmitted, the relative risks of infection and how it can be prevented. 1986, 36 pp., free.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Care Delivery and Assistance, Office of Maternal and Child Health, Rockville, MD 20857; 301/443-2330.

UNDERSTANDING AND PREVENTING AIDS—A BOOK FOR EVERYONE

Chris Jennings

Written in clear and concise language and dealing with a wide range of topics, this book truly is "for everyone." Tables are used effectively throughout and the detailed chapter summaries are helpful. 1988, 230 pp., \$24.95.

Health Alert Press, Post Office Box 2060, Cambridge, MA 02238; 617/497-44190.

YOU CAN DO SOMETHING ABOUT AIDS

Sasha Alyson, editor

A free book from the publishing community — for the millions of Americans whose energy and compassion will win the battle against AIDS. 1988, 126 pp., free.

The Stop AIDS Project, Inc., 40 Plympton Street, Boston, MA 02118; 617/542-5679.

PERSONAL PERSPECTIVES

AIDS: THE WOMEN

Ines Rieder and Patricia Ruppelt, editors

A collection of experiences, told by women whose lives have been affected by AIDS. Mothers, sisters, wives, friends, and lovers share their personal accounts of their struggles to come to terms with the disease. 1988, 251 pp., \$9.95.

Cleis Press, PO Box 8933, Pittsburgh, PA 15221.

BORROWED TIME: AN AIDS MEMOIR

Paul Monett

The love story of two men battling AIDS together. *Newsweek* called it, "A powerful account of shattering eloquence." 1988, 352 pp., \$18.95.

Harcourt Brace Jovanovich, 111 Fifth Avenue, New York, NY 10003; 212/614-3000 or 1-800/346-8648.

EPIDEMIC OF COURAGE: FACING AIDS IN AMERICA

Lon G. Nungesser

The author, who himself has AIDS, talks with seven other people with AIDS about the impact the disease has had on their lives. He then talks with a lover, a mother, a brother, a health care provider, and a friend about the crises they have suffered while working with and loving people with AIDS. 1986, 255 pp., \$7.95.

St. Martin's Press, 175 Fifth Avenue, New York, NY 10010; 212/674-5151.

PRIVATE ACTS, SOCIAL CONSEQUENCES

Ron Bayer

Written by a medical ethicist, this book examines the politics of the AIDS epidemic since the early 80s. Topics covered include the politics of privacy, safety, identification, exclusion, control, persuasion, and public health. 1989, 282 pp., \$22.95.

The Free Press/Macmillan, Inc. 866 Third Avenue, New York, NY 10022; 212/702-2000.

REPORTS FROM THE HOLOCAUST

Larry Kramer

Controversial, yet often insightful, Kramer's collection of writings (dating back to 1978) capture the emotion engendered by the AIDS crisis. The collection, including a new essay, "Report From the Holocaust," is

fascinating and provocative. 1989, 284 pp., \$18.95.

St. Martin's Press, 175 Fifth Avenue, New York, NY 10010; 212/674-5151.

THE SCREAMING ROOM

Barbara Peabody

A mother's journal of a son's struggle with AIDS. A true story of love, dedication, and courage, told with directness and feeling. 1986, 254 pp., \$3.95.

Oak Tree Publications, Inc., 3870 Murphy Canyon Road, Suite 203, San Diego, CA 92123; 619/560-5163.

SAFER SEX

THE CONDOM BOOK: THE ESSENTIAL GUIDE FOR MEN AND WOMEN

Jane Everett and Walter Glanze

Includes a comprehensive, question-and-answer section on STDs, sexuality, and the correct use of condoms. A buyer's guide lists the condoms by product name, provides information about and a description of each product and its packaging, and offers a personal opinion of the condom by someone who has used it. 1987, 139 pp., \$3.95.

Signet, 1633 Broadway, New York, NY 10019; 212/397-8000.

HOW TO PERSUADE YOUR LOVER TO USE A CONDOM...AND WHY YOU SHOULD

Patti Breitman, Kim Knutson, and Paul Reed

Presents safer sex in a positive manner, while acknowledging and addressing the difficulties of adopting safer sexual practices. Includes a question-and-answer section on condoms and a "how-to" section for dealing with negative responses to condom use. A resource directory is included. 1987, 83 pp., \$4.95.

Prima Publishing and Communications, PO Box 1260 PC, Rocklin, CA 95677; 916/624-5718.

SAFE ENCOUNTERS: HOW WOMEN CAN SAY YES TO PLEASURE AND NO TO UNSAFE SEX

Beverly Whipple and Gina Ogden

This book explains that safer sex does not have to be unappealing or forbidding. Nonthreatening, the book is designed to make women feel more comfortable and aware in dealing with sexual issues in light of the HIV/AIDS epidemic. 1989, 222 pp., \$16.95.

McGraw-Hill Book Company, 11 West 19th Street, New York, NY 10011; 212/512-2000.

FOR YOUNG ADULTS

AIDS: TRADING FEARS FOR FACTS — A GUIDE FOR TEENS

Karen Hein and Theresa Foy DiGeronimo

The authors, writing especially for teens, are sensitive to the needs, fears, and concerns of this age group. Pronunciation of medical terms is given as the terms are introduced in the text for discussion, and photographs are used effectively in this attractive book. The book includes a resource directory. 1989, 206 pp., \$3.50.

Consumer Reports Books, 51 East 42nd Street, New York, NY 10017; 212/983-8250.

DON'T FORGET SHERRIE

(Audiovisual)

This audiovisual deals with two teenagers who have just begun a relationship when Tim learns that a former girlfriend has AIDS. The story examines the reactions different people have to such news and the effect it has on personal choices. 1988, 31:54 min., \$19.95.

American Red Cross. For more information, contact your local Red Cross Chapter.

A LETTER FROM BRIAN

(Audiovisual)

A letter from an ex-boyfriend forces a teenager to cope with the threat of AIDS.

American Red Cross. For more information, contact your local Red Cross Chapter.

FOR PARENTS

CHILDREN AND THE AIDS VIRUS — A BOOK FOR CHILDREN, PARENTS AND TEACHERS

Rosemarie Hausberr

Utilizing beautiful black-and-white photos, this book explains the facts about HIV/AIDS and its transmission. Large print is used for younger children and for older children in-depth discussions in smaller print are included at the bottom of the page. 1989, 48 pp., \$4.95.

Clarion Books, 52 Vanderbilt Avenue, New York, NY 10017; 212/972-1190.

DOES AIDS HURT?

Marcia Quackenbush and Sylvia Villarreal

The authors' intention in writing this book was "to offer children hope in a world that has no guarantees" and "to support parents, teachers, and others in guiding children through life with one less fear." They stress that a basic understanding of human sexuality is essential in learning about AIDS and suggest the means for facilitating this understanding. 1988, 149 pp., \$14.95.

Network Publications, a Division of ETR Associates, Post Office Box 1830, Santa Cruz, CA 95061-1830; 408/438-4081.

HOW TO TALK TO YOUR CHILDREN ABOUT AIDS

SIECUS

This booklet, designed to help adults talk with children about AIDS, offers age-appropriate guidelines for understanding and communicating the basic facts about HIV/AIDS. 1989, 16 pp., single copies free with SASE.

Publications, SIECUS, 32 Washington Place, New York, NY 10003; 212/673-3850.

TALKING WITH TEENS

(Audiovisual)

This excellent video will help parents talk with their teenage children about AIDS. 1988, 27 min., \$65.00.

San Francisco AIDS Foundation, P.O. Box 6182, San Francisco, CA 94101, 415/861-3397.

AIDS PREVENTION GUIDE FOR PARENTS AND OTHER ADULTS CONCERNED ABOUT YOUTH

Handouts from the National AIDS Information and Education Program's "America Responds to AIDS" campaign for the parents of children of different ages. 1989, free.

National AIDS Information Clearinghouse, 1-800/458-5231.

FOR CAREGIVERS

AIDS — CAREGIVER'S HANDBOOK

Ted Eidson, editor

This book, which deals with caring for a person with HIV/AIDS, includes articles by various authors on a wide range of topics. The clear and well-organized format makes it easy to

locate needed information. 1988, 331 pp., \$19.95.

St. Martin's Press, 175 Fifth Avenue, New York, NY 10010, 212/674-5151.

AmFAR DIRECTORY OF EXPERIMENTAL TREATMENTS FOR AIDS AND ARC

Each treatment included in this directory gives the chemical name of the drug; its manufacturer; a contact person; the status of the drug with the Food and Drug Administration; a general description of the drug's mechanism of action; clinical trial results; and side effects. Published quarterly. Single copies/\$10; subscription/\$30.

National AIDS Information Clearinghouse 1-800/458-523 or AmFAR, 1515 Broadway, Suite 3601, New York, NY 10036; 212/719-0033.

WHEN SOMEONE YOU KNOW HAS AIDS

Leonard Martelli, with Fran Peltz and William Messina

Without glossing over the difficulties of caring for a person with AIDS, this book offers support and suggestions for effective home care. Explanations of various opportunistic infections are made comprehensible for a lay audience. 1987, 238 pp., \$9.95.

Crown Publishers, Inc., 225 Park Avenue South, New York, NY 10003; 212-254-1600, 1-800/526-4264.

DIRECTORIES

AIDS INFORMATION SOURCEBOOK — SECOND EDITION 1989-90

H. Robert Malinowsky and Gerald J. Perry, editors

Alphabetically lists national and community-based AIDS organizations by type and state. Includes a comprehensive bibliography, which lists articles, books, brochures/pamphlets, curriculum/education programs, directories, fiction, films/video/audio resources, online databases, and periodicals. A subject index is also included. 1989, 215 pp., \$29.50.

Oryx Press, 2214 North Central at Encanto, Phoenix, AZ 85004-1483; 1-800/457-6799.

LEARNING AIDS

The American Foundation for AIDS Research

Comprehensive in scope, this resource directory lists materials by audience, provides a title index, and offers abstracts and evaluations of all the materials listed. 1989, 270 pp., \$24.95.

R.R. Bowker, 245 W. 17th Street, New York, NY 10011; 1-800/521-8110 or 212/337-6934.

FOR MORE INFORMATION

AIDS Information
US. Public Health Services
Office of Public Affairs, Room 721-H
200 Independence Avenue SW
Washington, DC 20201
202/245-6867

AIDS Public Education Program
American Red Cross
1730 D Street NW
Washington, DC 20003
404/329-2891

American Foundation for
AIDS Research
1515 Broadway, Suite 3601
New York, NY 10036
212/719-0033

Gay Men's Health Crisis
Box 274
129 West 20th Street
New York, NY 10011
212/807-6655

National AIDS Network
2033 M Street, Suite 800
Washington, DC 20036
202/293-2437

National Association of People
with AIDS
PO Box 65472
Washington, DC 20335
202/483-7979

National Hemophilia Foundation
110 Greene Street, Room 406
New York, NY 10012
212/219-8180

National Leadership Coalition on AIDS
1150 17th Street NW #202
Washington, DC 20036
202/429-0930

Sex Information and Education Council
of the U.S.
32 Washington Place
New York, NY 10003
212/673-3850

National AIDS Hotline
1-800/342-AIDS

National AIDS Information
Clearinghouse
1-800-458-5231

National Gay Task Force
1-800/221-7044

AIDS Crisisline
1-800/221-7044

STD National Hotline
1-800/227-8922

NEWS

Continued from Page 13

"Sound nutritional status can significantly improve the overall quality of life and well-being for the person with AIDS," concluded Dr. Winick. "More importantly, early, aggressive nutritional intervention in malnourished patients may help improve symptoms, reduce infection, and enhance response to drug therapy." Nutrition assessment at the time of diagnosis will establish a baseline from which changes can be noted and regular monitoring throughout the course of the AIDS progression will insure that appropriate nutrition support is offered at the earliest possible opportunity.

Members of the Task Force on Nutrition Support in AIDS include: Jeffrey A. Norton, MD, National Institutes of Health, Washington, DC; Richard J. Andrassy, MD, University of Texas Health Science Center, Houston, TX; Kassandra Rodriguez, MD, Jackson Memorial Hospital, Miami, FL; Donald Armstrong, MD, Memorial Sloan-Kettering Cancer Center, New York, NY; Carolyn A. Neary, RD, Swedish Hospital Medical Center, Seattle, WA; Donald P. Kotler, MD, St. Luke's-Roosevelt Hospital Center, New York, NY; Mary Anne Bryan, RD, Jackson Memorial Hospital, Miami, FL; Irwin H. Rosenberg, MD, Tufts University, Boston, MA; Kristin E. Weaver, RN San Francisco General Hospital, San Francisco, CA; and Ranjit K. Chandra, MD, Memorial University of Newfoundland, St. John's, Newfoundland.

New Toll-Free AIDS Information Number

The National AIDS Information Clearinghouse (NAIC), a service of the Centers for Disease Control (CDC), now has a toll-free number people can call to ask questions and order publications: 1-800/458-5231. Staff specialists with a broad knowledge of AIDS and HIV issues are available to give information, make referrals, and to suggest publications pertaining to HIV infection and AIDS.

NAIC also serves as a free centralized source for comprehensive information about HIV/AIDS programs, services, and materials for health professionals, for state and local AIDS program managers, and for

others responsible for educating the public about HIV and AIDS including minority populations and community-based organizations. They are, in addition, a source of free, government-approved HIV and AIDS educational materials — brochures, posters, point-of-purchase displays, etc., many of which are available in Spanish and in bulk quantities.

Choices: In Sexuality with Physical Disability

(16 mm & Video/Color/60 Mins.)

Produced for:
Institute of Rehabilitation Medicine
New York University Medical Center
Joan L. Bardach Ph.D., Project Director
Frank Padrone Ph.D., Co-Director

... Choices is a film which can be used time and time again in rehabilitation facilities human sexuality programs and in any group where issues of sexual interaction and adjustment to a disability are being discussed. If both parts cannot be purchased, Part 1 is a tremendously good discussion starter and should not be missed. . . .

Pam Boyle, Coordinator: Reproductive Health and Disabilities Program of the Margaret Sanger Center of Planned Parenthood. NYC.



Mercury Productions

907 Broadway

NYC 10011 (212) 869-4073

Two unique databases are the foundation of NAIC's information network. The Resources Database (a consolidated source of information about AIDS-related organizations and services that includes more than 6,000 descriptions of organizations that provide HIV and AIDS resources and services); and the Educational Materials Database (bibliographic information about HIV/AIDS information materials that includes more than 2,000 summaries of brochures, directories, fact sheets, information packages, manual, book chapters, monographs, posters, reports, study and teaching guides, sound recordings, videotapes, and advertising campaign materials). They have set up the NAIC Bulletin Board Services, a forum for NAIC and CDC staff and state and local AIDS officials, where ideas and information can be exchanged and plan to continue to develop database linkages and electronic bulletin board connections.

NAIC's Outreach Services staff members provide assistance to professionals involved in HIV and AIDS program development, management, and evaluation and exhibit and offer free information services at HIV and AIDS conferences. Two products of their outreach activities are the monthly *NAIC Conference Calendar*, which also includes a Clearinghouse publications list, and the *NAIC User Guide* (23 pp.), which provides step-by-step instructions on how to best use Clearinghouse services. Soon they will also offer a resource guide that identifies HIV and AIDS programs and resources for parents and youth — one of a number of targeted resource guides and packets planned for production. NAIC, in addition, works closely with the National AIDS Hotline.

NAIC's HIV and AIDS public resource center, soon to open its doors, will offer the opportunity to visit the Clearinghouse and, by appointment, to review and research information directly. The service is available from Monday through Friday, 9 a.m. to 7 p.m. eastern time. Requests for information can also be made by writing to: NAIC, Box 6003, Rockville, MD 20850 (FAX: 1-301-738-6616).

Call for Protection Of Privacy Between Health Professionals And Teenagers

Faced with recent court decisions, laws, and regulations that threaten the rights of privacy between teenage patients and their physicians and nurses, five national medical and nursing organizations have released guidelines aimed at protecting the privacy of their adolescent patients. The five organizations, representing more than 120,000 physicians and 20,000 nurses, said that "without some assurance of continuing confidentiality, we will be working under considerable disadvantage in trying to reduce adolescent suicide, teenage substance abuse, sexually transmitted diseases, and unintended pregnancy." They emphasized, "We are being forced by some recent court decisions, and by some laws and regulations, to violate the trust of confidentiality that we must have with teenagers if we are to be effective in treating their problems," and added, "Some of these laws and regulations are unduly restrictive and in need of revision as a matter of public policy. Ultimately, the health risks to the

(Continued on Page 30)

PERFORMANCE STANDARDS

For The Evaluation and Development of School HIV/AIDS Education Curricula for Adolescents

William L. Yarber, HSD

Member of the SIECUS Board of Directors
Professor, Department of Applied Health Science, Indiana University, Bloomington, Indiana

Most school districts in the United States provide HIV/AIDS instruction for adolescents and utilize curricular materials that have been produced outside of their schools. At the beginning of the human immunodeficiency syndrome crisis, only a few curricula were available. Now, there are several curricula that have different instructional approaches. Schools, therefore, are faced with the task of choosing the best curricula for their particular community. Further, many schools, in response to edicts for local determination of HIV/AIDS curricula, are developing their own programs. However, many of those responsible for curriculum selection and/or development lack adequate professional preparation and are not clear about the goal and philosophy of school HIV/AIDS prevention education. Hence, they are uncertain about the best content and methodological approach to employ.

Although some general guidelines suggesting instructional content have been developed, they do not delineate specific concepts for the major topic areas nor do they present detailed suggestions concerning pedagogical strategies. Because of a lack of universally accepted and adopted standards, the approaches of school HIV/AIDS education programs for adolescents have varied, which has resulted in some instruction being inadequate. Performance standards, against which current curricula can be evaluated and new material developed, are needed. The development of performance standards will contribute toward assuring greater quality of instruction and increase the schools' role in controlling HIV. This article briefly describes a model for the development of performance standards and includes a checklist that can be used for evaluating existing curricula and for developing new instructional materials.

A modified worth-assessment procedure was used in the creation of these standards. Such a procedure — a tool to assist decision-makers who must choose among acceptable alternatives that have multiple or complex attributes — generally involves the construction of a visual relationship among the objects' compo-

nents and a quantitative statement of priorities. The steps include creating a list of evaluation criteria; arranging them into a tree-like hierarchy with each subsequent branch defining the previous branch more precisely; and assigning relative worth weights to each branch. Finally, a performance standard is created for each evaluation criteria.^{1,2} This procedure — which has been used to evaluate sexually transmitted disease education material^{3,4} — has helped to pinpoint the strengths and weaknesses of material, making it attractive to those producing or assessing curricula.

For this project, the procedure has been simplified. No quantitative weights have been assigned to the hierarchy components; the specific criteria are presented as having equal value, which should increase the procedure's utility among practitioners and community members.

Analysis of professional literature and interviews with health scientists and educators were used in the development of the hierarchy and of the performance standards. Particular attention was centered on content and pedagogical approach,⁵⁻¹⁸ including learning and instructional theory.¹⁹⁻²⁰

It was determined that the most effective curriculum would include both student and teacher guides (figure 1). Components of the student guide include material content and material presentation (figures 2 and 3); the teacher's guide includes only material content (figure 4). Seventy-three specific criteria/performance standards have been developed (see the accompanying checklist).

The standards presented here represent an ideal curriculum — one that should be in every junior and senior high school throughout the country. Reality reminds us, however, that the content and pedagogical approach may need to be altered in some schools because of the political climate. Nonetheless, all persons responsible for HIV/AIDS education for adolescents should make a commitment to teach an ideal program. The students' right to an educational experience that maximizes their ability to protect their health demands nothing less.

(References Page 26)

Figure 1

Major Hierarchical Components of School HIV/AIDS Education Curricula for Adolescents

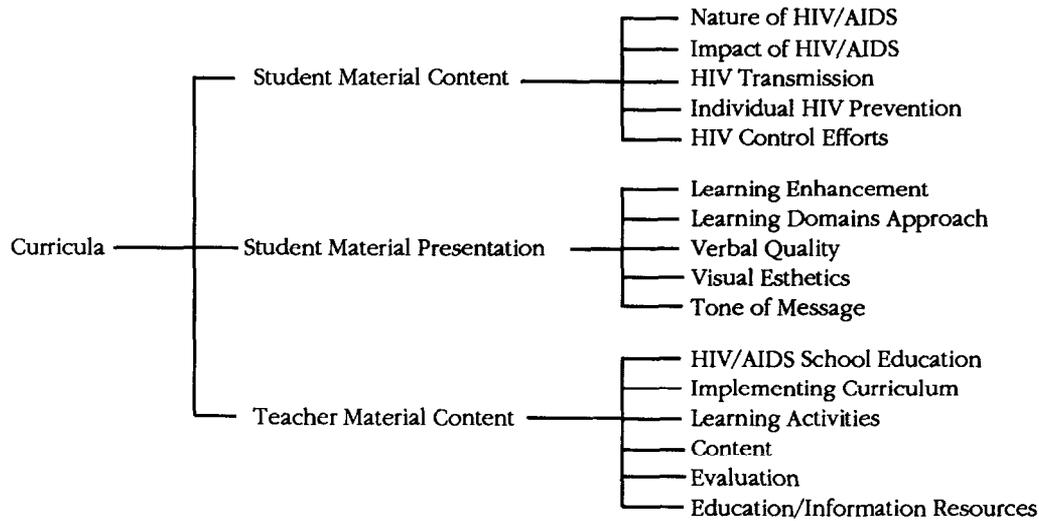


Figure 2

Specific Hierarchical Components of the Student Material Content

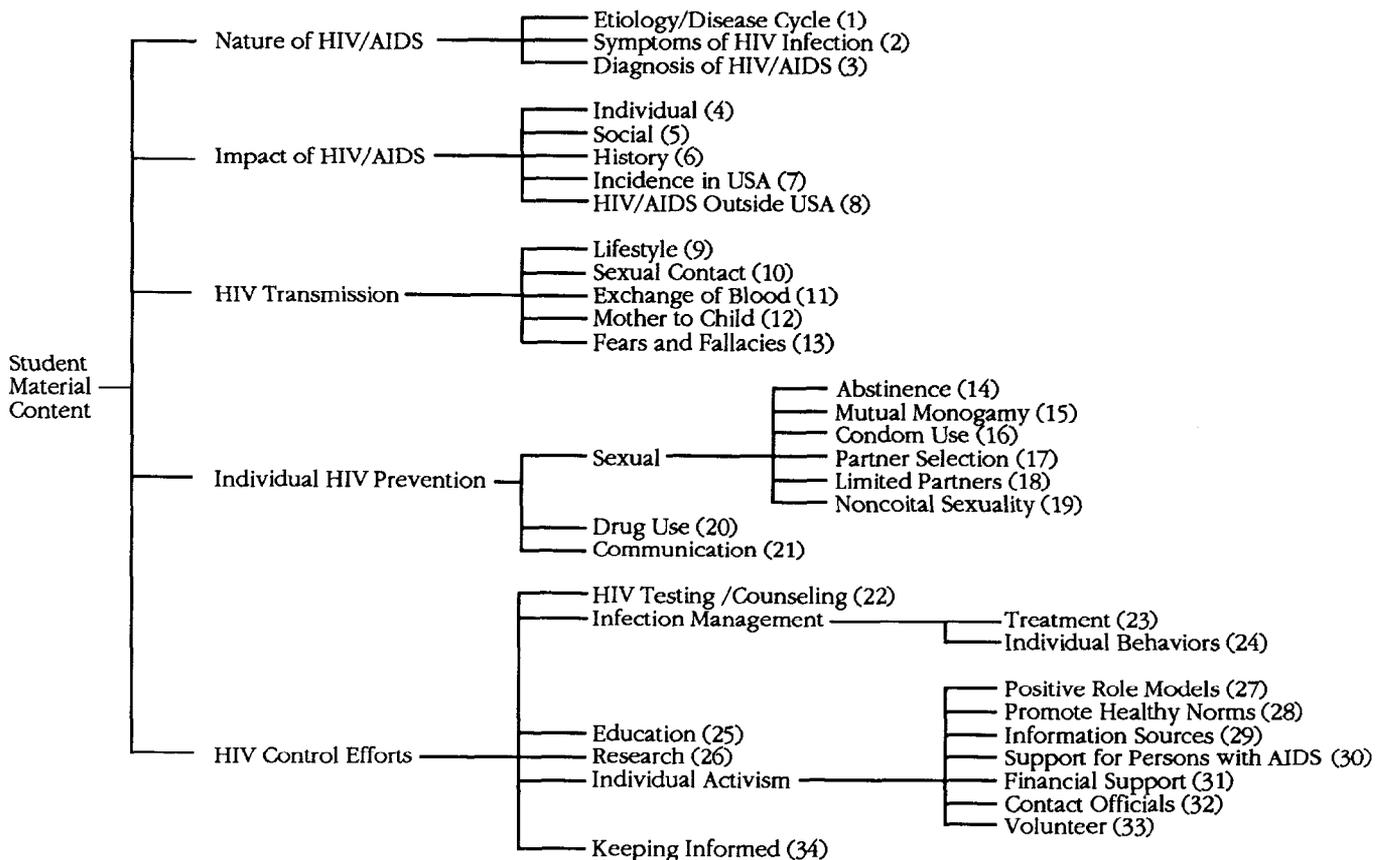


Figure 3
Specific Hierarchical Components of the Student Material Presentation

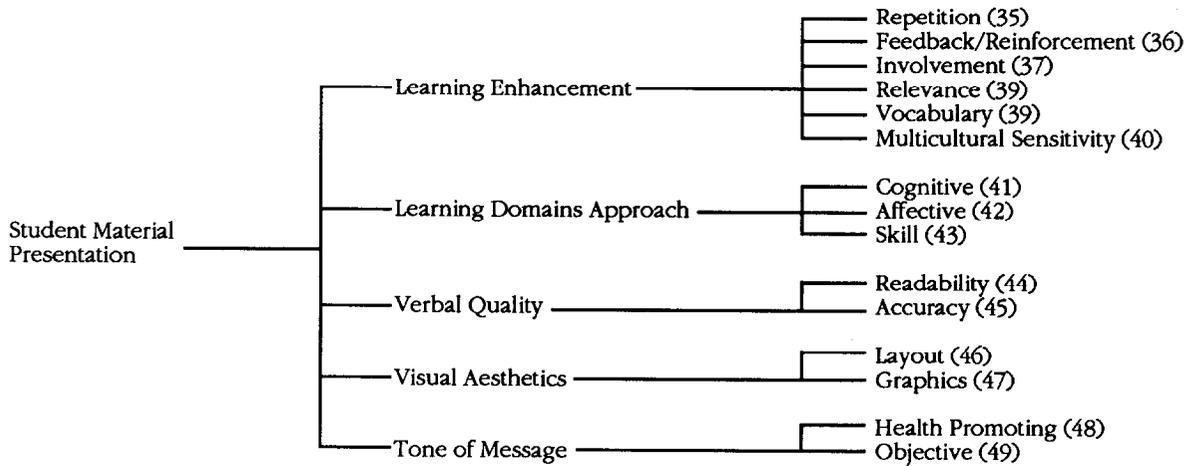
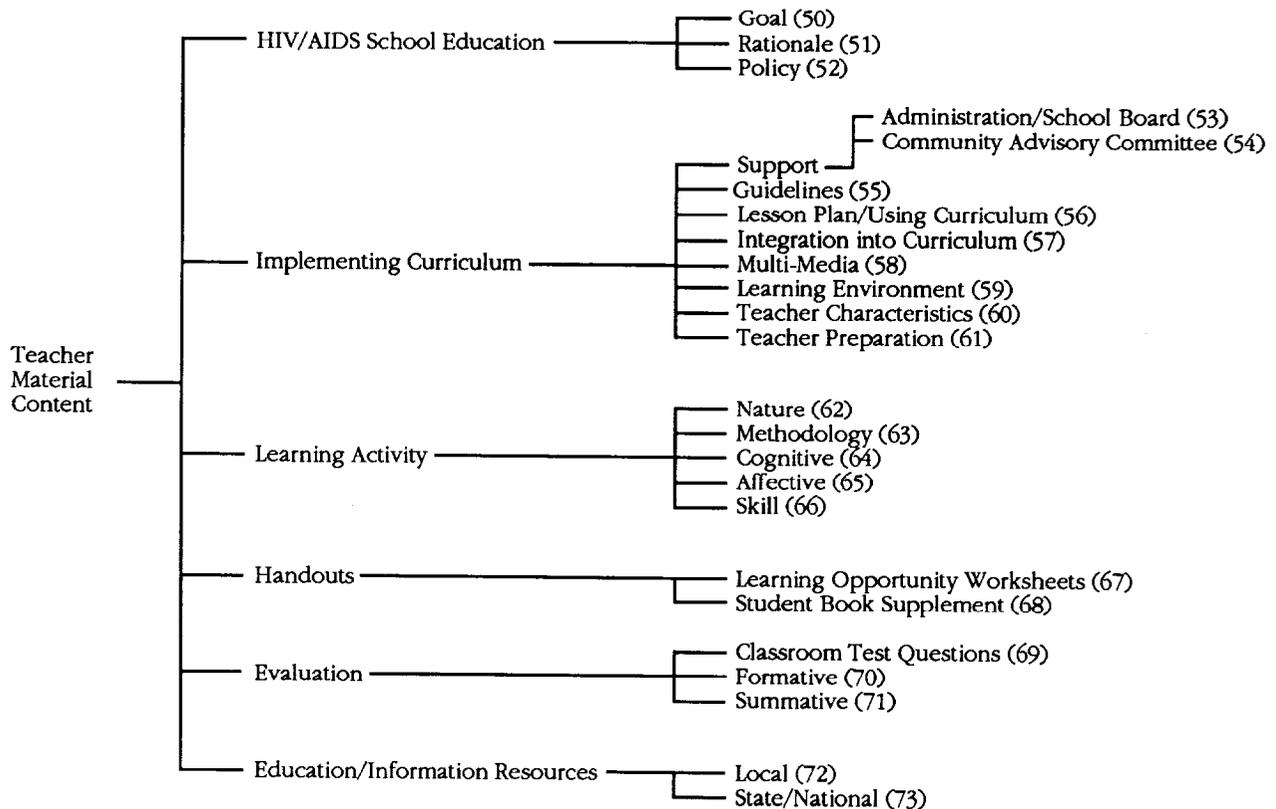


Figure 4
Specific Hierarchical Components of the Teacher Material Content



**Performance Standards
For School HIV/AIDS Education Curricula
For Adolescents
CHECKLIST**

The following checklist includes a listing of 73 specific criteria/performance standards. Under each are the topics to be discussed and the behaviors that should be promoted and encouraged by the instructional material.

**Student Material Content:
Nature of HIV/AIDS**

1. Etiology/Disease Cycle

- Disease names
- Causative organism
- Body fluids having HIV
- Infectious period
- Difference between HIV infection and AIDS
- Percent of infected developing AIDS
- Meaning and examples of opportunistic diseases
- Lack of vaccine
- Impact of HIV on body

2. Symptoms of HIV Infection

- Incubation period
- Symptom's similarity to common minor illnesses
- Symptoms of HIV infection
- Inconsistent presence and severity of symptoms
- Lack of suspicion of infection until symptoms appear
- Persons having symptoms of HIV infection for more than two weeks are encouraged to see a physician

3. Diagnosis of HIV/AIDS

- Diagnosis of HIV infection
- Time of antibody appearance
- Accuracy of antibody test
- Types and meanings of test results
- Fallacy of self-diagnosis
- Criteria for classification as having AIDS

**Student Material Content:
Impact of HIV/AIDS**

4. Individual

- Consequences of HIV/AIDS
- Others as a support system

5. Social

- The impact and outcome on various community segments
- Community efforts in combating HIV/AIDS

6. History

- Date of first reported AIDS case
- Increasing incidence
- Cumulative incidence (HIV infections, AIDS cases, deaths)
- Changing geographic distribution
- Blood transfusion inoculation prior to 1985

7. Incidence in USA

- Most recent year incidence
- AIDS incidence groups
- Black and Hispanic over-representation
- Infection in all states and types of towns
- Projected future incidence

8. HIV/AIDS Outside USA

- World regions having AIDS cases
- Number of countries reporting AIDS cases
- Major incidence groups in USA and Europe
- Major incidence groups in Central Africa, Latin America, and the Caribbean

**Student Material Content:
HIV Transmission**

9. Lifestyle

- Behavior as the risk factor for HIV infection, in

contrast to sexual orientation

10. Sexual Contact

- Known and possible risk-behavior transmission
- No possible infection from noninfected person
- Increased HIV infection risk for STD infected
- Heterosexual and male homosexual/bisexual transmission
- Limited lesbian transmission
- Possibility of transmission of other STD

11. Exchange of Blood

- IV drug use, risk behaviors
- Screening of donated blood, semen, tissues, and organs
- Safety of blood supply
- Treatment of blood for persons with hemophilia
- Donation of own blood prior to surgery
- Safety of donating blood
- Persons at high risk for having HIV are encouraged not to donate blood.

12. Mother to Child

- Percent of pediatric AIDS cases
- Transmission mechanism
- Probability of child infection from infected mother
- Women with a positive HIV-antibody test are encouraged to avoid pregnancy and not to breastfeed.
- Pregnant women are encouraged to insist that partner uses a condom if he has practiced high-risk, HIV-related behavior.

13. Fears and Fallacies

- Unreasonable fear of HIV infection
- Difference between HIV and other transmissible diseases
- Transmission possibility by kissing
- No risk for family members caring for person with AIDS
- Ways HIV are not transmitted

Student Material Content: Individual HIV Prevention

14. Abstinence

- Definition and certainty of method
- Normalcy of method
- Benefits
- Risks of early sexual involvement
- Naturalness of sexual feeling
- Religious and societal views
- Factors to be considered prior to coitus
- Coital-readiness criteria
- Value of abstinence, and other prevention methods, for avoiding STD/pregnancy
- Value of delaying coitus
- Persons are encouraged to identify and resist sexual peer pressure.

- Persons are encouraged to consider many factors when deciding about coitus and to delay coitus until coital-readiness criteria are met.

15. Mutual Monogamy

- Definition and benefits
- Monogamous relationship other than marriage
- Limitations
- Religious and societal views
- Persons are encouraged to delay coitus until they are able, at the least, to form a long-term, mutually monogamous relationship with an uninfected person.
- Persons sexually involved, and desiring to remain so, are encouraged to establish and/or maintain mutual monogamy.

16. Condom Use

- When to use
- Type to use
- Use suggestions
- Effectiveness
- How to discuss
- How and where to acquire
- Spermicides and nonoxynol-9
- Ineffectiveness of other birth control methods
- Persons are encouraged to use condoms if uncertain about HIV infection status of partner.

17. Partner Selection

- Value of careful partner selection
- Value of knowing if partner is at risk
- Fallacy of judging HIV status by looking at person
- Persons at increased risk
- Discussing HIV prevention with partner
- Persons are encouraged to carefully select partners
- Persons are encouraged to talk about HIV prevention with possible partners and not to have sex with those who will not discuss AIDS.

18. Limited Partners

- The risk of multiple sex partners
- Persons are encouraged to avoid multiple sex partners

19. Noncoital Sexuality

- HIV-preventive advantages of noncoital sexuality
- Types of noncoital intimacy
- Persons are encouraged to limit partner affection to noncoital intimacy until coital-readiness criteria are met.

20. Drug Use

- Dangers of illicit drug use
- Value of not using drugs
- Persons are encouraged not to use illicit drugs; persons using drugs are encouraged to never share needles and syringes
- Persons are encouraged to identify and to resist drug use pressure
- Persons presently using illicit drugs are encouraged to seek professional help

21. Communication

- Need for and value of communication
- Suggestions for improvement
- Importance of values
- Persons are invited to clarify own values and stand by them
- Persons are encouraged to rehearse good communication skills
- Persons are encouraged to talk with parents or other adults about good communication skills.

Student Material Content: HIV Control

22. HIV Testing/Counseling

- Who should be tested
- Benefits/limitations
- Confidential/anonymous testing
- Voluntary/mandatory testing
- Counseling/testing for adolescents
- Local resources
- Toll-free telephone numbers
- Persons who have practiced high-risk behaviors are encouraged to seek counseling/testing
- Persons who have practiced high-risk behaviors within 12 weeks of a negative test are encouraged to take another test
- Persons are encouraged not to donate blood to determine HIV-antibody status
- Persons with negative test results are encouraged to practice behaviors that reduce their chances of infection

23. Treatment

- Lack of HIV/AIDS cure
- Experimental efforts
- Present treatments
- Treatment of opportunistic diseases
- Future outlook

24. Individual Behaviors

- Responsible behavior for infected persons
- Persons infected are encouraged to practice sexual abstinence or low-risk behavior, and never to use or share IV drug needles and syringes
- Persons infected are encouraged to make sure their sex and needle-sharing partner(s), and perhaps their babies and children, have counseling/testing
- Persons infected are encouraged not to donate blood, semen, organs, or tissues
- Persons infected are encouraged to follow medical advice and seek support/counseling

25. Education

- Values and goals
- Groups receiving education

26. Research

- Groups conducting research
- Need for and goals of research
- Prospect of finding a cure and vaccine
- Priority of AIDS research

27. Positive Role Models

- Value of role-modeling
- Ways to serve as role model
- Persons are encouraged to practice HIV prevention as a healthy role model, as well as for personal safety

28. Promote Healthy Norms

- Risky behaviors as the norm for young adults and reasons for the behaviors
- Persons are encouraged to influence peer norms toward being more healthy

29. Information Sources

- The prevalence of misconceptions about HIV/AIDS
- Persons are encouraged to correct fallacies when talking with others
- Persons are encouraged to create an HIV/AIDS resource center in the school or town

30. Support of Persons with AIDS

- Fear of being with persons with AIDS
- Safety of casual contact
- Needs of persons with AIDS
- Needs of families of persons with AIDS
- Persons are encouraged to continue being friends with someone who has AIDS

31. Financial Support

- The need for and use of financial resources
- Persons are encouraged to organize fundraising drives or to contact a local AIDS agency to see what can be done

32. Contact Officials

- Ongoing development of HIV/AIDS policies by various organizations
- Persons are encouraged to be advocates for HIV education, research, and health care services
- Persons are encouraged to be alert to proposed legislation and to voice opinions to officials and legislators

33. Volunteer

- Ways to volunteer for AIDS causes
- Persons are encouraged to serve as HIV/AIDS volunteers

34. Keeping Informed

- Discovery and value of new information
- Importance of information
- Sources of information
- Value of persons being sources of accurate facts
- Persons are encouraged to keep up-to-date.
- Persons are encouraged to inform their friends that

they know the latest facts and would be willing to share them

Student Material Presentation: Learning Enhancement

35. Repetition

- Major concepts are presented several times

36. Feedback/Reinforcement

- Opportunities are provided for students to test their learning with prompt feedback and reinforcement

37. Involvement

- Learning opportunities that require a student's involvement and use of major concepts are provided

38. Relevance

- Information is specifically geared to adolescents based on developmental principles

39. Vocabulary

- Definition and pronunciation of technical and possibly unknown/difficult terms
- Terminology familiar to adolescents is used

40. Multicultural Sensitivity

- Material is congruent with social, family, and personal life of various racial/ethnic groups
- Material is not condescending or prejudicial toward any racial/ethnic group

Student Material Presentation: Learning Domains Approach

41. Cognitive

- Major emphasis is on health behaviors related to HIV transmission and prevention and minimal biomedical/technical information is presented
- Learning opportunities (e.g. pretest and posttest) concerning major cognitive concepts are provided

42. Affective

- Learning opportunities (e.g. pretest and posttest) concerning attitudes toward HIV/AIDS are provided

43. Skill

- Learning opportunities that require rehearsal of skills related to HIV transmission and prevention are provided

Student Material Presentation: Verbal Quality

44. Readability

- Reading level is sixth/seventh grade: minimal use of words with more than three syllables and long, complex sentences and paragraphs are avoided
- Syntax is sound, with precise and simple presentation of concepts

45. Accuracy

- Information is correct according to contemporary understanding

Student Material Presentation: Visual Esthetics

46. Layout

- Pages have ample "white-space"
- Print is an adequate size, layout has a logical, natural flow, and a variety of print-types and/or colors are used

47. Graphics

- Photos, graphs, and illustrations are used to enhance student interest and understanding
- No negative, confusing, or prejudicial effects are produced

Student Material Presentation: Tone of Message

48. Health Promoting

- Material emphasizes self-directed, health-conducive behavior, including responsibility for the health of others

49. Objective

- Material is absent of moral judgments, overly emphatic adjectives or adverbs, obtrusive style, or offensive material
- Anxiety-alleviating material is included

Teacher Material Content: HIV/AIDS School Education

50. Goal

- The major instructional objective of preparing individuals to protect themselves and others from HIV infection is stated

51. Rationale

- The need for HIV/AIDS education for adolescents, including the value of early preventative education and the extent of risk behavior among youth is stated

52. Policy

- Material encourages schools to develop HIV/AIDS education policies and policies for managing blood/body fluids spillage, personal health records, and students/staff who may be HIV infected

Teacher Material Content: Implementing Curriculum

53. Administration/School Board

- Importance and value of administrative and school board approval and support of HIV/AIDS education are stated
- Suggestions for how to secure approval and support are given

54. Community Advisory Committee

- Importance and role of a community advisory committee are discussed
- Material describes the composition of the advisor committee and encourages the inclusion of students and members of various racial/ethnic groups.

55. Guidelines

- Material encourages school to follow HIV/AIDS education guidelines (local, state, and/or federal) in implementing HIV/AIDS instructional program

56. Lesson Plan/Using Curriculum

- A lesson plan for the curriculum that suggests daily activities is provided
- Materials needed to implement the curriculum are listed

57. Integration into Curriculum

- Material describes the rationale for and encourages HIV/AIDS instruction as part of a comprehensive, K-12, health science education

- program, which also includes human sexuality, sexually transmitted diseases, and communicable diseases education
- Material provides suggestions on how to integrate HIV/AIDS instruction into the curriculum

58. Multimedia

- Material encourages a multimedia approach, particularly presentations that include various racial/ethnic groups

59. Learning Environment

- Material describes and encourages the creation of a safe classroom environment for HIV/AIDS instruction
- Material encourages integration of racial/ethnic groups, with class discussion of common and differing values, beliefs, and behaviors

60. Teacher Characteristics

- Material describes the desired teacher characteristics required for quality HIV/AIDS instruction
- Material encourages the use of a qualified, regular, classroom teacher for HIV/AIDS instruction, and utilizes carefully selected outside authorities only as supplemental speakers

61. Teacher Preparation

- Material encourages schools to provide inservice education for persons assigned to provide HIV/AIDS instruction

Teacher Material Content: Learning Activities

62. Nature

- Learning opportunities provided maximize student participation in learning, cover the three learning domains, emphasize health behaviors, and involve the family
- Several different learning opportunities are provided for each domain to allow local selection based on diverse student maturity and community mores

63. Methodology

- Purpose, objective, and utilization procedures are included in learning opportunities

64. Cognitive

- Cognitive learning opportunities included stress major concepts related to HIV transmission and prevention

65. Affective

- Affective learning opportunities stress personal examination of attitudes related to HIV/AIDS health behaviors and other issues
- Directions for utilization suggest following

standard procedures for values clarifications activities, including optional and anonymous student participation

66. Skill

- Skill learning opportunities provide practice and simulation of HIV prevention behaviors, including decision-making, problem-solving, communication, and refusal skills

Teacher Material Content: Handouts:

67. Learning Opportunities Worksheets

- Any student worksheets required for the learning opportunities are included and are printed in a format that permits easy duplication

68. Student Book Supplement

- Any material that may be too controversial to include in the student book is given in a format that is easily duplicated and may be distributed to students based on local discretion

Teacher Material Content: Evaluation

69. Classroom Test Questions

- Several types of questions that evaluate cognitive learning are included
- Questions that assess cognitive levels beyond memory are included

70. Formative

- Material describes rationale for and encourages conducting curriculum preparation studies, process evaluation, and program refinement
- Material suggests resources and basic strategies for conducting formative evaluation

71. Summative

- Material describes rationale for and encourages determining program effectiveness on student knowledge, attitudes, and behavior related to HIV/AIDS
- Material suggests resources and basic strategies for conducting summative evaluation.

Teacher Material Content: Education/Information Resources

72. Local

- Material describes types of local resources that can assist in education and that can provide HIV/AIDS information, and advises careful use of such resources
- Materials encourage use of various racial/ethnic groups in HIV/AIDS education

73. State/National

- Material describes types of state and national resources that can assist in education and that can provide HIV/AIDS information, and encourages careful use of such resources

References (From Page 18)

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Conference/Seminar Calendar

INTERNATIONAL CONSULTATION ON HIV-RELATED DISEASE AND ITS IMPACT ON FOOD PRODUCTION, NUTRITION AND RELATED ISSUES, October 16, 1989; FIRST NATIONAL CONFERENCE ON AIDS PREVENTION, EDUCATION AND SERVICE DELIVERY TO PEOPLE WITH DISABILITIES, November 1-3, 1989. New York, New York. Contact: George Marshall Worthington, Conference Chairperson, 345 West 21 Street, Suite 3D, New York, NY 10011-3509, 212/243-5883 or 459-8627.

FIRST RESPONDERS AIDS AWARENESS AND PREVENTION: STD '89, October 18-20, 1989; MANAGEMENT OF THE HIV-INFECTED PERSON: STD '89, October 23-25, 1989; AIDS EDUCATION FOR DENTAL PROFESSIONALS: STD '89, November 6-7, 1989; FIRST RESPONDERS AIDS AWARENESS AND PREVENTION: STD '89, November 15-17, 1989, and PHYSICIANS AIDS UPDATE, December 11-12, 1989. Contact: Sarah Ferrell, Birmingham STD Prevention/Training Center, 1400 6th Avenue South, Room 102, Birmingham, AL 35202, 205/933-9110, 205/933-9110.

SEXUALITY TODAY: AN INSTITUTE FOR EDUCATORS & COUNSELORS, October 19-21, 1989. Will provide up-to-date information about sexuality; learn effective strategies and practical techniques for implementing family life and AIDS education curricula; clarify values and attitudes with special emphasis on working with children and adolescents; and broaden professional skills for educating and counseling about sexuality. Holiday Inn Somerset, Somerset, New Jersey. Contact: Marcia Kosofsky, Program Director, Department of Environmental & Community Medicine, University of Medicine & Dentistry of New Jersey, Robert Wood Johnson Medical School, 675 Hoes Lane, Piscataway, New Jersey 08854-5635, 201/463-4823.

AMERICAN PUBLIC HEALTH ASSOCIATION (APHA), "STRENGTH THROUGH DIVERSITY," October 22-26, 1989. The largest public health forum in the world — serves as the focal point for professional dialogue on public health. Hundreds of seminars, workshops, and panel presentations for peer discussion of current research, issues, practice, and policies in public health. Contact: APHA, 1015 15th Street NW, Washington, DC 20005, 202/789-5600.

HIV/AIDS PREVENTION IN YOUR COMMUNITY, November 1-3, 1989. Designed for health educators. Spokane, Washington. Contact: Pattie Simon, STD Prevention/Training Center, 820 NE 45th Street, Suite #1, Seattle, WA 98105, 206/543-9750.

6TH NATIONAL SCHOOL BASED CLINICS (SBC) CONFERENCE, "KEEPING THE PROMISE: A BRIGHTER FUTURE FOR ALL YOUTH," November 1-3, 1989. Stouffer Harborplace Hotel, Baltimore, Maryland. Contact: Support Center for School-Based Clinics/CPO, 5650 Kirby, Suite 242, Houston, Texas 77005-2443, 713/664-7400.

SECOND INTERNATIONAL CONFERENCE ON DRUG RESEARCH IN IMMUNOLOGIC AND INFECTIOUS DISEASES • AIDS, November 6-9, 1989, Arlington, Virginia. Contact: Marla Simpson, Conference Director, New York

Academy of Sciences, 2 East 63 Street, New York, NY 10021, 212/838-0230.

32ND ANNUAL MEETING OF THE SOCIETY FOR THE SCIENTIFIC STUDY OF SEX (SSSS), "SEXUALITY EXPANDING THE BOUNDARIES," November 9-12, 1989. "Latest research and clinical findings and educational techniques in the field of sexual science will be presented and discussed." Royal York Hotel, Toronto, Ontario, Canada. Contact: SSSS, 608 Fifth Avenue North, Mount Vernon, IA 52314, 319/895-8124.

1989 CLINICAL CONFERENCE AND EXHIBITION OF THE NATIONAL PERINATAL ASSOCIATIONS, "TODAY'S BIRTHS, TOMORROW'S LEADERS," November 10-14, 1989. Cosponsored by March of Dimes Birth Defects Foundation and Children's Hospital National Medical Center. "Children born today will be our leaders in the year 2020. What are we going to do to insure their start in life allows them to be intellectually, physically and financially able to lead us through the next century?" Washington Hilton Hotel and Towers, Washington, DC. Contact: National Perinatal Association, 10 1/2 S. Union Street, Alexandria, Virginia 22314-3323, 703/549-5523.

11TH ANNUAL CONFERENCE ON PATIENT EDUCATION, "PATIENT EDUCATION: A FAMILY AFFAIR," November 16-19, 1989. Sponsored by the American Academy of Family Physicians, Society of Teachers of Family Medicine, and Trinity Lutheran Hospital of Kansas City, Missouri. The conference is noted for its emphasis on interdisciplinary interaction, team development, and practical information and skills to enhance the patient education efforts of health care professionals. Contact: Barbara Widmar, Conference Coordinator, Health Education Department, American Academy of Family Physicians, PO Box 8723, Kansas City, MO 64114-0723, 816/333-9700 or 800/274-2237.

NATIONAL ORGANIZATION ON ADOLESCENT PREGNANCY AND PARENTING (NOAPP), "GRASSROOTS ORGANIZATIONS: MOVING AHEAD IN THE 90s," November 16-18, 1989. "This year's conference will be a skill-building program with 'hands-on' workshops on topics crucial to the development and maintenance of successful adolescent pregnancy prevention and care programs, as well as local and state coalitions." Capitol Hill Quality Inn, Washington, DC. Contact: NOAPP Office, PO Box 2365, Reston, VA 22090, 703/435-3948

FOURTH NATIONAL FORUM ON AIDS AND HEPATITIS B: TARGETS OF OPPORTUNITY, STRATEGIES FOR CONTROL, November 19-21, 1989, Washington, DC. Contact: National Foundation for Infectious Diseases, 4733 Bethesda Avenue, Suite 750, Bethesda, MD 20814, 301/656-0003.

AIDS UPDATE/MULTIDISCIPLINARY, November 21-22, 1989, Cincinnati, Ohio. Contact: Sandy Johnson, Cincinnati STD Prevention Center, 3101 Burnet Avenue, Cincinnati, OH 45229, 513/352-3152.

WORLD AIDS DAY, December 1, 1989, worldwide. Contact: Global Programme on AIDS, World Health Organization, 1211 Geneva 27, Switzerland.

Recommended Resources

AIDS & PRISONS: The Facts for Inmates and Officers (1988, 8 1/2x5 1/2, 14 pp. *booklet*, also in Spanish).

"Today a phantom haunts American prisons and jails. This phantom is AIDS-phobia — the fear of Acquired Immune Deficiency Syndrome (AIDS). Prisoners and correction officers alike are worrying, asking themselves if they are at risk simply by being inside prison walls. This booklet will shed light on this phantom. We want to give you the facts about AIDS in prison. We want to help each prisoner and officer fight the real enemy — which is AIDS, and not the phantom enemy — the fear of AIDS." The booklet (available in Spanish as well) provides definitions of related terms; covers questions and answers about AIDS; discusses avoiding HIV in prison, medical care for people with AIDS or HIV, and inmates' and officers' legal rights and responsibilities; and tells how to get more information about AIDS. A bibliography, *AIDS and Prisons*, is also available (\$5). *AIDS Information, The National Prison Project, 1616 P Street NW, Washington, DC 20036, 202/331-0500. Prices: one free with self-addressed, stamped envelope; 100/\$25; 500/\$100; 1000/\$150.*

The **American Indian Health Care Association (AIHCA)**, begun in 1975 and representing 35 urban Native American health care programs, was formed to promote the improved health status of Native Americans living in urban areas. "Due to eligibility requirements of the Indian Health Service, most urban American Indians cannot receive health services from IHS facilities. Yet over 80% of the Native American population resides in urban areas. Culturally sensitive urban Indian health programs fill the gap in the provision of health services for this needy population." The organization collects and analyzes data; analyzes and develops policy; offers program development management; provides onsite consultations and telephone technical assistance; develops technical materials; reviews and evaluates manuals, procedures, policies, and systems; and provides AIDS information and education. It also holds an annual National Conference for Urban Indian Health and regional workshops and seminars. Publications available from AIHCA are **AIDSBRIEFS** (first edition published September 1988,

free quarterly *newsletter*) includes up-to-date articles, news, and information concerning AIDS and Native Americans. Four posters (\$5 each) are also available: "**AIDS Is Not a Quick Kill**"; "**No Glove, No Love**"; "**You Can't Get AIDS By.../ You Can Get AIDS By...**"; and "**Dance to Life.**" **THE URBAN INDIAN HEALTH PROGRAM: Summary of Urban Indian Health Programs** (1985, 8 1/2x11, 111 pp. *directory*). Although written in 1985, this free directory of programs provides a useful overview of the types of health centers (2-4 pages devoted to each) that are serving urban American Indians. Includes individual program background and history; sources of funding; services offered; future organizational plans; and addresses and telephone numbers. AIHCA is also in the process of developing culturally sensitive AIDS education brochures. *Joan Myrick, AIDS Education, American Indian Health Care Association, 245 E. Sixth Street, Suite 499, St. Paul, MN 55101, 612/293-0233.*

CLOSE ENCOUNTER: Does Tony Really Care About Jackie? How Far Will Jackie Go to Impress Tony? Can Tanya Save Jackie from Getting AIDS? (December 1988, 8 3/8x10 1/2, 14 pp. *comic book*). This excellent comic book clearly presents the facts about AIDS to teenage students in a contemporary, multi-ethnic way not often seen in this type of format. Graphically eye-catching, the story and characters come across as real, with their expressions and engaging, simple, intelligent, and direct language effectively conveying important information about AIDS and HIV infection. The comic book also covers a topic not often dealt with when discussing young people and HIV/AIDS — that recreational drugs, not just IV drugs, can affect one's judgment and put one at risk for contracting AIDS, "being high or drunk makes it harder to find a reason to say 'no' to something you're not sure about." It also mentions that "Not being able to say 'no' to sex, especially with someone you don't know, means exposing yourself to lots of diseases...gonorrhea, herpes, syphilis...and AIDS, not to mention un-wanted pregnancy," talks about correctly using condoms, and clearly depicts a close encounter with someone infected with HIV. Includes the New York state hotline number. *New York State Health Department Publications, Box 2000, Albany, NY 12220, 518/474-5370. Single copy free to New York State residents; for others, reprint arrangements.*

HOW CHILDREN REACT WHEN A FAMILY MEMBER HAS AIDS (1988,

3 3/4x9 1/4, *foldover pamphlet*) has been created by the Children in AIDS Families Project (CAFP) at Beth Israel Medical Center, in operation since 1987. The project is designed to help children cope with the crises that ensue when a parent or other family member has AIDS. Often when this happens, attention in the family is centered around the person with AIDS, leaving the other children in those families lacking guidance and support at a time when it is greatly needed. CAFP takes a family-centered approach and all services are provided by mental health clinicians trained in working with children and AIDS. The pamphlet includes information on AIDS and families; how children react to AIDS; how children show their feelings; what families can do; and how their center can help. *Lock McKelvy, Project Coordinator, Children in AIDS Families Project, Beth Israel Medical Center, First Avenue at 16th Street, New York, NY 10003, 212/420-2851. Single copies free.*

ILLICIT DRUG USE AND HIV INFECTION; A Report of the Special Initiative on AIDS of the American Public Health Association (January 1989, 8 1/2x11 *report*). Third in a series of reports by panels of experts dealing with the AIDS epidemic in the United States, this report summarizes the epidemiology of HIV infection, the characteristics of illicit drug use, the scope of the HIV epidemic, and those activities that place illicit drug users at risk for HIV infection. It reviews strategies to reduce the risk of HIV infection among drug users, including education, health care, drug treatment services upon demand, and programs to reduce the risk of HIV infection via injection equipment and sexual activity. Other reports in the series are *Casual Contact and the Risk of HIV Infection*, *Contact Tracing and Partner Notification*, and *Mandatory HIV Testing* (forthcoming). *Publications Office, American Public Health Association, 1015 Fifteenth Street NW, Suite 300, Washington, DC 20005, 202/789-5667. Price for each, \$3; membership and bulk rates available.*

THE NATIONAL HEMOPHILIA FOUNDATION HIV INFECTION AND HEMOPHILIA: Your Questions Answered (January 1989, replaces the 1986 edition which should be removed from shelves, 8 1/2x11, 16-page *report*) prepared by Glenn F. Pierce, MD, PhD, chair of the National Hemophilia Foundation's (NHF) AIDS Task Force. This educational tool, in question-and-

answer format, is designed to assist people with hemophilia and their families in better understanding current medical and psychosocial aspects of living with hemophilia in an "era of HIV infection and AIDS," and to assist providers in their counseling efforts. Many of the questions and answers are those that have frequently arisen during counseling sessions. The clear, precise information presented here is useful for anyone concerned about HIV/AIDS. Broad topic areas covered are hemophilia and AIDS; clotting factor safety; HIV testing; risks to your child; safer sex; family planning; AIDS treatment; and research efforts. A Spanish translation is in preparation. *Single copies are available from the National Hemophilia Foundation, The Sobro Building, 110 Greene Street, Room 406, New York, NY 10012, 212/219-8180; multiple copies are available from the Foundation's chapters and/or Literature Distribution Center, 2026 Lee Road, Cleveland Heights, OH 44118,*

The **National Native American AIDS Prevention Center (NNAAPC)**, main office in Oakland, CA and satellite office in Minneapolis, MN, is an AIDS information and education center funded by the Centers for Disease Control to:

- Provide training to American Indian, Alaskan Native and Native Hawaiian communities, tribes, and organizations.

- Provide a national hotline where individuals can speak with specially-trained Native American volunteers (1-800/283-AIDS); and establish an online computer bulletin board ("Indian AIDS Network," available through DIALOG) for physicians and other health care providers on Native American and AIDS-related issues.

- Serve as a national clearinghouse for Native American AIDS curriculum materials and help locate specialized AIDS resources.

NNAAPC is planning to conduct workshops to assist local communities in establishing AIDS prevention programs. "At present time, there are almost no direct services to Native American PWAs within Native communities." Sharon Day, chairperson of the Minnesota American Indian AIDS Task Force, in **SEASONS** (NNAAPC's elegant, free, quarterly *newsletter*) said that the biggest difficulty encountered has been "denial in the community, and among health care providers that

Indian people are at risk for AIDS," perpetuated, according to NNAAPC, by state and federal agencies who, until recently, had no separate reporting category for American Indians and thus no separate available data. Day noted some denial among Native Americans about high risk behaviors as well. "There is a notion that we don't practice homosexuality. Therefore, AIDS is looked upon as a gay, white male disease." Prevalent also is the belief that IV drugs are not being used by Native Americans. In order to deal with such denials, accurate information is now being gathered and distributed. Available from NNAAPC also are a free, 4-page, 8 1/2 x11 handout, **AMERICAN INDIANS, ALASKA NATIVES, NATIVE HAWAIIANS AND AIDS** that discusses basic information about AIDS in Native American communities and a free, 5-page **NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTER RESOURCE LIST** that lists a variety of resource material available from NNAAPC and other agencies. *National Native American AIDS Prevention Center, 6239 College Avenue, Suite 201, Oakland, CA 94618, 415/658-2051, FAX 415/658-5613.*

Staff reports of the **Select Committee on Children, Youth and Families**, One Hundredth Session: First Session, **A GENERATION IN JEOPARDY: Children and AIDS, with Additional Views and Dissenting Minority Views** (December 1987, 181 pp.). Several hearings were conducted by the Committee from which they compiled the most up-to-date research and available information for this report. The report, which covers what has been discovered about the threat of AIDS to infants, young children, and teenagers and how its escalating toll can be prevented, includes an introduction, a summary of the findings, and discussions, in separate sections, on infants and young children, adolescents, legal and ethical considerations, federal efforts, additional views, and minority views. In addition, there are references, Centers for Disease Control guidelines, and a listing of resources. *Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, order #052-070-06406, 202/783-3238. Price: \$5.50.*

TEACHING SAFER SEX (1989, 8 1/2x11, 92 pp. *manual*) developed and written by Peggy Brick with Catherine Charlton, Hillary Kunins, and Steve Brown. This 20-lesson manual, designed to supplement existing curricula on sexuality, AIDS, and other sexually transmitted diseases, addresses specific behaviors needed to assess and reduce or eliminate the risk of disease. The curriculum has been written as a response to limitations found in education about AIDS that have focused on

epidemiology and have failed to provide the explicit sexuality education needed by people who choose to be sexually active. The manual is designed to correct that omission so that individuals may be enabled to develop the willingness and skills necessary for practicing safer sex.

Each lesson confronts one or more of the social and psychological barriers that keep young people from acting safely and responsibly and is accompanied by reproducible worksheets that actively involve students in rehearsing decision-making and communication skills. Each includes objectives, a rationale, materials needed, and a step-by-step description of the procedure for conducting the lesson. The activities, field-tested by the staff in a variety of settings, are also useful for training professionals and parents to talk with adolescents and young adults about sexual issues. Lesson topics include: Who Speaks Up for Safer Sex?, Outercourse is In: Sex is More Than Just Intercourse, You Would (Use a Condom) If You Loved Me, and Safer Sex Appeal. Special lessons are included by outside contributors: "A Continuum of Possibilities" by Deborah Roffman, which examines the wide range of sexual behaviors that exist between abstinence and intercourse; "A Workshop for High Risk Youth" by Andy Humm and the Hetrick-Martin Institute for the Protection of Gay and Lesbian Youth; "A Safety Dance" by Jay Friedman, which features A Danceable History of Rock and Roll. Other resources available from the Center are: *The New Tradition: Safer Sex Counseling in Family Planning Agencies*, a complete package for training staff in counseling about safer sex and for introducing safer sex into the regular counseling routine (\$89, plus \$3 p/h). *Condom Talk*, a 4-minute trigger video (\$29.95, plus \$3 p/h) that includes three lessons for promoting condom comfort. *Positive Images: A New Approach to Contraceptive Education* (second edition 1987, \$15, plus \$2 p/h), a 17-lesson manual that offers an up-to-date approach on teaching birth control in agencies and schools. *Swept Away Is Not OK: Teens Make Decisions About Sex and Contraception* (10-minute video, \$49.95, plus \$3 p/h), narrated by teens for teens, it warns that in a society that gives confusing and contradictory messages about sex, teens must protect themselves. *The Center for Family Life Education, Planned Parenthood of Bergen County, 575 Main Street, Hackensack, NJ 07601, 201/489-1265. Price: \$19.95, plus \$3 p/h.*

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adolescents are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed health care."

The guidelines urge physicians and nurses treating teenagers to make "every reasonable effort to encourage the adolescent to involve parents in medical decisions. . . . Parents support can, in many circumstances, increase the potential for dealing with the adolescent's problem on a continuing basis." However, the guidelines state, "health professions have an ethical obligation to provide the best possible care and counseling to their adolescent patients" and "young people will not confide in health professionals in many cases if they feel that these discussions will be reported to their parents."

Often parents and their children are patients of the same health professionals. When physicians or nurses establish "an independent relationship with adolescents, they should make the new relationship clear to both parents and teenagers."

The new relationship will mean that:

The adolescent will have an opportunity for examination and counseling that will be private and apart from the parent.

The adolescent must understand that in life-threatening emergencies the provider will abrogate this confidentiality.

Parents should work out means to facilitate communication about appointments, payment, or other matters during the transition period when the adolescent is moving toward responsibility toward his or her health.

The five organizations supporting these new guidelines are: the American Academy of Family Physicians; the American Academy of Pediatrics; The American College of Obstetricians and Gynecologists; NAACOG: the Organizations for Obstetric, Gynecologic, and Neonatal Nurses; and the National Medical Association.

Names Project's Final Showing of Complete Quilt

The last showing of the Names Project: A National AIDS Memorial will take place the weekend of October 6-8, 1989 in Washington, DC. The quilt,

a patchwork of panels made by individuals to commemorate those who have died of AIDS, has grown too large to travel as a whole for viewing. It now covers fourteen acres and will nearly fill the entire Ellipse, the field in front of the Washington Monument where the viewing is scheduled to be held. Though this will be the final showing of the quilt in its entirety, Names Project chapters and various AIDS organizations will continue to bring parts of the quilt to all regions of the country. After Washington, the next large showing is scheduled for October 1990 in Buffalo, New York. For more information on the October showing in Washington, DC, or on how to bring a section of the Project to your area, call The Names Project Display Coordinator in San Francisco at 415-863-1966.

The Children's Quilt Project

"Every stitch put into a quilt made for an AIDS child is an affirmation of love and of faith that the child who sleeps beneath the quilt will be healed." The Children's Quilt Project (CQP) was formed to serve a three-fold purpose. The first is to provide AIDS children with the comfort of a quilt. The second is to serve as a bridge between AIDS children and the community by providing outreach for their special needs. The third is to facilitate means by which volunteers can cope with their own concerns about the AIDS epidemic through direct and constructive involvement. Nancy Katz, The Names Project's outreach coordinator said of CQP, "Like The Names Project, the Children's Quilt Project provides creative outreach and support for children directly affected by HIV infection. We enthusiastically support their efforts."

The multi-ethnic women of CAP who come together to make quilts for AIDS children come from all walks of life and selflessly give the little free time they have not just to acknowledge the existence of America's AIDS children but to love them. In many cases, they say, affected youngsters remain in hospitals because they have been orphaned or because there is no one to care for them at home. The families that do exist experience extreme isolation. Quilts are given individually to children and through HIV programs in hospitals. The identities of the children remain confidential; only the child's age and gender are needed for the purpose of designing the quilt.

The group is working on exhibition quilts for outreach and fundraising activities. Their quilt mural, "A Quilt Can Be a Friend," will be joining the Names Project on its national tour to Washington, DC this October. "Someday, it is our dream

to see this friendship mural displayed in the United Nations on behalf of all AIDS children." Children who wish to participate in this project are invited to send in 10"x10" white, cotton blocks (preshrink fabric before beginning and allow for a quarter-inch margin, which can be easily made using quarter-inch masking tape). The pictures should display themes of friendship and be painted with fabric paint or (permanent only) markers. The artist's name and age may be written on the block. Twenty-four blocks will be assembled into a panel that will be shown individually or collectively.

Others can join in this project and/or display the quilts at exhibitions, festivals, or receptions. The group offers quilting guidelines, will distribute quilts made by others, and will help individuals in setting up their own CQP project. They also would gratefully accept cotton fabric in bright colors, needles, thread, batting, hoops (large), lamps, sewing machines, office equipment and supplies, a computer, work space, and technical advisers (MBA, CPA, and LLD). Contact the Children's Quilt Project, BOX 186, 1478 University Avenue, Berkeley, CA 94702, 415/548-3843, for further information.

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