

HETEROSEXUAL TRANSMISSION OF HIV INFECTION

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As the epidemic of acquired immunodeficiency syndrome (AIDS) in the United States enters its second decade, it is marked by a widening geographic focus, changing demographics, and shifts in the relative importance of different modes of transmission of the human immunodeficiency virus (HIV). As part of this evolving picture, concern about the extent and impact of the heterosexual transmission of HIV continues to evoke considerable interest and debate.

Although most cases of AIDS in the United States still occur in homosexual or bisexual men and intravenous (IV) drug users, the number of cases of heterosexually-transmitted AIDS has been increasing steadily and more rapidly than cases in any of the other transmission categories. Since currently reported cases of AIDS are the result of infections with HIV that took place an average of 10 years ago, these observed trends reflect past changes in HIV transmission patterns.

Evidence that HIV can be transmitted via heterosexual contact was provided early in the epidemic, with reports of male-to-female transmission of HIV infection in sexual partners of IV drug users and in spouses of hemophiliacs with AIDS.¹⁻⁴ In 1983, the Centers for Disease Control (CDC) published reports of heterosexual transmission of AIDS from men to women,⁵ and in 1984, the CDC began tracking cases attributed to heterosexual contact with persons with or at risk for AIDS as a separate exposure category.⁶ Within the next few years, epidemiologic reports of patients with AIDS in Africa suggested that, worldwide, HIV is probably more commonly transmitted via heterosexual rather than homosexual contact.⁷⁻⁹

Since then, the question of the extent to which the HIV/AIDS epidemic will spread throughout the heterosexual population in the United States has remained controversial. Epidemiologic data suggest that the risk of acquiring HIV infection through heterosexual contact varies widely by geographic region, race or ethnicity, gender, and age.¹⁰ Although heterosexual men and

women who use IV drugs remain the primary source for heterosexual transmission in the United States, important questions remain about the efficiency of heterosexual HIV transmission in this country and its reach beyond the immediate sexual partners of IV drug users and other persons at high risk.

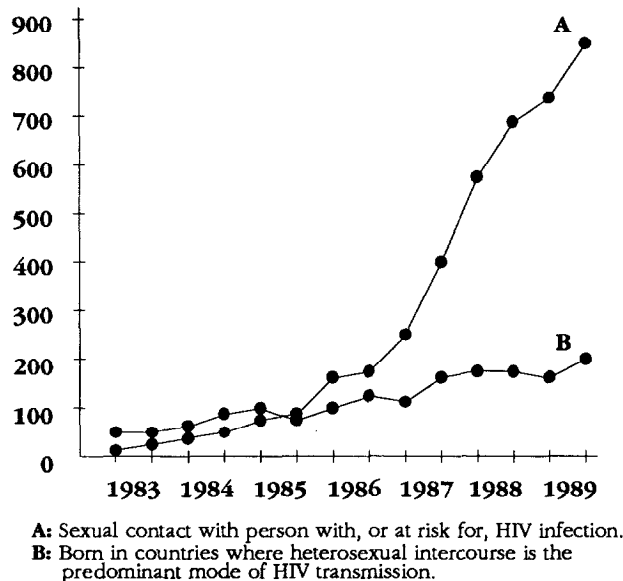
Heterosexually-Acquired AIDS Cases

U.S. AIDS cases, which have been reported from all 50 states, the District of Columbia, and four U.S. territories, exceeded 100,000 during the summer of 1989 and continue to increase. While the responsibility for AIDS case surveillance rests with individual city, state, and territorial health departments, which determine their own disease reporting requirements, the CDC supports voluntary AIDS surveillance and compiles national AIDS case statistics.

The proportion of all cases that are attributed to heterosexual contact remains small (see Table 1 on page 3). Overall, a cumulative total of 140,822 cases of AIDS in adults and adolescents were reported to the CDC from 1981 through July 1990; 5% of these cases were attributed to heterosexual contact. While the number of heterosexually-acquired AIDS cases reported each year has increased — from 120 reported in 1985 to 1,954 reported in 1989 — the overall proportion has remained relatively stable at about 4% to 5% since the mid-1980s.

"Heterosexual contact" cases are divided into two groups: those who are classified in this category because they were born in countries in Africa or the Caribbean where HIV is spread mainly through heterosexual intercourse (designated Pattern II countries by the World Health Organization); and those who reported heterosexual contact with a partner with, or at increased risk for, HIV infection. In the United States, the earliest heterosexually-acquired AIDS cases were reported among persons born in Pattern II countries. Since 1986, however, persons reporting sexual contact with a heterosexual partner at risk have outnumbered AIDS cases from

Figure 1
Heterosexually-Acquired AIDS Cases
 By Half-Year of Report, United States, 1983-1989



Source: CDC. *HIV/AIDS Surveillance*, January 1990.

Pattern II countries (see Figure 1 above). By the end of July 1990, nearly three-fourths (74%) of all heterosexually-acquired AIDS cases were in persons with a partner at risk for HIV infection.

Nationwide, the heterosexual AIDS epidemic is strongly linked to IV drug use. Of the 5,289 AIDS cases reporting heterosexual contact with a sexual partner at risk for HIV infection through July 1990, 71% (3,759) had heterosexual contact with IV drug users (see Table 2 on page 3). Another 8% (430) were women reporting heterosexual contact with bisexual men. The remaining heterosexual contacts were with persons with hemophilia (1%), transfusion recipients (2%), persons born in a Pattern II country (2%), and persons with an unspecified risk for HIV infection (15%).

Because of the hierarchical classification system used by the CDC for AIDS surveillance, the number of cases attributed to heterosexual transmission is probably underestimated.¹⁰ According to information from mid-1989, nearly 3,000 persons with AIDS, who were classified by risk category as bisexual men, IV drug users, and persons with hemophilia, also reported heterosexual contact with a person at risk and may have acquired HIV infection via that route. In addition, some persons with an undetermined risk may have become infected through heterosexual contact. Persons with an undetermined risk have been found to be demographically similar to AIDS patients who report IV drug use or sexual contact with a partner at risk. In an analysis of AIDS case data through September 1987, nearly 40% of persons with an undetermined risk had self-reported histories of a sexually transmitted disease (STD), and one-third of men with an undetermined risk reported sexual contact with a female prostitute.¹¹

Reported cases attributed to heterosexual contact with a partner at risk for HIV infection are increasing faster than any other category of AIDS cases — up 27% between 1988 and 1989 (see Table 3 on page 4). The proportional increase in this group of heterosexually-acquired cases has been most pronounced for women: the proportion of women with AIDS resulting from heterosexual contact increased from 15%, reported in 1983, to 29%, reported in 1989. The proportion of men in this same category increased during the same period from 0.1% to 1.7%.

Projections

Projections of HIV incidence and AIDS cases were estimated recently by a panel of statisticians and epidemiologists at a workshop convened by the CDC.¹² Participants concluded that AIDS cases in the United States will continue to increase through 1993 in each of the principal transmission categories. It is now estimated that 3,700-4,000 AIDS cases resulting from heterosexual transmission will be reported in 1990, increasing to a cumulative total of 29,000-38,000 heterosexually-acquired AIDS cases reported through 1993.¹³

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Table 1

U.S. Adult and Adolescent AIDS Cases by HIV Exposure Category

Reported 1981 Through July 1990

<i>Exposure Category</i>	<i>Males</i>		<i>Females</i>		<i>Total</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
Male homosexual/ bisexual contact	84,241	66%	—	—	84,241	60%
IV drug use (female & heterosexual male)	23,379	18%	6,877	51%	30,256	21%
Male homosexual/bisexual contact & IV drug use	9,609	8%	—	—	9,609	7%
Hemophilia/coagulation disorder	1,227	1%	31	<1%	1,258	1%
Heterosexual contact	2,904	2%	4,271	32%	7,175	5%
Contact w/ person at risk for HIV infection	1,527	—	3,762	—	5,289	—
Born in Pattern-II country	1,377	—	509	—	1,886	—
Receipt of blood transfusion, blood components, or tissue	2,055	2%	1,296	10%	3,351	2%
Other/undetermined	4,012	3%	920	7%	4,932	4%
<i>Total Adult/Adolescent</i>	127,427	100%	13,395	100%	140,822	100%

Source: CDC. HIV/AIDS Surveillance, August 1990.

Table 2

**U.S. Adult and Adolescent AIDS Cases Resulting from Heterosexual Contact
With a Person at Risk for HIV Infection**

Reported 1981 Through July 1990

<i>Heterosexual Contact Category</i>	<i>Males</i>		<i>Females</i>		<i>Total</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
Sexual contact with:						
IV drug user	1,077	71%	2,682	71%	3,759	71%
Bisexual male	—	—	430	11%	430	8%
Person with hemophilia	4	<1%	60	2%	64	1%
Transfusion recipient with HIV infection	36	2%	80	2%	116	2%
Person born in Pattern-II country	60	4%	46	1%	106	2%
HIV-infected person, risk not specified	350	23%	464	12%	814	15%
Total	1,527	100%	3,762	100%	5,289	100%

Source: CDC. HIV/AIDS Surveillance, August 1990.

Table 3

**Percent Change in Reported U.S. AIDS Cases by HIV Exposure Category
1988 to 1989**

Exposure Category	Reported Cases			
	1988	1989	%	% Change
Homosexual/bisexual men	18,130	19,652	55.8%	8%
IV drug users				
Women & heterosexual men	7,580	7,970	22.6%	5%
Homosexual/bisexual men	2,129	2,138	6.1%	0%
Persons w/hemophilia				
Adult/adolescent	300	295	0.8%	-2%
Child	39	26	0.1%	-33%
Transfusion recipients				
Adult/adolescent	869	768	2.2%	-12%
Child	66	40	0.1%	-39%
Heterosexual contacts	1,229	1,562	4.4%	27%
Persons born in Pattern-II countries	374	392	1.1%	5%
Perinatal	468	547	1.6%	17%
No identified risk	1,012	1,848	5.2%	-
<i>Total</i>	32,196	35,238	100.0%	9%

Source: Centers for Disease Control. *MMWR*, 1990, 39, 81-6.

Demographic Characteristics of Reported AIDS Cases

The distribution of AIDS cases varies greatly among geographic areas, racial and ethnic groups, and other subpopulations. Men make up 90% of all AIDS cases, a reflection of the large number of cases in homosexual and bisexual men and male IV drug users. However, the proportion of cases in adult and adolescent women has been steadily increasing — from 7% in 1982 to 11% in 1989 — most markedly in cases attributed to heterosexual contact.¹³ Heterosexual contact cases (excluding persons born in Pattern II countries) are the only transmission group made up mostly of women (71%); the proportion of women with AIDS in this category has increased annually since the early years of the epidemic. Since most women with AIDS are of childbearing age, their children are at risk of perinatal infection: nearly 30% of children with AIDS were born to women who acquired HIV through heterosexual contact.¹³

Heterosexually-acquired AIDS cases are not uniformly distributed in the United States. Most cases have been reported from only four states: New York, Florida, New Jersey, and California. There is also a striking disparity in the AIDS burden among blacks and Hispanics as compared with whites — especially in women, children, and heterosexual men. Of the 143,286 AIDS cases reported through July 1990, blacks and Hispanics

accounted for 72% of the adult and adolescent women, 77% of the children, and 83% of the heterosexual men.¹³ The cumulative incidence of cases of AIDS attributed to reported heterosexual contact per million adults in 1983-1988 was more than 10 times higher for black men and four times higher for Hispanic men than for white men. Among women, the incidence was more than 11 times higher for blacks and Hispanics than for whites.¹⁴

These variations in rates by geographic area and race/ethnicity are related directly or indirectly to comparatively high rates of HIV infection in black and Hispanic IV drug-using men and women, and the subsequent transmission of HIV to their sexual partners. In an analysis of AIDS case reports through 1988, IV drug users made up a substantially lower percentage of the male sexual partners for white than for black or Hispanic women, and bisexual men comprised a much larger percentage of the male sexual partners for white women with AIDS than for black or Hispanic women with AIDS.¹⁴

Reported rates of AIDS are slightly lower in Asians, American Indians, and Alaskan Natives than in white Americans. However, between 1988 and 1989, cases reported in American Indians and Alaskan Natives showed the most rapid increase, suggesting that HIV infection may have been more recently introduced into these populations.

Prevalence of HIV Infection

Because of the long and variable incubation period between infection with HIV and diagnosis of AIDS, cases currently reported reflect HIV transmission that occurred several years ago. However, HIV-seroprevalence surveys and studies do provide information on more recent patterns of HIV infection. To learn more about the prevalence and incidence of HIV infection in the United States, the CDC implemented a national HIV surveillance system in more than 30 U.S. metropolitan areas in 1988. The national HIV surveys have four components:

- The monitoring of HIV infection in patients in STD clinics, women's health clinics, tuberculosis clinics, and drug treatment centers.
- Screening in sentinel hospitals, clinical practice networks, and laboratories.
- Testing of newborn blood samples to ascertain infection rates in childbearing women.
- Systematic collection of information from routine HIV-screening programs in large population groups, such as blood donors and civilian applicants to the military.¹⁵

Relatively few HIV-seroprevalence surveys collect information on risk factors. Therefore, only limited information regarding the spread of heterosexually-acquired HIV infection is available. In 26 studies of HIV transmission from infected persons to their steady heterosexual partners without other risk factors, conducted through 1988, the risk ranged from 0% to 58%, with a median of 24%.^{16,17} Data are more limited for heterosexual men and women who are not sexual partners of persons known to be infected with HIV or at increased risk for HIV infection. Studies of heterosexual men and women attending STD clinics show the highest HIV-seroprevalence rates in IV drug users, their sexual partners, and others from communities where HIV infection is common in IV-drug-using populations. In an ongoing study begun in New York City in January 1988, 47% of heterosexual STD clinic clients with a history of IV drug use, and 13% of clients with a sexual partner who used IV drugs, were HIV seropositive.¹⁸ A 1987 STD clinic survey in Baltimore showed seroprevalence rates of 15% in men and 22% in women with a history of IV drug use, and 11% in women who reported sexual contact with men who used IV drugs or were bisexual.¹⁹ In contrast, for those who did not report specific risks for HIV infection, seroprevalence was 4% in men and 5% in women in New York City, and 3% in men and 2% in women in Baltimore.

The level of HIV infection in larger populations is measured through ongoing HIV-antibody testing of blood donors and civilian applicants for military service, two groups prescreened to exclude persons at risk for HIV infection. Of 1.3 million male and 1.2 million female first-time blood donors tested between April 1985 and September 1988, 0.067% and 0.014%, respectively, were HIV-seropositive.¹⁰ In an ongoing follow-up study of seropositive blood donors at 20 sites in 16 cities, 249 (47%) of 512 interviewed donors reported male homosexual contact or IV drug use; 36 (9%) of 388 interviewed seropositive males and 66 (53%) of 124

interviewed seropositive women reported heterosexual contact with a partner at risk for HIV infection; women were more likely than men (41% and 27% respectively) to have no risk identified.²⁰ Of approximately 1.5 million male and 253,547 female civilian applicants for military service screened between October 1985 and September 1988, 0.15% and 0.07% respectively, were HIV seropositive.¹⁰ In limited follow-up studies of seropositive male applicants, most had risk factors for HIV infection other than heterosexual contact.^{21,22} Too few seropositive women were available for meaningful analysis.

Findings, from seroprevalence studies conducted in 26 large sentinel hospitals in urban U.S. communities, show great variation (more than 70-fold) in HIV infection rates, with very high rates in the few urban areas known to have very high AIDS incidence rates.²³ Although males ages 25-44 years showed the highest seroprevalence of any group, the male-to-female seroprevalence ratio decreased as the overall HIV seroprevalence increased, suggesting that even more AIDS cases in women will likely occur in the same geographic areas where they are now being diagnosed. The results of these surveys also suggest a disproportionately greater role for heterosexual transmission and for the IV-drug-use-associated transmission of HIV in the main geographic centers of the epidemic.

Results, from the HIV screening of blood collected from newborns for routine metabolic screening, indicate that substantial numbers of childbearing women are already infected with HIV. The most recent national estimate of the prevalence of HIV infection in childbearing women is approximately 0.14%, or 1.5 per 1,000 childbearing women, with wide variation by geographic area.²⁴ Epidemiologic evidence shows that approximately 30% of infants born to infected women will themselves be infected.

Adolescents are another emerging group in the epidemiology of HIV infection, and are an important indicator of the epidemic's future. Data from surveys of college students, Job Corps applicants, and applicants for military service show that HIV seroprevalence may rapidly increase during adolescence, with the prevalence of infection rising progressively from the 17 to 19-year-old age group through the late twenties. Most persons diagnosed with AIDS in their early twenties were probably infected during adolescence through sexual contact or IV drug use.

Efficiency of Heterosexual HIV Transmission

Among couples with exclusively monogamous sexual relations, when neither partner is infected with HIV, there is no risk of HIV infection regardless of sexual practice or sexual orientation. For all others, the precise risk of HIV transmission through heterosexual intercourse is difficult to estimate. Transmission of HIV has been reported after only one sexual contact with an infected partner; conversely, some persons remain uninfected despite hundreds of sexual contacts with an infected partner.^{25,26} The wide variation in infection rates reported among heterosexual partners of persons with HIV infection — coupled with the apparent lack of a relationship between the risk of infection and the number of exposures through sexual intercourse — suggest that there is

NOTE FROM THE EXECUTIVE DIRECTOR:

I am dismayed every time I hear of another book, article, or radio show on the "myth of heterosexual transmission." Although HIV disease has not spread as rapidly through the heterosexual population as once feared, heterosexual transmission is no myth. In fact, there are more cases of AIDS spread by heterosexual transmission in the United States than most countries' total number of AIDS cases; in many parts of the world, heterosexual transmission is the major mode of transmission. Heterosexual transmission is no myth to the partners of IV drug users, bisexual men, transfusion recipients, adolescents in the epicenters, and increasingly men and women who do not know the sexual and drug histories of their partners.

Therefore, we decided to go to "the source" for the most up-to-date statistical information about heterosexual transmission. SIECUS is a partner with the Centers for Disease Control, through a Cooperative Agreement, on a number of projects. We are pleased that the CDC staff agreed to prepare this material for our readers. We hope it will be helpful in counseling and educating your students, clients, friends, and families about the very real risk of HIV disease.

significant heterogeneity in infectivity and/or susceptibility within the population.²⁷

Heterosexual transmission of HIV has been documented both from men to women and from women to men. Heterosexual transmission occurs mainly through vaginal intercourse. Some studies have suggested that anal intercourse has a higher risk of transmission, but others have found no difference in risk.²⁸⁻³¹ There is also a theoretical risk associated with oral intercourse, but the magnitude of the risk cannot be quantified with current data.

The relative efficiency of heterosexual transmission in either direction also has not been accurately determined, although there is some evidence that HIV is more easily transmitted from men to women than from women to men. A recent study of 325 California couples with one HIV-infected partner found less than 2% of 58

males (one man) became infected over a five-year period, while about 20% of 269 women became infected.³² The couples averaged 300-400 sexual contacts over five years.

Factors That May Influence HIV Transmission

Several factors may determine whether a single episode of heterosexual intercourse with an HIV-infected person will result in transmission of HIV. Since many different strains of HIV exist, it is possible that variation in strains could influence the transmissibility of the virus, but no current evidence supports this theory. Some persons may also be more efficient transmitters than others, as is the case with carriers of hepatitis B. This possibility was demonstrated in a report of 19 women without apparent risk factors who had sexual contact with the same HIV-infected heterosexual man; of the 18 women tested for HIV antibodies, 11 were found to be seropositive.³³

There is also evidence that infectiousness varies over the course of HIV infection. Some studies have found an association between the advanced clinical stage and the low CD4 lymphocyte count in the infectious partner, and the increased risk of HIV infection in the susceptible partner.^{34,35} The possibility that infectiousness increases as the immune system becomes more compromised is corroborated by studies showing that pregnant women in the later stages of disease are more likely to transmit HIV infection to their babies.^{36,37}

An association between HIV infection and the presence in the susceptible partner of genital ulcerative disease has been documented in reports from Africa and the United States.^{30,38-40} Breaks in the genital mucosa caused by genital ulcerative diseases such as chancroid, primary syphilis, and genital herpes may increase the infectivity of the infected person or the susceptibility of the noninfected person. In addition, the increased numbers of lymphocytes and macrophages associated with inflammation may increase the pool of HIV-infected cells in the seropositive partner and target cells in the seronegative partner.⁴¹ However, at least one study in the United States failed to show a significant association between genital ulcerative disease and HIV infection among persons attending an STD clinic.⁴²

Nonulcerating STDs have also been implicated in HIV transmission, although their role is not clear-cut. In general, genital infections that cause an inflammatory response or erosions may increase the possibility of HIV transmission. In a study of prostitutes in Zaire, seroconversion was associated with a higher incidence of gonorrhea, chlamydial infection, and trichomoniasis.⁴³ These and other recent findings regarding the relationship between nonulcerating STDs and HIV transmission are especially troubling, because these diseases are so much more prevalent than genital ulcerative diseases and may therefore represent a much more significant source of risk in the population.

Results from studies in Kenya show an increased risk of HIV infection in uncircumcised men, independent of a history of genital ulcer disease.^{30,44} Studies in the United States have not, however, confirmed these findings. Trauma and/or exposure to blood during sexual activity have been shown to be risk factors for heterosexually-

transmitted HIV infection in both high-risk STD clinic patients in Africa and in sexual partners of men infected through transfusions.^{26,45} In older women, atrophic vaginitis and resultant bleeding abrasions during intercourse may facilitate HIV transmission.²⁷ Whether menstrual blood affects the likelihood of sexual HIV transmission in either direction has not been clearly established. Theoretically, increased exposure to HIV-infected blood could increase the HIV risk. A multicenter study in Europe that pooled data from 65 HIV-infected women and their male partners did find that men were significantly more likely to become infected with HIV if they had sexual intercourse at least once with an infected woman during menses than if they always abstained from vaginal intercourse during menses.⁴⁶ However, vaginal secretions harbor the virus regardless of the presence of menstrual blood. For purposes of giving advice regarding HIV prevention, it is important to communicate that women with HIV infection can transmit the virus whether they are menstruating or not.

The Role of Smokable "Crack" Cocaine and Other Sexually Transmitted Diseases

The relationship between the use of the smokable, cocaine-derivative "crack" and the transmission of HIV infection is also of considerable concern. Many of those dependent on this highly addictive drug — the majority of whom are young persons from minority populations — frequently exchange sexual services for drugs or money to buy drugs. In areas where HIV infection and crack use are common, increased sexual activity among young, mostly minority, women has been shown to enhance heterosexual transmission of HIV — a development that has grave implications for these women and their children and families.⁴⁷

Related to this are the skyrocketing trends in rates of STDs in some parts of the country, particularly among men and women of color. For example, between 1981 and 1989, the incidence of primary and secondary syphilis in the United States increased 34%, reaching a rate in 1989 (18.4 cases per 100,000 persons) that was higher than at any time since 1949.⁴⁸ Between 1985 and 1989, incidence among blacks more than doubled, from 52.5 to 121.8 cases per 100,000; the increase was greater for black women than for black men (176% versus 106%). These trends are markers for the same high-risk sexual practices that promote transmission of HIV. High rates of STDs, especially those that cause genital ulcerative disease, in urban populations in sub-Saharan Africa have been postulated as one reason for the fast spread of HIV infection in this part of the world.⁴⁹ A similar scenario can be envisioned in U.S. populations that are affected by widespread STDs, patterns of sexual behavior characterized by early onset of sexual intercourse and prostitution, and increasing use of drugs such as crack cocaine that promote high-risk heterosexual behaviors.¹⁰

Conclusion

Although heterosexual intercourse is the predominant mechanism of HIV transmission in many parts of the world, heterosexually-acquired AIDS cases currently

constitute only a small part of the AIDS case burden in the United States. The geographic variability in the epidemiology of heterosexually-acquired HIV infection is most likely the result of differences in behavioral and biologic factors among populations and of different times of introduction of the virus.⁴¹

AIDS has been diagnosed in no more than about 10% of the approximately one million persons currently infected with HIV in the United States. A minimum of 40,000 new infections are estimated to be occurring yearly in adults and adolescents.¹² Once infected, these persons remain infected — and infectious — presumably for life. The risk of acquiring HIV infection during heterosexual contact depends in general on the likelihood of contact with an infected partner and the likelihood of transmission if the partner is infected. Because of the larger number of men with HIV infection and AIDS currently in the United States, women are more likely than men to have an infected heterosexual partner; infected male partners are most likely to be bisexual men or IV drug users. Given that women are the main source of infection in children, as the number of HIV-infected women of reproductive age continues to increase, so will the number of perinatally infected children.

For most heterosexual women and men in the United States, the risk of HIV infection remains low and probably will remain low in the near future. However, among populations in the United States with high rates of drug use and STDs, heterosexual transmission of HIV is already a significant problem. The increasing problem in adolescents and young adults warrants widespread education about the risks of HIV infection and other STDs, along with increased efforts to understand behaviors associated with the heterosexual transmission of HIV. This understanding is essential for effective intervention efforts to curb the spread of HIV infection in this country and around the world.

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GIVING AIDS A HUMAN FACE

Why People with AIDS Are Effective in Providing AIDS Education to Adolescents

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When a San Francisco high school teacher announced that two people with AIDS (PWAs*) were coming to talk about AIDS prevention, the captain of the football team announced the team's intention to bash any gay people who dared to come through the front door of the school. After much reflection, the school staff decided that they should go ahead with the assembly in spite of the threat. As the program opened, an electric current ran through the auditorium; the usually rowdy crowd was quiet, attentive, and slightly on edge.

The first guest speaker was Edgardo Rodriguez, a Puerto Rican who spoke to the audience in both English and Spanish. "I never thought I could get AIDS," he said, "all I saw in the newspaper was that gay white males had it."¹ He went on to describe the disproportionately large numbers of AIDS cases found in black and Puerto Rican communities because of IV drug use and the perinatal transmission of HIV. Rodriguez, a former teacher from the middle school that some of the students had attended, used his own family experience as a chilling object lesson: his brother, an intravenous drug user, died from AIDS; his brother had infected his wife; and their child had not yet been tested for the antibodies that show exposure to the virus because, he said, the family could not face the possibility of another AIDS casualty.

The second speaker, Christian Haren, a former Hollywood model who appeared on billboards throughout the country as one of the rugged Marlboro men, explained: "Today, now that we understand how HIV is transmitted, you make decisions that mean you get it or you don't. You probably wonder how I got infected. I

was brought up to be a hard-drinking, hard-playing, womanizing man. I joined the Marine Corps, then later went to Hollywood and realized I was gay. It is not easy to be gay in this society. I had fears and insecurities, and all of this led me not to take care of myself. When I was loaded on cocaine I didn't care about anything, and I put myself at risk of this disease." He challenged the students: "Yes, the disease is caused by a microorganism, but the virus can only get into your body through something you decide to do, based on how you feel about yourself and how you do, or do not, take care of yourself. It is not who you are, it is what you do. Let's figure out how you can get the survival skills and the life skills you need to protect yourself."²

Haren also described his confrontation with death. Two years earlier, he was diagnosed with toxoplasmosis, a condition often rapidly fatal; he went blind, slipped into a coma, and became paralyzed from the waist down. The doctors, discussing his case in the hospital room where he lay semiconscious, predicted that he would be dead within a few days. Feeling sorry for this blind man who was dying, Haren suddenly realized with a shock that the doctors were talking about him. He eventually recovered, gradually taught himself to walk again, and decided that he would devote his life to helping young people avoid HIV/AIDS.

After hearing these presentations, the students peppered Rodriguez and Haren with questions: "Are you afraid of dying? Is your family sticking with you? Have you ever thought of suicide?" You could hear a pin drop in the auditorium. As the talk drew to a close, there were many wet eyes in the crowd. Tough kids, who had entered the room making homophobic jokes, lined up to shake the speaker's hands and give them hugs of encouragement. The captain of the football team came up, introduced himself, and apologized for his previous behavior. One student, describing her reaction to hearing the PWAs speak, said: "At first, one could feel the tension about having gay men come and tell us about a gay

* The movement of people with AIDS has insisted on the use of the term "PWAs," rather than the terms, "AIDS patients" or "victims," which imply that people are overwhelmed and unable to deal with their situation. As this article attests, PWAs are quite active and make important contributions. It should also be noted that for convenience the term PWA is used in this article to cover both people with AIDS and those who are infected with HIV.

disease. We were all a bit uncomfortable and wary...but as they began to speak, they drew from us much love and respect... We had a need to tell them everything would be all right. We learned that AIDS was not a gay disease, but a deadly disease that affects all people. We also learned that there is no longer room for prejudice in this world. And most importantly, we were introduced to people with a tremendous gift to share."³

The other day some PWAs went into a really tough school to do an AIDS presentation — as we were coming up the steps they were already making [homophobic] jokes. The first 15 rows in the auditorium was solid gang members, all leather jackets, with security guards all around. At first the kids wouldn't let us talk, it was just one [homophobic] joke after another. We [the visitors] talked to each other. Then we sent the security guards out of the auditorium and said to the students, 'Fine, if you have something more important to say, why don't you take the mike.' They shut up and we talked. And at the end, those 15 rows were the first to stand up and give us a standing ovation. Because they realized that their story was the same as ours, except some of us sleep with men. It breaks down the idea of 'them against us' when they realize it could easily be them who has AIDS." — Paul Maingot, Program Outreach Coordinator, Toronto PWA Foundation.⁴

Participation in AIDS education is meaningful not just for the teens, but also for the PWAs involved. As Paul Maingot, program outreach coordinator of the Toronto PWA Foundation, eloquently said, "When you have AIDS, so much is taken from you. But speaking to young people gives me back something. I'm not just a person with AIDS sitting back waiting to die, I'm a person who's been very involved with fighting for my life, fighting for understanding, and fighting to educate other people that *yes*, this *could* happen to them."⁵

Another PWA educator emphasized, "Participating in the program is an overpowering experience, because younger people do not have their minds closed already. Young people listen, and the feedback you get back is very raw, very truthful. This strengthens me when I come out as having AIDS. Because we are reaching people, we are saving people."⁶

Participation in AIDS education is also beneficial for the families of PWAs. They can channel their grief by helping to educate and protect other people's children (see Mildred Pearson's comment, mother of a PWA, on page 13).⁷

The Social and Political Context of the Epidemic

The subject of AIDS has plunged the American public into a cauldron of issues, many of which are surrounded by the silence, guilt, and taboos often associated with sexuality, homosexuality, the fear of death, and IV drug use. Also, unfortunately, the epidemic in the United States initially struck hardest two already heavily stigmatized groups: gay men and IV drug users. By the end of 1988 — partly due to the prevalence of

One of the Wedge Project volunteers, a young PWA named Steven said that before he died he would like to make a movie to educate other young people about the very real dangers of AIDS. Steven got his wish and was able to share his story in the video described below. In May 1990, at age 19, after spending the last year of his life offering an AIDS prevention message to thousands of young people, Steven died in San Francisco.

Teen AIDS in Focus

An Audiovisual Review by Vicki Legion

Teen AIDS in Focus should come with a warning label:

Administrators and educators:

Do not be tempted to use this video as a substitute for bringing PWAs into schools. Use the video, instead, to convince your school boards that PWAs can make excellent AIDS educators.¹

I have watched *Teens AIDS in Focus* five times, and each time it has left me crying. The video, which has a multicultural cast and is targeted to youth ages 13 to 21, tells the stories of three real San Francisco teenagers who are living with AIDS: Steven, Vickie, and Chris. The three tell their stories with an honesty and vulnerability that makes one feel that one is talking with old friends.

We learn that HIV/AIDS can mean dreams deferred, and a daily grind of sickness laced with fear. We hear about a friend who never came around after hearing the diagnosis of HIV/AIDS, and about another who came through. Most of all, we learn about the courage and dignity of young people who are willing to share their confrontation with illness and death in order to motivate other young people to live and love safely.

This 16-minute color video has a forceful message. In Steven's words: "It isn't cool to have unsafe sex — what do you want to do, kill your friends? I don't want to kill mine."

Each of the teenagers explodes the all-too-prevalent myth that "it can't happen to me." Chris warns, "Don't think that just because you're young, you can't get AIDS." Vickie echoes him: "I thought you had to be gay or be a needle user. I was wrong."

IV drug use in poor black and Latino communities — 42% of all AIDS cases were found among this 20% of the U.S. population. Also, statistics indicate that the young blacks and Latinos, who are volunteering for the United States army today, are 3 to 10 times more likely to be infected with HIV than are white volunteers. In addition, black women are 12 times, and Latinas nine times, more likely to become infected with the virus than are white women.⁸ An epidemic with these dimensions inevitably becomes charged with some of the toughest issues in our society: homophobia, racism, and sexism.

Teenagers are now extremely vulnerable. Although the Center for Population Options estimates that as many as one-fifth of the current AIDS cases may have become infected with HIV as teens, the fact that the virus can be latent for as many as 11 years also means that the deadly consequences of infection may be invisible to one's teen peer group.⁹ Moreover, although the seroconversion rate

One of the most moving scenes is of Vickie and a friend playing with Vickie's two young children, one of whom is a baby boy born infected with HIV. She says, "I wanted Augustin to grow up and get married, but realistically, I don't think it will happen that way. I just want him to get all the love he can while he's alive."

Teen AIDS in Focus is an excellent motivational tool, but it cannot stand alone. It does not offer guidelines for safer sex, for instance; it does not touch on transmission by IV drug use; nor does it give any indication of the social context and the power dynamics that influence individual behaviors. At one point, Vickie berates herself with: "I was doing unsafe sex, I wouldn't listen, so I really have no one to blame but myself." In the film itself, however, this all-too-common blame-the-victim type of thinking is never challenged.

The video takes viewers also into a high school classroom where PWAs Edgardo Rodriguez and Christian Haren are speaking with students — the talk is gritty, real down to earth. The film comes to an end with several students hugging Rodriguez and Haren.

Teen AIDS in Focus, accompanied by a 22-page discussion guide that suggests classroom activities and discussion questions, is extremely effective as the focal point for a warm-up session before a PWA visit to a classroom or a community group. In addition, it is suitable for use in urban schools and community groups and can be used effectively with parent groups.

1. Cranston, E & Yates, RB. Survey of knowledge and attitude changes among high school age adolescents following an educational intervention that utilizes persons with AIDS. Presentation at the Sixth International Conference on AIDS, San Francisco, June 1990. In measuring changes in knowledge, attitudes, and behavior among 400 Massachusetts high school students, the researchers found that the scores of the group which met with a person with AIDS were significantly greater than the scores of the group that viewed and discussed a video.

Produced by the San Francisco Department of Public Health, this 16-minute color video, in 1/2" VHS format, is closed captioned for the hearing impaired. There is a preview policy; 1-2 copies are \$89 each; and bulk rate discounts are available. Distributed by the San Francisco Study Center, PO Box 5646, San Francisco, CA 94101; 415/626-1650.

among youth still appears to be low, it is doubling every year. This may be due to the fact that many sexually-active youth are engaging in the unsafe behaviors which have enabled HIV to spread widely in the adult gay male population — unprotected sexual intercourse, often with frequently changing partners.¹⁰ Sexuality educator Peggy Brick, commenting on some of the social forces that affect adolescents and make them vulnerable, said:

Messages about sex are conflicting and confusing. Media messages are overwhelmingly exploitative, provocative, permissive and unsafe. Other messages that emphasize only the dangers and evil of sex result in many young people, especially women, feeling guilty and embarrassed and therefore, reluctant to plan for sex or discuss safer sex with a partner.

Gay youth may be at special risk not only because of the present epidemiology of AIDS, but also because often they are victims of homophobia. When this leads to low self-esteem, risky behavior like unprotected sexual activity or drug use may result. Given the fact that 1 in 10 people are gay or lesbian, it is important that safer sex education not ignore homosexual young people who are likely to be present in any audience...Homophobia is also a problem in the education of heterosexual youth when they believe AIDS is only a gay disease and they are therefore exempt from risk.¹¹

Education of Youth at Risk for HIV Infection

Teenagers are caught in a dangerous bind. They are scissored between high rates of risky behaviors and low rates of preventive behaviors (see the sidebar on Youth at Risk for HIV Infection on page 12). Despite the many risk factors, however, painfully few teenagers are taking steps to protect themselves. For instance, Strunin found that although 70% of adolescents in a random sample of 870 Massachusetts adolescents reported that they were sexually active, only 15% reported any change in their sexual behaviors due to concern about HIV/AIDS.¹² Only 3% were using effective methods of prevention. Two years later in 1988, after more than 8 out of 10 teens had an opportunity to discuss HIV/AIDS in school, two-thirds of sexually active Massachusetts teenagers still reported engaging in sexual intercourse without the use of condoms.¹³

Other studies have shown that knowledge about AIDS transmission does not automatically translate into behavioral changes, and that the acquisition of new behavior patterns is surprisingly complex.^{14,15,16} Three hundred and twenty-five sexually active adolescents in San Francisco were surveyed as to changes in their perceptions and use of condoms during 1987, a year when the media and schools had intensified their AIDS education activities. Although there was consensus among both males and females that using condoms is of great value and importance in preventing STDs, the rates of condom use or the intention to use them still remained very low: only 2.1% of females and 8.2% of males reported condom use every time they engaged in sexual intercourse; the males' intentions to use condoms actually declined during the study year.¹⁷ The researchers concluded that information alone was not enough to make teenagers feel personally vulnerable to contracting a sexually transmitted disease from their sexual partners, and suggested that targeting perceptions of personal vulnerability might be one way of increasing teens' motivation to use condoms.

Perspectives on Effective Educational Interventions

It is the conclusion of the authors that in order to provide effective AIDS education interventions for teenagers, the following issues must be confronted:

1. *Youth need help in obtaining the skills, and access to the resources, that are needed to manage lower risk behaviors.* A recent article by William A. Fisher in the *SIECUS Report*, "Altogether Now" (April/May 1990, Vol. 18, No. 4), details the skills teenagers need to obtain, including knowing how to negotiate sex-related prevention with partners and how to carry out public

Youth at Risk for HIV Infection

- By age 19, 78% of young women and 86% of young men in U.S. metropolitan areas have engaged in sexual intercourse. Three-quarters of U.S. teenagers have engaged in sexual intercourse by the time they are 19.¹ In some urban neighborhoods, the average age when sexual intercourse first occurs is 12½.²
- Government surveys released in June 1990 indicated that 20% of U.S. high school students have had more than three sexual partners; 3% have injected drugs.³ In addition, more than one million teenagers become pregnant every year.⁴
- In interviews with young women at an urban clinic, 25% acknowledged having had anal intercourse, two-thirds within the preceding three months. Condoms are less likely to be used for anal intercourse than for vaginal intercourse.⁵
- Various studies have reported that 17-37% of adolescent males have had at least one homosexual experience. One 1986 study of gay male teenagers found that their sample had about seven sexual partners a year; the partners were, on the average, seven years older than the teenagers.⁶
- 2.5 million teens get a sexually transmitted disease each year.⁷ By high school graduation, one out of every five high school seniors will have had an STD.⁸
- Although people with hemophilia represent only 1% of the population infected with HIV, because of the infected blood products used between 1978 and 1985, approximately 50% of people with hemophilia are now infected with HIV.⁹ When "the CDC analyzed 1,159 cases [of AIDS] in persons ages 13 to 21 years in 1988...it was noteworthy that 80% of the younger males (11 to 17) were people with hemophilia."¹⁰

1. Zeman N. The new rules of courtship. *Newsweek* (special edition), Summer/Fall 1990.

2. Clark, SD, Zabin, LS & Hardy, JB. Sex, contraception and parenthood. *Family Planning Perspectives*, 1983, 16(2).

3. Associated Press. AIDS misconceptions still prevalent among teens, U.S. says. *Chicago Tribune*, June 15, 1990, 16.

4. Center for Population Options. Peer education: Teens teaching teens about AIDS and HIV infection prevention. Washington, DC: CPO, 1988, 4.

5. Jaffee, LR et al. Anal intercourse and knowledge of AIDS among minority-group female adolescents. *Journal of Pediatrics*, 112(6), 1005-1007.

6. CPO, 4.

7. CPO, 4.

8. Koop, CE. Surgeon General's report on AIDS. Washington, DC: PHS, U.S. Department of Health and Human Services, October 1986.

9. Augustyniak, I, Kramer, AS & Fricke, W. U.S. HIV seroconversion surveillance project: Regional seropositivity rates for HIV infection in patients with hemophilia. Sixth international conference on AIDS abstract, Volume II, June 20-24, 1990.

10. Hein, K. AIDS in adolescence: Exploring the challenge. *Journal of Adolescent Health Care*, 1989, 10(3), 10S-36S.

preventive acts, such as purchasing condoms and foam. On the issue of access, a Washington, DC study of drug and convenience stores, found that teenagers find it difficult to locate and buy condoms and that females have more negative experiences in buying condoms than do males.¹⁸ In addition, the National Adolescent Student Health Survey (1989) found that 49% of high school students have trouble paying for condoms and other STD prevention supplies.¹⁹ New York City recently took an important step toward addressing this problem by deciding to distribute condoms free in school-based clinics. Youth need help in negotiating psychological and external obstacles to safer sex policies need to be changed so that youth have fewer hurdles to surmount.²⁰

2. *Perceived community norms (what people think other people are thinking) play an important role in determining individual behaviors. Interventions, therefore, should not simply target the knowledge, attitudes, and beliefs of individuals, but the norms articulated by an entire community.* The San Francisco Stop AIDS project documented that some gay men who are very

knowledgeable about HIV transmission nevertheless still engage in risky sexual behaviors.²¹ Focus groups also revealed that "participants held perceptions that unsafe sexual practices would be expected by potential partners, believed that their own personal inclinations toward safe[r] sex were not shared by others, felt their fears about risks were overshadowed by potential rejection by sex partners, and felt an extreme lack of confidence about managing communication about AIDS as a part of sexual intimacy."²²

The leaders of Stop-AIDS have concluded that the main obstacles to change are *not* lack of knowledge about modes of transmission and safer sex techniques, but rather perceived community norms. In other words, safer sex has to be legitimized by the community. Community norms can be influenced by the development of public discourse and a self-affirming culture that emphasizes the necessity of a community protecting itself.

3. *AIDS educators must understand the social and political factors that shape individual attitudes and behaviors.* Some important studies have broken out of the narrow confines of a strictly technical perspective to

examine the significant power dynamics that surround race, gender, sexual preference, and age — those factors that influence whether or not people feel that they can “afford” to insist upon safer sex and yet not jeopardize losing their relationship and/or economic security.^{23,24,25}

For instance, Dooley Worth of the Montefiore Medical Center in New York City points out that “women’s sexual bargaining power is affected by the shortage of men that is found in many inner city communities. Decreased sexual bargaining power results in more risk-taking, and is an obstacle to the use of barrier contraceptives, such as condoms insofar as the woman’s ability to persuade her partner to use them is concerned.”²⁶

Increasingly, the male/female population imbalance in some communities is acute. For instance, in Cook County, IL, nearly one-third of young black men ages 20 to 29 were arrested and jailed during 1989. Spencer Cook, director of the Cook County Department of Corrections, warns that “by 2010, we just may be looking at one out of two blacks in that [20 to 29] age group in jail.... This is the age when young black men should be finishing college, they should be marrying, they should be starting careers.... you’re seeing a generation being wiped out.”²⁷

Sexism also distorts the cultural values and power dynamics that play into negotiations around safer sex. Some male’s logic leads them to conclude that if a woman is prepared for sexual intercourse, she must be “on the make” — a “slut.”

Individual behaviors then, cannot be understood by looking only at “what goes on between a person’s ears.” People cannot be abstracted from their real life circumstances, which are shaped by race, nationality, gender, sexual preference, class, and age. Creating the conditions for healthier interpersonal and sexual relationships therefore will require a large-scale social transformation.

As PWA Educator Richard Rector says: “We must not only prevent the spread of HIV. We must also assist in shaping acceptable social attitudes toward people with AIDS and HIV, as well as the communities that are perceived to be at risk. If we fail to accept this responsibility, we will allow our own individual communities and the world as a whole to continue to travel on a road that leads to isolation which will threaten to do lasting damage to our societies, even after effective medical therapies are found.”²⁸

PWAs Can Help Overcome Deadly Denial and Fear

Dr. Karen Hein, director of the Adolescent AIDS Program at Montefiore Medical Center, and others have noted that two epidemics confront us: the epidemic of AIDS itself, and the epidemic of the fear of AIDS, “AFR-AIDS.”²⁹ Exclamations about HIV/AIDS, such as the following can be heard throughout the country: “It can’t happen to me,” “I don’t have to worry because I’m not a gay man or a druggie,” and “Talking about it openly will only put ideas into young people’s heads.” Many individuals and groups are reacting to the AIDS crisis with fear and denial.

Comments from PWA Programs and Educators Around the World

Philly Bongoley Lutaya, a well-known Ugandan pop musician made the surprise announcement at a press conference that he had been diagnosed with AIDS. “From now till my death I’m going to give AIDS a human face, be involved actively in programs aimed at the prevention of the further spread of the deadly disease, and appeal to the public to treat people with AIDS with compassion, love and understanding.” Lutaya gave a free concert to more than 30,000 fans in Kampala, returned home in December 1989, and died two weeks later.¹

Pluss, a Norwegian organization of PWAs, runs weekend courses for health and social workers. Workshop participants stay with PWAs in their homes and go out for dinner and entertainment after the workshop. One workshop participant said, “It gave me faces; [people infected with HIV] are no longer numbers and statistics.” Said another, “My emotions surfaced. It seemed like something loosened in me.”¹

Frontliners is a British group of PWAs whose purpose is to support PWAs and build public awareness. Jim Wilson reports: “the main reaction from audiences is that they are

always amazed that we, as people with AIDS, look just like everyone else. There is a popular idea that we should all look sick — as if we are about to drop dead.... The second reaction is that people say that, if they were about to be diagnosed, their biggest fear would be that other people would not see or help them; that in fact they would be totally isolated; that they would lose all of their friends and family. I think it raises a lot of awareness for them when we explain to them, yes, that sometimes that happens, but it can happen in reverse — that you gain friends and friendships become stronger.”¹

Brooklyn AIDS Task Force has organized speaking engagements for Mildred Pearson, an African-American mother of 14 who cared for her gay son as he was dying of AIDS. “Bruce was a wonderful son. My son was gay. I didn’t like that, but he was. He did not leave me any babies or a whole lot of money, but he left me his strength. My son died with dignity.... These children who are dying, these are the same children who loved us. How can we leave them forgotten, abandoned? I cannot understand why people don’t want to deal with this disease.” Mrs. Pearson has spoken to tenants groups, health care workers, and churches.²

1. Panos Institute, Special Report: Who would like to be seen as a virus? *WorldAIDS: A News Magazine Reporting on AIDS and Development*, London, England, January 1990.

2. Morgan, T. Mother shares story of AIDS to help. *The New York Times*, November 25, 1988.

AIDS, Not Us

An Audiovisual Review by Carolyn Patierno

As the title suggests, denial is one of the main topics of this video. Jose narrates the stories of the characters — Miguel, Skyman, Jose, Andy and Chris — “the posse.” The young men are each at different stages of understanding and denying the threat of HIV and their perceived risks of infection. As viewers become acquainted with each character, so do they become acquainted with additional HIV information.

Miguel is the character most entrenched in denial. He is referred to as a “player” — a young man who enjoys the intimate company of many young women. We see him with a young woman, who insists that he wear a “jimmy hat” (condom), if they are to engage in sexual intercourse. He is incredulous, becomes angry, and leaves her in a rage.

The ensuing scene — one of the most informative scenes in the video concerning condom use — ends with an especially creative and appealing spontaneous rap song about condoms. Miguel offers arguments against using condoms, hitting on several serious issues: the possibility that his partner will think that he is infected with HIV or other STDs if he uses a condom; his partner will perceive condom use as a judgment that she is “loose”; his fear of losing his erection; his disbelief that a man can become infected by a woman infected with HIV (he believes that AIDS is strictly a disease of gay men); and finally, he says, “If a lady loves me, there shouldn’t be anything between us.” Skyman, however, refutes each of Miguel’s arguments immediately. He also offers advice on how to introduce condom use into lovemaking and suggestions for emphasizing the erotic potential of using a condom, as well as emphasizing the attractiveness that offering protection holds.

There are many memorable scenes in this video. Two in

particular are scenes in which Miguel confronts Chris with questions about his sexuality. Chris finally confirms Miguel’s suspicions that he is involved with a man, explaining to Miguel that he is the same person that he has always been. Miguel initially reacts very negatively, refusing to accept Chris being gay. Later, however, Miguel says to Chris, “I don’t get it and I’m not gonna get it [but] I came to the decision that it ain’t gotta matter.” The topic of homosexuality — too often ignored in videos for teen audiences — is dealt with sensitively, simply, and straightforwardly here.

We also see Skyman struggling with the illness of his brother, Freedom, and the reaction of the rest of the “posse” as they learn that Freedom has AIDS. In addition, there are two sensitive scenes involving Andy: one in which he and his girlfriend discuss condom use and their relationship, and another in which his younger sister struggles with the prospect of having sexual relations with a young man she has just begun to see.

The video, however, is most definitely a video about “the guys,” and as such, it will be most effectively used as an educational tool with male audiences. The two formerly mentioned scenes are the only two which deal, in any depth at all, with the female perspective.

As the video begins, the producers thank the young people who assisted them for sharing their “lives, knowledge, and language.” The sharing is evident, as the characters are completely believable and convincing.

Produced by HIV Center for Clinical and Behavioral Studies, 1989, \$125 plus \$5 p/h. HIV Center Video Library, PO Box 050-168, Staten Island, NY 10305-0004; 718/720-4488.

“PWAs are living reminders that denial will not make the epidemic go away.”

PWAs can play a critical role in helping to change attitudes and behaviors that are based on fear and denial, by their mere presence, and by their willingness to speak out and address relevant issues directly. Individuals and communities benefit from contact with PWAs and from the attitudinal changes that come about when people are brought together with others who are able to address the impact of HIV/AIDS from personal experience.

Moreover, it is important to note that just as in some black and Puerto Rican neighborhoods literally every family has been personally touched by AIDS, so in the future will there be, in every high school, students who will personally be touched by classmates with AIDS or by classmates with family members who have AIDS. This has already begun to happen. Maingot found, that in a number of high schools visited in the last eight months, people have come forward to disclose that they or their family member has AIDS. “When a PWA comes to speak and seems to be accepted by their classmates,” he said, “it makes students feel safe enough to say what

is going on with them.” Guest speaker PWAs can also help isolated, newly diagnosed PWAs connect with available resources in the wider community. Maingot explained: “When someone discloses, we wait for them after the talk, and we chat with them, tell them what support is available, and try to get them in touch with other kids who have HIV or family members with HIV.”³⁰

Also, by giving students leadership on the importance of respecting, caring for, and not fearing PWAs, educators may be able to help avert some of the personal tragedies that occur when families and communities cast out their sons and daughters who are infected with HIV. As Christian Haren said, “Our job is to break the denial before it kills them. Let young people talk with someone who has AIDS, let them shake hands with us, let them be real with someone who has had three friends die this week, and who is facing death himself.” PWAs are living reminders that denial will not make the epidemic go away. Personal contact with them helps adolescents see that real people, not stereotyped images, can become infected, and this realization helps to pierce their veil of denial, as well as close the dangerous gap between *knowing* the facts and *acting* on them. As Haren said, “These kids recognize the truth when they

hear it. No more television fantasies. You cannot learn about AIDS just by reading a book or seeing a video. Because AIDS is not just a virus — it is about isolation, loneliness, anger.” He stressed: “To prevent AIDS, young people have to know who they are, they have to respect themselves, they have to care about other people and accept certain responsibilities. I can talk about it because I have AIDS.”³¹

The stigmatization of AIDS not only creates the two-headed hydra of denial and needless fear, it also gives rise to the belief that the epidemic only affects “others,” the stereotyped “bad people,” gay men and drug users. This makes many people feel invulnerable and unprepared to protect themselves from the real dangers. The myth of invulnerability is particularly acute among teenagers (who represent 10%, or 25 million, of the U.S. population.)³³ Adolescents also fear what is *not* dangerous — casual contact with PWAs and, not surprisingly, as one study has indicated, adolescents with the least amount of information are the most frightened of casual transmission.³²

Perceived susceptibility, among other factors, is important in establishing the motivation to change sexual risk behaviors. Studies in Chicago and San Francisco show a correlation between risk perception and several measures of risk reduction.³⁴ A number of studies suggest that one’s perception of personal risk is affected by whether one has personally known someone with AIDS, or has known someone who has died of AIDS,³⁵ or remembers a visual image of someone in the advanced stages of HIV disease.³⁶ Yet, the cruel irony is that because of the virus’ long latency period, for significant numbers of people to personally know someone who has died of AIDS, the virus must have a long history and wide prevalence in a community. And, unfortunately, as happened in the gay community of San Francisco, the alarm often sounds too late, after the infection has already silently spread.

Today, the urgent need is for interventions that can capture young people’s attention and short-circuit the devastating experience of “learning the hard way.” One of the reasons why PWA educators are often effective in breaking through deadly denial has been clearly stated by sexuality educator and author, Lynda Madaras: “After all, the PWA speaker didn’t think it could happen to him either. If he was wrong, maybe you could be too!”³⁷

Wedge — A Model Program

One of the first organized programs to take PWAs into the schools was the San Francisco Wedge program (named after a football play that requires great team work), which is sponsored by the San Francisco Department of Public Health and works closely with the San Francisco Unified School District system. Launched and developed by PWA Christian Haren and author Kimberlee Cox in 1986, the program, funded by the federal Centers for Disease Control (CDC), today reaches thousands of adolescents in public schools and community-based organizations each year — 85% of whom are black, Latino, Asian or Native American.³⁸

The Wedge program evolved from an initial sending of PWAs into classrooms to do one-time presentations

to the four-session program now used by schools and community groups. Program Coordinator Nancy Evans stresses that it is helpful for students to have had some prior education on human sexuality and STDs, and about homosexuality, before they enter Wedge-like programs.

The First Session. The first one-hour session is led by a health educator or trained classroom teacher who covers “AIDS 101.” Although abstinence is discussed as a safe option, the program recognizes the reality that most teenagers will be sexually active, so the students are also presented with guidelines for safer sex practices, including the use of condoms. Common AIDS misconceptions also are confronted — for example, the myth that it is possible to “just know that someone has AIDS” and the myth that young people or heterosexuals are not at risk for HIV infection.

The Second Session. The second session, led by a health educator, is crucial for preparing the class to meet the PWA educator in the third session. Students are encouraged in this session to express any concerns they may have about the forthcoming meeting, such as fears of death, fears of “catching the virus” from the visitor, homophobia, and unresolved feelings about illness or death. Health educator Cox, commenting on this session, said, “I knew from my teaching experience that we would have to deal with homophobia when sending PWAs out to speak. As a matter of fact, I had students coming up to ask if a person could get AIDS by hitting a person in the mouth when you bashed them.” She added, “You cannot just throw students into a room with someone with HIV/AIDS and expect it to go well.”³⁹ Cox’s opinion is born out by a recent survey indicating the wide prevalence of homophobia: three-fourths of high school age young men, and one-half of the the young women, said it would be bad to have a homosexual neighbor.⁴⁰

Nancy Evans said that, in many cases, enlightened students will confront their more prejudiced classmates. She explained, “We have ground rules, we don’t let students use derogatory terms. We discuss prejudice, which many of the students can understand through their own experiences with racism. We help the students understand that gay people’s sexuality is just a natural part of who they are as human beings.”⁴¹ Some programs, such as the YOUth Can Stop AIDS program in New York, encourage young people to go beyond acceptance of PWAs by taking active responsibility in confronting the epidemic, whether by organizing an AIDS prevention program or by providing volunteer services to PWAs.⁴²

The Third and Fourth Sessions. The heart of the Wedge program, however, is the third session in which a PWA makes a presentation, such as the one described at the beginning of this article. The fourth and final session is again led by a health educator, and students have an opportunity to pursue the issues generated by the PWA presentation. This session also covers skill-building, decision-making, and assertiveness training.

When possible, trained teen peer educators are asked to participate in the fourth session, and teenagers may present original skits. In one skit, for example, the leading lady donned a plastic garbage bag to portray a condom and the leading man wore a shower cap covered

PWA AND TEEN PEER EDUCATOR RESOURCE ORGANIZATIONS AND USEFUL MATERIALS

Organizations

COALITION FOR AIDS PEER EDUCATION (CAPE). Ten Seattle area community agencies have developed an AIDS peer education program at the high school level. PWAs often do presentations at the schools and at community events, and are involved in the training of teen peer educators. Cape, 2211 East Madison, Seattle, WA 98112; 206/328-7719.

EDUCATORS WITH HIV TECHNICAL ASSISTANCE PROJECT provides technical assistance in establishing an Educators with HIV program in local communities. Randy Yates, Coordinator, Educators with HIV Technical Assistance Project, Health Care of South Eastern Massachusetts, 728 Brockton Avenue, Abington, MA 02351; 617/857-1025, fax 508/224-8103.

MIDWEST AIDS TRAINING AND EDUCATION CENTER (MATEC) incorporates PWAs in its training of health care workers and offers guidelines for maximizing PWA effectiveness. Caryn Berman, MATEC, 808 South Wood (M/C 779), Chicago, IL 60612; 312/996-0681.

MULTICULTURAL INQUIRY AND RESEARCH ON AIDS (MIRA) is a useful resource for educating PWAs and educators on the cultural and economic aspects of the epidemic. Publishes a free quarterly newsletter and research articles that focus on AIDS in Black and Latino communities. MIRA Project, 6025 3rd Street, San Francisco, CA 94124; 415/822-7114.

MULTICULTURAL RESOURCE ORGANIZATION (MCRO), particularly useful for PWAs and teen peer educators working in black and Latino communities, has a resource library of culturally appropriate videos and materials. Jim Jackson, Librarian, MCRO, 1520 Market #220, San Francisco, CA 94102; 415/861-2142.

NATIONAL ASSOCIATION OF PEOPLE WITH AIDS (NAPWA) has a speaker's bureau and can put people in touch with service providers who provide AIDS education. NAPWA, PO Box 18345, Washington, DC 20036; 202/429-2856.

TORONTO PWA FOUNDATION provides half-day workshops in schools that combine an assembly with smaller

class sessions between students and PWAs. Paul Maingot, Program Outreach Coordinator, Toronto PWA Foundation, Outreach Department, 464 Younge Street #201, Toronto, Ontario, Canada M4G 2W9; 416/952-7112.

VIDA/SIDA, a program of the Puerto Rican Cultural Center, has extensive experience with teen peer educators and community organizing in Puerto Rican communities that incorporates family-based organizing strategies and gay-positive approaches. Carlos Ortiz, Coordinator, Vida/SIDA, Puerto Rican Cultural Center, 2048 West Division, Chicago, IL 60622; 312/278-6708.

THE WEDGE PROGRAM provides detailed information on how to set up Wedge-type programs in communities and outlines training and evaluative data. Nancy Evans, Program Coordinator, Wedge Program, San Francisco Department of Public Health, 25 Van Ness, Suite 500, San Francisco, CA 94102, 415/554-9098 or 554-9101.

Publications

TEACHING SAFER SEX by Peggy Brick et al is an excellent curriculum that provides 21 active exercises for classroom use especially useful for sessions #1 and #4 of the Wedge program (or for any other PWA program). It "rejects fear tactics and moralizing and, instead, seeks to develop positive images of safer sex and of the people who practice it to protect their lives and their futures." Counters the invisibility of lesbian and gay youth. Planned Parenthood of Greater Northern New Jersey, 575 Main Street, Hackensack, NJ 07601, 201/489-1265.

YOUTH FORCE. YOUth Can Stop AIDS. This upbeat, spunky, humorous, accurate, and professional 16-page booklet, written and illustrated by youth, for youth, and about youth, has been produced by the Youth Force organization. "Youth Force was created to get the word out to young people that we have the ability and the right to act for change. We are committed to giving ourselves and other youth the skills and opportunities we need to participate actively in the running of our schools, neighborhoods, and city" — a 17-year-old PWA. Citizens Committee for New York City, 3 West 29th Street, New York, NY 10001, 212/684-6767.

with cotton balls to portray foam; in another, a young woman is caught in a debate between an "angel," who urges her to protect herself by insisting on using a condom and a "devil," who mouths all the classic objections to condom use; and, in yet another, the actors model condom use negotiations during a romantic encounter. The teen actors also model how the uncomfortable silence that surrounds these subjects can be broken, allowing students to see how they can negotiate safer sex or abstinence with humor and affection.

Students are also given time to analyze and alter aspects of the skits. For example, they may rehearse comebacks to common condom resistance lines, such as "What's the matter, do you think I have something?" In a culture that still associates condoms with prostitution and "dirty, impersonal sex," talking about condoms, as a sign of caring and loving, is an important factor in transforming community norms.

Each student also practices putting a condom on an anatomical model. Cox informally estimated that a

quarter of the students she has observed have attempted to put the condom on upside down, and of these, more than 10% tore the condom in the process. She emphasized, "If you have never touched a condom, there is a very high likelihood that something will go wrong in that first situation. Or people might not use it because they feel too awkward and embarrassed." Cox stresses the importance of teenagers having hands-on experience in safe and appropriate settings: "It is not unusual to have condoms in school, but for years and years sexuality educators stood in front of the room and demonstrated their prowess at this, and the young people were passive learners. Health education theory tells us that this is not the way people learn."⁴³ Skill-building also includes discussion about how to feel more comfortable in purchasing condoms and information on where they may be obtained.

Parent/Teen Mini-Wedge Program. In addition to the above four-session program, Wedge has developed an optional two-hour condensed evening session for parents and teens (including middle school teens). Contrary to concerns that parents might feel uncomfortable discussing sexual issues with teenagers, especially 12 and 13 year olds, the two-hour program has been extremely well-received by both parents and students. An enthusiastic young student wrote, "This program should be in all middle schools, because a lot of teenagers have sex and use drugs before high school. We should talk to them *before* they do something that will affect them for the rest of their lives."⁴⁴

Recruiting and Training Wedge PWA Volunteers

Wedge PWA volunteers are recruited through support groups, PWA organizations and residences, and counselors who work with PWAs. Word-of-mouth has also been an effective recruitment tool. Although initially volunteers were predominantly white gay men, the group has gradually become more balanced and diverse.

Most PWAs participating in Wedge-type programs are adults, although teenagers with HIV would be excellent as educators among their peers.⁴⁵ The Wedge program has also found that people of color and women are very effective in speaking with high-risk youth in their communities. The Toronto PWA Foundation has also stressed that it is important to have women PWAs speak in order to break through the stereotype that only young men get AIDS.

PWA volunteer educators complete a two-day training program in which they learn the fundamentals of adolescent development, discuss multicultural issues, watch demonstration presentations, and practice responding to teenage peer educators who grill them with frequently-asked questions. The new recruits practice their presentations and receive feedback from the program health educators, experienced PWAs, and peer educators, and are then ready to go into the schools with an experienced presenter either to observe or to make their first presentations. In recognition of their time and effort, they are given honoraria each time they speak.

Evaluation of the Wedge Program and Other Similar Programs

Parents have been extremely supportive of the Wedge program, which has served more than 10,000 students and has required signed parental permission for students to participate in the program.

In 1989, Wedge conducted a pilot evaluation of 565 high school-age participants who had completed a four-session Wedge program. Pretests and posttests measured HIV knowledge and behavioral intent regarding sexual activity, use of condoms, abstinence, IV drug use, and the use of clean needles. The evaluation indicated that there had been changes in several areas.

Knowledge scores were high both before and after the intervention, which could be attributable to the fact that the pilot evaluation was done in San Francisco, a center of the epidemic where a great deal of information is available.

While there is no data on the long-term impact of the Wedge program, clear but modest changes in *behavioral intentions and attitudes* were also documented. The posttest evaluation after the Wedge program found that the percent of students planning to have sexual intercourse in the next month fell slightly from 45% to 39%. Also, when the students were asked, "Do you think you will do anything different because of the Wedge Program?" the most frequent intended change was "to use condoms," followed by the more general vow "to practice safer sex." For those planning to be sexually active, the intention to use a condom showed a statistically significant increase, from 79% before the program to 90% after the program.⁴⁷

Plans are presently underway for a comprehensive evaluation of the Wedge program that will compare pretest and posttest results at program completion, and several months thereafter.

As the Wedge program has gained national prominence, AIDS educators in other parts of the country have attempted to implement similar programs in their communities. The Educators with HIV Technical Assistance Project, drawing on the experience of San Francisco and other programs, now consults with communities across the country on how to establish and maintain community-based PWA educator programs. Christian Haren, the national chair of this project, said that they rely heavily on the fact that "in almost every little town there is at least one dedicated parent or teacher who is implementing an AIDS education program, although sometimes with very little help. Our job is not to replace these people, but to complement their efforts"⁴⁸ Haren and other consultants also offer technical assistance in identifying PWA volunteers, and then train, in a two-and-a-half day workshop, the hosts and PWAs. Their goal is to prepare local communities to run PWA programs on their own.

Kevin Cranston and Randall Yates have carried out an initial controlled study on the impact of education by PWA participants in a Wedge-like program. Three hundred eighty Massachusetts high school sophomores completed a 41-item pretest and posttest survey of knowledge, attitudes, and beliefs, slightly modified from a similar instrument developed by the CDC. The students

were divided into three intervention groups. The first group participated in an "AIDS 101" skillbuilding session, involving discussions of relative risk, risk reduction, and decisionmaking only; the second group covered AIDS 101 and met with a PWA; and the third group covered AIDS 101 and viewed the video, "Teen AIDS in Focus," featuring three teenage PWAs (see the audiovisual review on page 10). Comparing matched pretests and posttests for the three groups, significant attitudinal changes were observed in the group that met with the PWAs in regard to the following questions: "Should a student with AIDS/HIV be allowed to go to your school?" and "Would you be willing to be in the same class with a student with AIDS/HIV infection?" No significant changes were observed in the other intervention groups. The students who viewed the video, however, registered a significant change in knowledge in regard to their response to the question, "Can you tell if people are infected with the AIDS virus (HIV) just by looking at them?" The authors concluded that the intervention yielded promising results and are continuing their research.⁴⁹

PWA Educators and the Political Environment

It was probably no accident that the Wedge program was first developed in a progressive city and a center of the gay and lesbian movement in the United States. The question quickly arose as to whether PWAs would be able to serve as AIDS educators as easily in other communities across United States.

Helene Sethuraman, STD coordinator for the government health department in Evanston, a suburb of Chicago, IL, says "yes," if PWAs are presented in settings where the stage has been set for their acceptance. She regularly asks PWAs — who range from gay men with HIV and recovering intravenous drug users, to women who became infected with HIV through heterosexual contact, to those who became infected from blood products — to speak in high school assemblies and classrooms. "I tell the students: 'Our guests are going to share their real life stories and talk from their heart. As people with AIDS, they are dealing with the possibility of death. But they think that *you* are important, and they have chosen to spend their time with you. They will share with you what they may not have shared even with their families. This takes a lot of guts.'⁵⁰

Nonetheless, in many small communities, although PWAs may have access to the adults in business and other community groups, it is not as easy to gain access to the schools and young people. For example, Ron Jerrell, founder and president of the National Association of People with AIDS affiliate in Kentucky, grew up and presently works in a small town where the local preacher forbade makeup and social dancing. The organization has an active speakers bureau that receives calls from organizations and businesses for PWA educators, but they receive no calls from schools. The school doors have remained closed to PWAs.

Many school systems attempt to draw lines between the so-called "innocent" PWAs — those who became infected from contaminated blood products and children infected perinatally — and the so-called "guilty" PWAs,

who became infected through other routes. Jerrell said, "When I have been approached by school systems, they seem to want me to talk without mentioning homosexuality, condoms, sex or intercourse. They seem to think that if we do not talk about these subjects, they will all go away. I cannot in good conscience agree to these terms — I would feel foolish standing up in front of students with nothing to say." He commented, "In one case, a principal asked how I had become infected. I would not answer that — as it would be an invasion of privacy. So the principal refused permission to have me speak."

Such narrowness, Jerrell pointed out, can spell future HIV infection for students in school systems that prohibit frank communication. Emphasizing this point, he said, "The new cases are young, intravenous drug users, many heterosexual. They got involved in unsafe activities before we ever had a chance to educate them."⁵¹

It may be virtually impossible to offer complete Wedge-type programs in some parochial schools, as they often place restrictions on the provision of AIDS education, especially when it includes discussions of safer sex and condom use. Even in such a liberal epicenter as the San Francisco area, the Wedge program has found it necessary to systematically build professional and community support. The concept was originally presented and approved by a council of approximately 40 community health groups who set up a working committee, which included a representative of the school district and a parent advocate. In addition, guidelines for the speakers were prepared, and the school superintendent and district approved all training materials. Regular updates also were given to the advisory committee for family life education.

Cox, nonetheless, argues that school districts should take the risk of starting a potentially-controversial yet effective program. "There is a mountain of research evidence that there are great limitations to knowledge-based AIDS education programs, because behavior does not correspond to knowledge. Especially with AIDS education, where the stakes are so high, we cannot just reproduce old methods that do not work." She emphasized, "We have to start sticking our necks out. We have to say, 'This is what the data shows...' The same old lecture just is not working. We are not aiming to get two inches on the map, we need to get a yard on the map. Let's try something that is comprehensive, that involves the whole person as an active participant."⁵²

Conclusion

Today, 12 years into the AIDS epidemic, there are signs of "AIDS burnout" among young people. Confronted with yet another dry lecture on "the facts," teens might be forgiven for groaning, "Oh, no, not that again, we had *that* already!" We have also learned that knowing the facts is not enough to persuade young people that they are vulnerable to HIV/AIDS and must take action to protect themselves, others, and their communities. And, although we have learned that denial falls away rapidly when a friend or a loved one dies of AIDS, we cannot afford to wait until young people actually have this personal experience.

Fighting to live, and yet living in the shadow of

death, PWAs possess a unique power and authority as AIDS educators. They are able to give our children a gift of life, a moving confrontation with reality, and a vivid call to protect themselves and their communities. In PWA programs, teenagers are challenged and trusted to take on and deal with hard questions and issues, such as fears of death and illness, sexuality, homophobia, the drug epidemic, and relationships between women and men. When given this respect, they respond and grow. The concrete benefits can be measured, not only in the percentage of teenagers who actually begin to protect themselves and enact other prevention behaviors, but also by the communities that are learning to value, respect, and care for those who are so often despised and rejected — people living with AIDS.

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HOMOPHOBIA IN HIV/AIDS EDUCATION

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In delivering a basic HIV presentation to a group of high school students, a nurse epidemiologist referred to HIV as affecting only those in the "high risk groups" — gay men and IV drug users. "Those other poor, innocent people — hemophiliacs and newborns — were just minding their business when they got what the homosexuals and IV drug users got." In response, one young man whispered to another, "[gay people] with AIDS should be shot so that the rest of us don't die." Hearing this comment, a third young man's stomach turned over: suspecting for years that he is gay, he is now more determined than ever not to let anyone know about his secret feelings.

A few minutes later, in the same class, the nurse began to feel nervous when the time came to talk about prevention. She reasoned with herself that most people find it difficult to talk about sexuality — especially with teenagers. She is particularly uncomfortable with having to talk about anal intercourse, as it has always seemed abnormal to her, even though she knows that many people engage in it. In trying to explain to the class why anal intercourse is risky in regard to the transmission of HIV, she simply stated, "the anus was not meant for sex."

Blaming, hostility, denial, and misinformation are not unique issues for HIV educators. They are common manifestations of homophobia, broadly defined as the fear and hatred of those who love and sexually desire people of the same gender. Homophobia is deeply ingrained in American society. It is present in most educational settings, and because of the necessity of discussing same-gender sexual activity, it is present in virtually all HIV education.

Sadly, neither teachers nor students are immune to homophobia. For instance, in the above situation, the teacher's homophobia prevented her from providing accurate and explicit information, and the students' homophobia prevented them from assimilating important information about their personal risks, the risks of others, and the ways for minimizing such risks. It should become quickly apparent why such denial, hostility, and prejudice is not acceptable.

HIV education can either perpetuate homophobia (as with the nurse epidemiologist) or begin to dismantle it. Few people admit that they are homophobic, sexist, or racist. It is difficult not to be homophobic in our society. Most of us were presented with inaccurate and highly prejudiced information about homosexuality as children, and the culture in which we live continuously offers, perpetuates, and promotes — on a daily basis —

prejudiced and inaccurate information about homosexuality. As a result, many adults tend to rely on and perpetuate the information they received as children. However, in spite of this, some youth and adults have attempted to obtain accurate information, are working to overcome their prejudices, and are attempting to educate others in overcoming theirs.

Overcoming any type of prejudice requires a great deal of work and time. Above all, it requires a commitment to study, and to take action. However, within the context of HIV education, there are some concrete steps that can be taken *now* to reduce denial, prejudice, and hostility.

This article presents information about homophobia and some guidelines for delivering nonhomophobic education. The term HIV/AIDS education is used broadly here, to designate any methodology and audience where the purpose is to stop new HIV infection, and to encourage compassion and care for those already infected. Therefore, the term HIV/AIDS educator will refer to any person whose work requires them to teach others about HIV/AIDS, whether this education takes place in counseling sessions, in classrooms and community settings, and/or through the distribution of written, audiovisual, and audiocassette materials.

The Manifestation of Homophobia...

At the individual level. Homophobia manifests in several ways. At the individual level, like other forms of oppression, it is a learned behavior. Individual homophobia can be identified across a broad range of behaviors. Participation in, listening to, and laughing at so-called gay jokes is homophobic, for example. On a slightly more hostile level, expressions of aggression toward gays, lesbians, and bisexuals, such as the expressions of a young man who angrily stated: "[gay people] should be shot" and "all that [lesbian] really needs is a good lay" is homophobia. At the extreme end of the range of hostile expressions and behaviors, is the terrifying reality of "bashing" — physical violence directed at lesbians and gay men simply because of their sexual orientation. Such violence has reportedly increased dramatically since the advent of HIV/AIDS hysteria.

At the organizational level. At the organizational level, homophobia manifests wherever there is the assumption that everyone is heterosexual — and that if they are not, they should be.

The heterosexual assumption of normalcy is played out organizationally in pervasive *acts of omission*: institutions often fail to recognize the presence of lesbian and

gay members on their staffs or to offer insurance opportunities to committed same-gender partners. In addition, they do not provide the same special support services for gay men and lesbians and their significant others, including personal leave in the event of illness or death, as are offered to heterosexual partners and families. The message is clear: same-gender partners and families do not, and should not, exist. *Acts of commission* at the organizational level also abound. There are rules that forbid the granting of security clearance to "known homosexuals," and policies that allow the firing of gay and lesbian teachers, solely on the basis of their sexual orientation.

At the Cultural Level. At the cultural level, homophobia manifests as a broad social indictment of homosexuality. In virtually all media, the heterosexual assumption is reinforced through pervasive and persuasive heterosexual images. Families are depicted as having a mother and father, and lovers are never of the same gender. The heterosexual lifestyle is portrayed, not just as the norm, but as the ideal. At the same time, when gay men, lesbians, and bisexuals are made visible, they are most often presented as oversexed, deviant, and sick. The word promiscuous, for example, is a label generally used only to describe women and gay men. How often do we hear heterosexual men being referred to as promiscuous? As for deviance, it is commonly assumed that gay men are driven by their attraction to boys; yet, research clearly tells us that 95% of those who sexually abuse children are heterosexual men. Lastly, in HIV education programs, educators are invariably asked about the causes of homosexuality. The implicit assumption is that if the cause can be found, a cure can also be found; homosexuality, thus, must be a sickness.

At the Classroom Level. Such expressions of homophobia inevitably find their way also into our classrooms, where such statements, as those made by the nurse epidemiologist, remind us that homophobia is not just an issue for students, but it is also an issue for educators. Clearly, the nurse's choice of language about innocence has strong attitudinal implications: if some people infected with HIV are innocent, then there must be others who are guilty. Assigning blame allows people to see others as different from themselves. It then becomes a battle between them and us, and between those who are infected with HIV, and those who believe they never will be. Additionally, this mindset builds walls against compassion for those who are infected with HIV and inhibits our ability to live in a world and work with people who are different from us.

HIV educators — regardless of the context — share immense responsibility not to reinforce, indirectly or unintentionally, the misinformed and misguided values and beliefs of clients, students, and audiences. This responsibility is magnified when the message one wishes to convey involves the life and death decisions of the people with whom one is working. HIV educators also must examine their attitudes and actions before they begin to educate others about HIV.

The following guidelines are proposed as a basis for this examination.

Guidelines for Delivering Nonhomophobic HIV/AIDS Education

1. Language is powerful, so select your words carefully; use clear, accurate, and explicit language when describing sexual behaviors.

Even a seemingly innocuous phrase can resonate with homophobic overtones. Like the nurse above, many educators begin a discussion of anal intercourse by saying, "The anus was not meant for sex." Such a statement implies that anal intercourse is abnormal. The next assumption is that only abnormal people, i.e., gay men, engage in anal intercourse. Some educators even call it "homosexual intercourse." When speaking about anal intercourse, it should be called that, and not "homosexual intercourse." (Heterosexuals engage in anal intercourse, and many homosexuals never engage in anal intercourse.) When speaking about penile-vaginal intercourse, it should be called that, and not "regular" or "normal" intercourse.

Also, one should talk about "high risk behaviors," not "high risk groups." By focusing on high risk groups, educators invite the "us and them" mentality, and falsely reassure those who would deny their own HIV risk by implying that HIV is someone else's disease. Speaking about high risk *behaviors* neutralizes the issue and is more truthful; it helps people understand that it is what they do that could infect them, not who they are.

In addition, do not make assumptions about the sexual orientation of clients, students, or audiences. When discussing sexual partners, use gender-free terminology. Use the words lover or partner, instead of husband, wife, boyfriend, or girlfriend. The use of neutral language acknowledges a broad, diverse range of sexual feelings and expressions. It also helps establish some safety, and acceptance, for students who do engage in sexual contact with same-gender partners.

2. Confront your clients, students, and audiences on their homophobic attitudes and behaviors.

Respond to homophobic comments with interventions that encourage critical thinking skills. For example, if someone insists that gay men should be quarantined to protect public safety, challenge that person by systematically asking a series of logical questions that can elicit rational responses. Ask the person, "Knowing what you know about HIV transmission, why is that a good idea?" Or, "You also realize that unprotected anal, and penile-vaginal, intercourse is a transmission route for HIV. Should all people, including heterosexuals, who engage in such behavior be locked up or quarantined?" Let this person explain his or her solution against the facts.

Challenge those who would blame, however subtly, gay men for the HIV pandemic. For example, a young girl may express her fear of becoming infected through sexual contact by a "homosexual boy who lies." Help the participant accept self-responsibility by repeating how she can protect herself from being infected through safer sexual practices. This is an opportunity to stress one's personal responsibility in stopping transmission, rather than placing blame on one's partner or questioning whether one can entirely trust what one's partner says about his or her sexual history.

3. Give credit to the gay community for their effective and quick response to HIV.

Nearly every teaching situation affords the opportunity to point out how effectively the gay community has reacted to HIV. It was, by and large, the gay community that initiated and created effective support networks for people with HIV infection and immediately developed educational programs in order to prevent the spread of HIV. These efforts have resulted in documented decreases in rates of new infection among gay men in several major U.S. cities.

4. Demonstrate, through familiar examples, an acceptance of a full range of sexual behaviors.

Examples that are familiar — with which people can quickly identify — can be extremely effective in providing them with a broader sexual perspective. One way to do this is by using examples that will help them understand that there is no such thing as “normal” sexuality, but rather that there is a full range of diverse, normal sexual experiences. There are, however, certain acts of violence, and coercive acts in relationships, that when sexually played out, are damaging; these should be addressed, and it should be understood that they are not to be tolerated.

5. Deal positively with clients', students', and audiences' misinformation and fears. Do not blame them for their feelings or for what they do not know. Remember that homophobia is learned and that HIV is frightening.

An effective strategy, when it is used well, is the misinformation of another person. Even when it is of a homophobic nature, the misinformation put forward by someone can be used to educate others. For example, a student may raise his or her hand and very matter-of-factly ask, “My mom says only [gay people] and druggies get this virus. Is that true?” Such misinformation can be explored rationally, and one can diplomatically challenge an audience to examine and debate these views.

Legitimate fears also should be acknowledged. When one's clients, students or audiences reveal how uncomfortable and fearful they are of gays and lesbians, reassure them that diversity, while it should be celebrated, sometimes makes us uncomfortable. Explore the importance of confronting and managing such feelings. Most people will gain reassurance from the information provided.

6. Use educational materials which assume that the world is full of people of all sexual orientations.

Design materials that include same-gender couples, and lesbian and gay youth. If you use role-playing or case studies, be sure to include lesbian and gay characters.

7. Ask yourself if your clients, students or audiences see you as a “safe” person with whom they can discuss concerns and questions about sexual orientation.

For example, acknowledging the gay community, discussing the struggles that gay men and lesbians face because of HIV, and having referrals available for those

who are questioning their sexual orientation, are all ways in which safety and trust can be built. Educators who affirm lesbians and gay men will be trusted and sought out.

Conclusion

For HIV education to be effective, it must be free of homophobia. Those who care about social justice will see HIV education as an opportunity to challenge the form of oppression known as homophobia. Even when educators and their educational materials are nonhomophobic, the topic is guaranteed to stimulate an audience's homophobia, which provides an excellent opportunity to educate.

When we as educators are successful in helping people unlearn cultural stereotypes that reinforce prejudice, we will also be successful in helping them change their behaviors, so that they will be able to stop engaging in oppressive and hurtful acts. In doing so, the greatest challenge of HIV education will be achieved, which is reflected in the letter below, from an eighth-grade student to a person with HIV, who spoke at the student's school:

“I was really uncomfortable and didn't listen at first. I don't like [gay people] and the way they act and my friends beat people up like that, I have too. You really had courage answering my question about how you feel about being treated differently the way [gay people] are. You know you're going to die, but you still came to talk to us and answer my smartass questions. I think I shouldn't treat gays the way I done before. They already have a lot of problems without some smartass kid picking on them. They're people too. After all, I could die of HIV just like you and them.”

Teaching people the facts about HIV is fairly easy; confronting the values that get in the way of true behavioral change is both difficult and scary. However, to ignore the values that lead to denial, prejudice, and hostility is to ignore our duty as educators. When those values serve to keep people in a state of fear and ignorance, we have no choice but to challenge such values directly, and in turn, to provide support and affirmation to those who are oppressed.

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SAFER SEX AND HIV/AIDS EDUCATION

A SIECUS Annotated Bibliography

This annotated bibliography profiles resources about safer sex. In order for people to feel empowered and knowledgeable enough to adopt and maintain safer sex practices, they must have practical information as well as emotional, psychological and motivational support. The resources listed below — books, audiovisuals and audiocassettes, and special kits — offer both. If you are unable to find the resources listed in this bibliography, the publishers'/producers' addresses and telephone numbers are provided after each listing so that you may contact them directly.

Although SIECUS does not distribute any of the materials

listed in this bibliography, they are available for use within our reference library.

This bibliography has been prepared by Carolyn Patierno, SEICUS' AIDS associate, and has been funded through a cooperative agreement with the Centers for Disease Control. It can be reproduced as long as SIECUS is acknowledged (please send a copy to the Publications Department for our records). A single copy can be obtained, free upon request, with a self-addressed, stamped, business envelope by writing to: Publications Department, SIECUS, 130 West 42nd Street, Suite 2500, New York, NY 10036, or by calling 212/819-9770.

FOR ADULTS

THE BOOK OF QUESTIONS: LOVE AND SEX

Gregory Stock

This book may be used to examine personal attitudes toward sexual and relational issues. Provides a comfortable way to present these issues and can be used to foster effective communication between sexual partners, friends, and family members. 1989, 207 pp., \$4.95.

*Workman Publishing Co., Inc.,
708 Broadway, New York, NY 10003;
in NY: 212/254-5900, elsewhere: 1-
800/722-7202.*

HOW TO TALK TO YOUR PARTNER ABOUT SMART SEX

Lonnie Barbach & Bernie Zilbergeld

Throughout this audiocassette, which provides examples of effective communication strategies for discussing safer sex with a partner, Barbach and Zilbergeld comment on the different approaches taken in each of the presented scenarios. Issues covered include condom use, spontaneity, denial, and sexual expression. May be used in its entirety, or in sections, as appropriate. 1988, 60 mins., \$13.

*Focus International, 14 Oregon
Drive, Huntington Station, NY 11746-
2627; in NY: 516/549-5320, elsewhere:
1-800/843-0305.*

MAKING IT: A WOMAN'S GUIDE TO SAFER SEX IN THE AGE OF AIDS

Cindy Patton & Janis Kelly

In a nonjudgmental and safe tone,

this book deals with all women — heterosexual, bisexual, and lesbian. Sex-positive, while thoroughly discussing risk behaviors, the guide includes a section on drug use and another for sex workers. The book is in Spanish when flipped over. 1988, 30 pp., \$3.95.

*Firebrand Books, 141 The Commons,
Ithaca, NY 14850; 607/272-0000.*

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

Beverly Whipple & Gina Ogden

This book, designed to make women feel more comfortable and aware in dealing with sexual issues in light of the HIV/AIDS epidemic, explains that safer sex can be pleasurable and exciting. 1989, 222 pp., \$4.95.

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

FOR TEENAGERS

BE SMART ABOUT SEX — FACTS FOR YOUNG PEOPLE

Jean Fiedler & Hal Fiedler

This book, containing anecdotal information from young people, fosters a better understanding of the realities of HIV/AIDS. Chapter topics include: Expressing Sexual Feelings; Thinking About Sexual Decisions; Facts About AIDS; and Four Rules for Safer Sex. 1990, 128 pp., \$17.95.

*Enslow Publishers, Bloy Street & Ramsey
Ave, Box 777, Hillside, NJ 07205; 201/964-
4116.*

RAPPIN', TEENS, SEX AND AIDS

Sala Udin

The two black and Latino characters in this empowering comic book — written in language that speaks clearly to teen readers — visit the school's health educator who talks to them about peer pressure, sexuality, and protection. 1988, 7 pp., \$1.

*Multi-Cultural Training Resource
Center, 1540 Market Street, Suite 320,
San Francisco, CA 94102; 415/861-
2142.*

RISKY TIMES, HOW TO BE AIDS- SMART AND STAY HEALTHY: A GUIDE FOR TEENAGERS

Jeanne Blake

This attractive, easy-to-read book, includes chapters on: How You Can't and Can Get Infected; Condoms; Decisions; and Questions. Six teenagers provide personal insights on each of the issues presented. Quotations from famous performers and athletes appear throughout the book. A companion guide is available for parents, written by syndicated columnist Beth Winship ("Ask Beth"), that is both sensitive and informative. 1990, 158 pp., \$5.95.

*Workman Publishing Co., Inc., 708
Broadway, New York, NY 10003; in NY:
212/254-5900, elsewhere: 1-800/722-
7202.*

CONDOMS

THE CONDOM BOOK: THE ESSEN- TIAL GUIDE FOR MEN AND WOMEN

Jane Everett & Walter Glanze

This guide lists condoms by product

name, provides information and a description of each product and its packaging, and offers personal opinions of the condoms by people who have used them. Includes a comprehensive question-and-answer section on STDs, sexuality, and the correct use of condoms. 1987, 139 pp., \$3.95.

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

THE GREAT COVER UP: A CONDOM COMPENDIUM

Victor Goodman & Susan Zimet

Described as a "light-hearted book about a serious subject," this attractively illustrated compendium includes interesting and entertaining facts about the history of condoms. Introduces a complex subject with a bit of humor. 1988, 124 pp., \$5.95.

Civan Inc., PO Box 358, New Paltz, NY 12561; 914/255-2117.

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

Patti Breitman, Kim Knutson, & Paul Reed

While presenting safer sex in a positive manner, this book also acknowledges and addresses the difficulties of adopting safer sex practices. Includes a question-and-answer section on condoms, a how-to section for dealing with negative responses to condom use, and a resource directory. 1987, 83 pp., \$4.95.

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

SAFER SEX KITS

THE CONDOM PACKAGE

Gay Men's Health Crisis

Offers HIV information in an innovative package that includes two condoms and a 3 oz. tube of water-based lubricant. Package illustrations are available with four different themes: play safe, through the night, dressed for success, and fly right. The same safer sex copy is presented in all. The minimum order is one box (includes 48 packages and display box), \$25.

Gay Men's Health Crisis, Inc., 129 West 20th Street, New York, NY 10011; 212/337-3697.

PLAY SAFE — A SAFE SEX KIT FOR WOMEN

Lyon-Martin Women's Health Services

This kit includes two condoms, a latex glove, and two dental dams — with instructions on how to use them — and an insert on communication

skills and safer sex guidelines for lesbian, bisexual, and heterosexual women. \$3 per kit.

Lyon-Martin Women's Health Services, 2480 Mission Street, Suite 214, San Francisco, CA; 415/641-0220.

AUDIOVISUALS

AIDS, NOT US

Five young men growing up in the city struggle with their personal risks for HIV infection in this video — each with a different perspective on the issue. Condom use, homosexuality, dealing with a family member living with AIDS, and communication skills, are covered. 1989, 36 mins., \$125 plus \$5 p/h.

HIV Center Video Library, PO Box 050-168, Staten Island, NY 10305-0004; 718/720-4488.

ARE YOU WITH ME?

Highlighting the issues women face when negotiating safer sex with their male partners, this video profiles a mother and daughter, both sexually active, and their frank and honest discussions with one another. The daughter's discussions with her partner are more candid than the mother's with her partner; the resulting tension between the two women, and the older woman's response to her daughter, encourages discussion. 1990, 17 mins., \$65 plus \$10 p/h.

Produced by AIDSfilms. Distributed by Select Media, 74 Varick Street, Suite 305, New York, NY 10013; 212/431-8923.

CONDOM-EZE

This 5-minute video uses old newsreels and narration to humorously introduce the subject of condom use to an adult audience. Professionals will find this video useful as a springboard for presenting condom information to students and clients in new ways. 1988, 5 mins., \$95 for purchase, free 10-day preview.

Intermedia, Inc., 1600 Dexter North, Seattle, WA 98109; 1-800/553-8336.

SERIOUSLY FRESH

Focusing on the lives of four young black men, one of whom becomes sick with AIDS-related illnesses, this video deals with family relations, drug use, safer sex, and gay issues, while also facing the realities of fear, rejection, confusion, and anger. 1990, 20 minutes; \$65 plus \$10 p/h.

Produced by AIDSfilms. Distributed by Select Media, 74 Varick Street, Suite 305, New York, NY 10013; 212/431-8923.

VIDA

Available in Spanish and English, this video, developed for use in Latino communities, confronts the importance of safer sex and protecting oneself in sexual relationships. 1990, 20 mins., \$65 plus \$10 p/h.

Produced by AIDSfilms. Distributed by Select Media, 74 Varick Street, Suite 305, New York, NY 10013; 212/431-8923.

FOR MORE INFORMATION

AIDS Information

U.S. 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
202/726-6554

American Foundation for AIDS Research

1515 Broadway, Suite 3601
New York, NY 10036
212/719-0033

Gay Men's Health Crisis

129 West 20th Street
New York, NY 10011
212/807-6655

National Association of People with AIDS

PO Box 18345
Washington, DC 20036
202/429-2856

National Hemophilia Foundation

110 Greene Street, Suite 406
New York, NY 10012
212/219-8180

National Leadership Coalition on AIDS

1150 17th Street NW, #202
Washington, DC 20036
202/429-0930

National Lesbian and Gay Health Foundation

1638 R Street NW, #2
Washington, DC 20009
202/797-3708

Sex Information and Education Council of the U.S.

130 West 42nd Street, Suite 2500
New York, NY 10036
212/819-9770

SIECUS NEWS...

NATIONAL COALITION TO SUPPORT SEXUALITY EDUCATION: Over the summer, the National Coalition To Support Sexuality Education grew to 31 members. SIECUS welcomes the American Association for Marriage and Family Therapy; Association of Reproductive Health Professionals, B'nai B'rith Women; National Urban League; United Church Board for Homeland Ministries; University of Pennsylvania; and YWCA of the U.S.A. The next meeting of the National Coalition will be in the spring.

NATIONAL SEXUALITY EDUCATION GUIDELINES TASK FORCE: SIECUS has received funding from the Carnegie Corporation of New York to develop national guidelines for sexuality education, kindergarten through high school. Chaired by SIECUS Board Member William Yarber, the task force includes: Peggy Brick, Maureen Corry, Brenda Greene, Debra Haffner, Marian Hamburg, Richard Jimenez, Robert Johnson, Martha Roper, Claire Scholz, Robert Selverstone, Stanley Snegroff, Mary Lee Tatum, Trish Torruella, Kathryn Voegtle, Jim Williams and Pamela Wilson. The first meeting of the Guidelines Task Force was held on September 21, 1990. The guidelines will be published next summer.

TRAINING SITES SELECTED: The demonstration sites for the SIECUS workshops on AIDS and sexuality for fiscal year 1991, which are funded through a cooperative agreement with the Centers for Disease Control, will be Chicago, IL, October 25-26; Myrtle Beach, SC, December 3-4; and Phoenix, AZ, January 24-25. The workshops are cosponsored by: The Chicago Women AIDS Project, The South Carolina Training Network, and The Arizona Family Planning Council.

NEW PUBLICATIONS: SIECUS has just published three new publications. *COMO HABLAR CON SUS HIJOS SOBRE EL SIDA*, an adaptation and translation of SIECUS' popular booklet for parents on educating children about AIDS, which was pilot-tested with families in New York and El Paso, Texas. (Single copies are free with a self-addressed, stamped, business-size envelope.) *AIDS: SIECUS Reprint Series #1* is a compilation of 23 articles on HIV/AIDS, which previously appeared in the *SIECUS Report*. (\$15, plus 15% p/h). *COMMUNICATIONS STRATEGIES FOR HIV/AIDS AND SEXUALITY: A Workshop for Mental Health and Health Professionals*, a manual for AIDS

trainers on conducting a training workshop on sexuality and AIDS based on SIECUS' successful AIDS training workshops (available free to AIDS trainers through SIECUS' cooperative agreement with the CDC with \$3.50 for p/h). To order these publications contact the Publications Department of SIECUS.

MEDIA COVERAGE: In recent months, SIECUS Executive Director Debra Haffner appeared as a guest on the *Donabue* show, the *Today* show, *Sonia-Live* (CNN), the *McLaughlin Report*, and *CSPAN-Live*, a television talk show, and SIECUS Board President Robert Selverstone appeared on *Good Morning America*. SIECUS staff have recently been quoted in *The New York Times*, *The Wall Street Journal*, the *Christian Science Monitor*, and *Parents Magazine*.

SIECUS TRAVELS: SIECUS staff continue to travel extensively, providing speeches and workshops on sexuality and AIDS education. During the past few months, programs have been presented at the annual meeting of the National Council of State Legislatures in Nashville, TN; the annual meeting of the National Gay and Lesbian Health Foundation in Washington, DC; the Funders Concerned About AIDS annual meeting in New York City; and the Children's Defense Fund policy forum in Washington, DC. Future presentations will be given in Pittsburgh, PA; Toledo, OH; Minneapolis, MN; Nashville, TN; Denver, CO; and Dallas, TX. Please call us if you are interested in a speaker for your meeting.

SIECUS LIBRARY OPEN AT 42ND STREET: The SIECUS library is open for fall visits, five days a week, including Tuesday and Thursday evenings. Call for an appointment if you plan to visit New York.

WE WANT TO HEAR FROM YOU: SIECUS is dedicated to meeting the needs of our members. We want to hear what you like, what you don't like, and your ideas and suggestions for our future. Please write Debra Haffner with your comments.

NEWEST MEMBER OF THE SIECUS FAMILY: Congratulations to Director of Program Services Diane de Mauro and Antonio Burr on the birth of their second son, Camilo Burr di Mauro, on Labor Day, 1990.

Make a Holiday Gift to SIECUS In the Name of Someone You Love

A very special gift for someone you love — and for SIECUS — is a gift contribution in that person's name.

Send us your gift contribution and the name and address of the person(s) for whom you are making the contribution. We will then send a personalized holiday card to those for whom you are making a contribution, acknowledging your gift. You will be supporting SIECUS in a special and much appreciated way. Write to Meredith Hollowell, SIECUS Director of Development.

Conference and Seminar Calendar

AIDS AWARENESS WEEKEND — TRACK II: ADVANCED, *November 30-December 1, 1990.* Fort Worth, Texas. Contact: Community Outreach Center, 1125 West Peter Smith, Fort Worth, TX 76104, 817/335-1994.

"CLINICAL CARE OF THE AIDS PATIENT," *December 10-11, 1990.* Sponsored by University of California San Francisco, School of Medicine. San Francisco, California. Contact: University of California San Francisco, Postgraduate Programs, C405, 521 Parnassus Avenue, Box 0656, San Francisco, CA 94143-0656, 415/476-5208.

MIDWEST CONFERENCE ON AIDS: "PERSPECTIVES FOR THE 1990s," *December 13, 1990.* Community Arts Auditorium, Wayne State University, Detroit, Michigan. Contact: Midwest Conference on AIDS, McGregor Conference Center, Wayne State University, Detroit, MI 48202, 313/577-5131.

"PASTORAL CARE FOR PERSONS WITH AIDS" — TELECONFERENCE, *December 18, 1990 and February 12, 1991.* New York, New York. Contact: James J. Gardiner, Catholic Telecommunications Network of America, 138 Waverly Place, New York, NY 10014-3845, 212/255-6731.

SIXTH ANNUAL ROCKY MOUNTAIN REGIONAL CONFERENCE, *January 11-12, 1991.* Sponsored by the Denver Department of Public Health, Colorado AIDS Project, and University of Colorado's AIDS Education and Training Center. Denver, Colorado. Contact: Peter Ralin, Denver Department of Public Health, 605 Bannock Street, Denver, CO 80204, 303/893-6300.

GAY MEN'S HEALTH CRISIS (GMHC) FELLOWSHIP PROGRAM, *January 15-February 8, 1991; March 11-April 5, 1991; May 6-May 31, 1991.* Four-week sessions will provide consultation and on-site training to AIDS service providers for improving the education, service, and advocacy programs of AIDS and community-based health care organizations. Contact: Lew Katoff, Director, Fellowship Program, GMHC, 129 West 20th Street, New York, NY 10011, 212/337-3603.

"AIDS AND VISION LOSS," *January 24-25, 1991.* Sponsored by the American Foundation for the Blind's Northeast Regional Center and by the Northeastern Association of the Blind at Albany. Albany, New York. Contact: Henry B. Stern, American Foundation for the Blind, 15 West 16th Street, New York, NY 10011, 212/620-2032.

FIRST INTERNATIONAL CONFERENCE ON ORGASM, *February 3-6, 1991.* Organized by the Indian Association of Sex Educators, Counselors, and Therapists. Taj Palace Intercontinental, New Delhi, India. Contact: Professor Prakash Kothari, First International Conference on Orgasm, 203 A, Shukhsagar, NS Patkar Marg, Bombay 400 007, India.

THIRD INTERNATIONAL SYMPOSIUM ON AIDS INFORMATION AND EDUCATION, "HEALTH PROMOTION IN ACTION," *February 3-7, 1991.* Organized by the government of the Republic of the Philippines and the World Health Organization, and cosponsored by UNESCO, UNICEF, and IUHE. Will address health promotion policy efforts to stop the spread of HIV, with sessions on AIDS and human rights, developing personal skills, strengthening community action, and reorienting health and social services. Manila, Philippines. Contact: Symposium '91, World Health Organization, Regional Office for the Western Pacific, PO Box 2932, Manila 1099, Philippines.

"ORAL MANIFESTATIONS OF HIV INFECTION," *February 12, 1991.* Columbus, Ohio. Contact: Ohio State University, Department of Family Medicine, East Central AIDS Education and Training Center, Area 300, 1314 Kinnear Road, Columbus, OH 43212, 614/292-1400.

ADOLESCENT RESOURCE NETWORK'S 1990-91 LECTURE SERIES: "Educator's Challenge: Teen Pregnancy," *March 7, 1991; "Ministering to Teens: Sorting Out Sexuality,"* *May 2, 1991; "How to Keep on Keeping On — Inspiration and Tools,"* *June 6, 1991.* Radisson Hotel, Monroeville, Pennsylvania. Will focus on successful teen pregnancy prevention strategies and offer an outline for action based on proven methods. Contact: ARN, 1200 Allegheny Tower, 625 Stanwix Street, Pittsburgh, PA 15222, 412/288-2139.

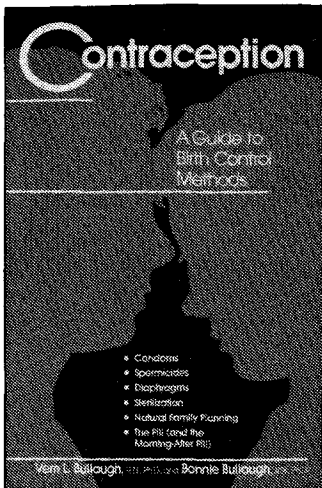
CENTER FOR EARLY ADOLESCENCE'S 1990-91 TRAINING SCHEDULE: "Planning Programs for Young Professionals," *April 10-12, 1991* (San Francisco, California); *May 15-17, 1991* (Boston, Massachusetts); *October 16-18, 1991* (Chapel Hill, North Carolina); **"Living with 10 to 15-Year-Olds: A Parent Education Curriculum,"** *July 10-12, 1991* (Chapel Hill, North Carolina); *July 24-26* (San Francisco, California); *November 6-8, 1991* (Chapel Hill, North Carolina). Contact: Center for Early Adolescence, University of North Carolina at Chapel Hill, Suite 211, Carr Mill Mall, Carrboro, NC 27510, 919/966-1148.

"FAMILIES 2000 — AN ECUMENICAL NORTH AMERICAN PROJECT: AN ENVISIONING EVENT," *April 10-14, 1991.* Sponsored by the Commission on Family Ministries and Human Sexuality of the National Council of the Churches of Christ. Will feature 20 presenters and 16 seminars on Sexuality/Spirituality, Economics, and Education. Congress Hotel, Chicago, Illinois. Contact: Families 2000, Box 603, Wayne, PA 19087; for hotel or travel information call 1-800/438-5828.

FIFTH ANNUAL MEETING OF THE NORTH AMERICAN SOCIETY FOR PEDIATRIC & ADOLESCENT GYNECOLOGY, "ISSUES AND ANSWERS IN PEDIATRIC AND ADOLESCENT GYNECOLOGY," *April 11-13, 1991.* Cosponsored with Jefferson Medical College. Topics will include Puberty and Menstrual Dysfunction; Psycho-Sexual Problems of Children; and Contraceptive Methods. Westin Cypress Creek, Fort Lauderdale, Florida. Contact: Carol Hangacs, Office of Continuing Medical Education, Jefferson Medical College of Thomas Jefferson University, 1025 Walnut Street, Philadelphia, PA 19107, 215/955-6992.

XXIII ANNUAL AMERICAN ASSOCIATION OF SEX EDUCATORS, COUNSELORS AND THERAPISTS (AASECT) CONFERENCE, "BACK TO THE FUTURE," *May 1-5, 1991.* Will focus on increasing practitioners' usable skills and knowledge, while providing a contextual framework for traditional and emerging methodologies related to sexuality education, counseling, and therapy. Workshops, brief presentations, and roundtables will address techniques and applications in education, counseling, and clinical practice. Marriott Pavilion Downtown, St. Louis, Missouri. Contact: David G. Lister, Cynthia Larson, or Celeste Emmens, AASECT, 435 North Michigan Avenue, Suite 1717, Chicago, IL 60611-4067, 312/644-0828, fax 312/644-8557.

THIRD ARAB INTERNATIONAL CONFERENCE ON AIDS, *May 3-6, 1991.* Sponsored by the Medical Scientific Society. Cairo, Egypt. Contact: Conference Secretariat, PO Box 85, Manial el-Roda, Cairo, Egypt, (2) 3625042 or 3623908, fax (2) 3631464.



Contraception

A Guide to Birth Control Methods

by Vern L. Bullough and Bonnie Bullough

This up-to-date sourcebook offers clear, factual, and detailed information on the many birth control options available today or planned for the future. The book begins with an overview of reproductive anatomy and the history of birth control, followed by an in-depth analysis of such current and forthcoming methods as the pill, condoms, natural family planning, sterilization (vasectomy/tubal ligation), diaphragms, cervical caps, spermicidal foams and creams, abstinence, contraceptive hormonal injections, the RU 486 pill, and more. Employing simple, nontechnical language and clear illustrations, each method is evaluated in terms of its success rate; safety; advantages and disadvantages; medical and psychological consequences; and relevant legal concerns.

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Introduction by Mary Steichen Calderone, Ph.D.

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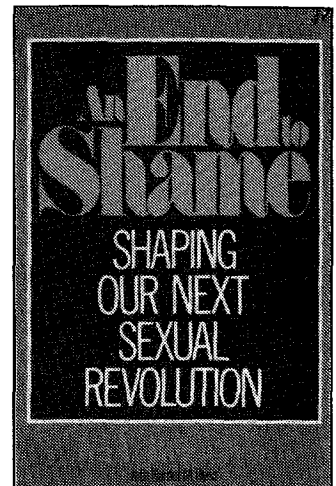
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