SIECUS Report

Vol. 23, No. 2
Dec. 1994/Jan. 1995
Sexuality Information and
Education Council
of the United States

HIV/AIDS: NEXT STEPS IN PREVENTION EDUCATION

SIECUS Report Vol. 23, No. 2
Dec. 1994/Jan. 1995
Sexuality Information and Education Council of the United States

***SIECUS REPORT* STAFF**

Executive Director
Debra W. Haffner, M.P.H.

Director, Program Services
Carolyn Patierno

Editor
Dore Hollander

The *SIECUS Report* is published bimonthly and distributed to SIECUS members, professionals, organizations, government officials, libraries, the media, and the general public. The *SIECUS Report* publishes work from a variety of disciplines and perspectives about sexuality, including medicine, law, philosophy, business, and the social sciences.

Annual SIECUS membership fees: individual, $75; student (with validation), $35; senior citizen, $45; organization, $135 (includes two subscriptions to the *SIECUS Report*); library, $75. *SIECUS Report* subscription alone, $70 a year. Outside the United States, add $10 a year to these fees (in Canada and Mexico, add $5). The *SIECUS Report* is available on microfilm from University Microfilms, 300 North Zeeb Road, Ann Arbor, MI 48106.

All article, review, advertising, and publication inquiries and submissions should be addressed to:

Dore Hollander, Editor
SIECUS Report
130 West 42nd Street, Suite 2500
New York, NY 10036
phone 212-819-9770 fax 212-819-9776

Design and Layout by Alan Barnett.
Proofreading by E. Bruce Stevenson.
Printing by Seaport Graphics & Communications.

Library of Congress catalog card number 72-627361.
ISSN: 0091-3995.

Publications Committee

SIECUS Board of Directors 1995

SIECUS is affiliated with the University of Pennsylvania
Graduate School of Education
3700 Walnut Street
Philadelphia, PA 19104-6216

HIV/AIDS: NEXT STEPS IN PREVENTION EDUCATION

FEATURES

DEPARTMENTS

FROM THE EDITOR

HIV/AIDS EDUCATION: The End of the Beginning

Dore Hollander

Thirteen years, thousands of deaths, and millions of words into the AIDS epidemic, what can be said about HIV/AIDS education? Are HIV/AIDS prevention messages getting across? Do they engage their intended audiences in ways that are meaningful and that motivate people to adopt, or maintain, risk-reducing behaviors? Or are they just the same old messages droning on to the same old audiences and going unheard—have they become white noise?

The many submissions we received for this issue of the *SIECUS Report*—both those that appear here and those that we simply do not have room to publish—made one point very clear: HIV/AIDS prevention is a dynamic science; and the educators, counselors, health professionals, and advocates who practice it do so energetically and with great determination. Prevention strategies are constantly evolving in response to research findings, social change, and the expressed needs of various populations. Prevention efforts are simultaneously expanding in scope—to include a wide range of target groups—and being fine-tuned—to speak as specifically as possible to the concerns and needs of each. Throughout the United States, one can find programs tailored for people who are young, people who are elderly, people who live on the street, people who have disabilities, people who are incarcerated, people who belong to various ethnic or racial groups, and people with different sexual orientations. Education takes place in schools, clinics, and religious settings; at the workplace and community gathering places; and on the street.

Perhaps most encouraging of all, HIV/AIDS educators are demonstrating a strong commitment to improve prevention strategies. As several of the authors in this issue point out, educators and counselors in a variety of settings are recognizing not only their potential for reaching particular groups, but also the limits to what they can expect to achieve. They are seeking out necessary information, implementing innovative teaching methods, frequently reviewing their approaches, and forming alliances with complementary community and professional resources.

Do all HIV/AIDS prevention efforts work all of the time? Do education programs unfailingly produce behavioral, or even attitudinal, changes? Of course not; it would be naive to pretend otherwise. In some communities, despair, discrimination, and ignorance deter people who are in need of prevention or treatment services from availing themselves of those services; in others, these same barriers keep professionals who could be contributing to prevention efforts from doing so. In certain situations, the notion that the message has been told, that it is out there, that we have heard all there is to hear, has produced a dangerous apathy. Indeed, the report of the survey on Americans' sexual lives that was released this fall, with its conclusion that the "general population" is not at substantial risk of HIV infection, will only reinforce some people's conception that those of us who have so far not been infected and who generally avoid risky behaviors are in the clear. In yet other cases, prevention specialists are working to get the message out in the best ways they know how, but still have not found the right way for the people they are trying to reach.

For now, as near as we can come to a solution to this crisis is a sustained commitment to open and flexible, even unorthodox, approaches to prevention education. Such strategies can keep the message very much alive for groups and individuals who have been unserved or underserved, those for whom efforts to date simply have not been effective. As various contributors to this issue make clear, programs that are sensitive to the social and emotional contexts of their clients' lives do manage to draw a substantial number of people into "the system," teaching them the importance of taking responsibility for their health and persuading them, despite their often well-founded resistance, to obtain appropriate services. The HIV/AIDS prevention message is getting across, but the medium must be appropriate.

HIV/AIDS is a major public health concern, and continued work on prevention and treatment strategies warrants the highest priority in both the public and the private sectors. To paraphrase Churchill, who spoke of a very different kind of battle, after more than a decade, we are clearly not at the end, nor even the beginning of the end, of the fight against AIDS. But if prevention efforts are driven by open-mindedness and insight, perhaps we are at the end of the beginning. We hope.

PREVENTION: Imagining the Future

Carolyn Patierno
Director of Program Services, SIECUS

Recently, there has been a lot of talk concerning the past, present, and future of HIV/AIDS prevention education. Entire conferences have been devoted to this subject. This issue of the *SIECUS Report* is dedicated to it. One track of the Tenth International Conference on AIDS and STDs dealt with it. Where have prevention efforts been? Where are they now? Where are they going? These are particularly provocative questions for me. I have been privately—and sometimes publicly—struggling with them for several months now. I have accepted speaking invitations to address these questions because I have thought doing so would finally force me to formulate a cohesive conclusion despite my deep-seated confusion.

The difficulty I have with these questions is that I do not understand why they are still being asked. I find myself responding, "I thought we knew." I thought educators had learned what seems to work. I thought educators knew what might work under the best of circumstances.

I thought educators knew the process that must be followed, the lives and cultures that must be honored. I thought it was now clear that to attack the problem of HIV/AIDS, each community being "targeted" for prevention services must be involved in the development and implementation of a program; that individuals must perceive that their peer groups are supportive of healthy behavior; that information alone does not change behavior; that people with AIDS make magnificent HIV/AIDS educators; and that workers must attend to cultural maladies concerning attitudes toward race, sexual orientation, gender, addiction, power, poverty, and sexual behavior.

I thought the goals of prevention were apparent. It is not likely that a culture will exist in which all sexually active people enjoy safe, pleasurable, sexual lives, or in which the absence of despair or oppression will make drug abuse a thing of the past. At least, however, one can hope that an acceptable treatment for HIV infection is not far off, and that prevention methods will soon be developed that sexually active people can readily embrace with the support of their family and larger community.

So, given all of this, why do these questions keep on arising? Because people—in every age, ethnic, social, and cultural group—continue to become infected despite prevention efforts, and educators and care providers are desperate for an explanation as to why. The problem is especially acute in the gay community, where educators have wanted to believe that programs have worked and there is "no longer a problem."

And yet, perhaps examining the past, present, and future is not enough. This plague, with its perverse mutations, forces a manner of thinking that is equally cunning. There needs to be closer examination of previously ignored or overlooked issues, ranging from personal attitudes that affect prevention work to larger questions concerning approaches. These are the issues I have been struggling with of late.

The Political Correctness Trap

The examination of personal values and attitudes is standard fare in sexuality education trainings. Theoretically, these exercises should never lose their resonance, since culture and, in turn, personal attitudes and values are not stagnant. However, it is an arduous effort to continually challenge oneself regarding one's own racism, homophobia, and sexism—attitudes that affect prevention workers' effectiveness. What is troublesome is the tendency toward believing that because one has been doing AIDS work for a significant amount of time, there is no need to continue this challenge, that the tough issues have been worked out. A vivid example of this shift presented itself during a recent SIECUS training I conducted for sexuality and HIV/AIDS trainers.

This two-day training is designed to offer workers the time to consider both personal and cultural sexuality issues that affect their work. During a portion of the second day that is devoted to issues concerning sexual orientation, heterosexism, and homophobia, I come out as a lesbian so that participants may feel comfortable asking questions. When I first began to do this training five years ago, the response would be perceptible. The nearly audible question was, "Now, why did she have to *tell* us?" The ensuing discussions were challenging, and in evaluations of the training, participants always rated this as a high point. But something very different is happening now.

In the town where this recent training took place, a small group of gay men and lesbians had been meeting for dinner on a weekly basis in their homes. When their sexual orientation was exposed to the larger community, they were all fired from their jobs. Because this town is in an extremely isolated area and employment opportunities are few, most of these people moved away. Given this background, and other information that participants had shared during the first day of the training, I believed that the portion of the training during which I came out would be most interesting and worthwhile.

Yet, when I came out, everyone seemed to know the politically correct thing to say to prove that there was not a problem—this despite the definite discomfort I sensed during the didactic session. I used every trainer's trick in the book to encourage discussion; none worked. But after the presentation, five women from the group came out to me in private. None of them felt safe enough to come out to their colleagues. The message was clear.

"This plague, with its perverse mutations, forces a manner of thinking that is equally cunning."

All of this shows that those who are doing the educating, counseling, care provision, and advocating—including people who are living with AIDS—can never sit back and feel comfortable in the belief that they have it all worked out. This perception only stymies our individual and collective abilities to grow and create more responsive approaches through that growth. Perhaps the sometimes oppressive idea of "political correctness" has stripped away the safety we used to feel in expressing discomfort around the tough issues involving race, gender, and sexual orientation. If one is not permitted to express and discuss these confusions, discrimination remains with us.

Putting Passion into Prevention

Once individual perspectives are clarified, an examination of the larger culture is necessary in order to move forward. Despite a significant amount of discussion concerning cultural competence, cultural differences, and cultural barriers, little discussion has focused on the dynamics of cultural change. Sweeping statements regarding culture and prevention attempt to explain what keeps programs from being truly relevant. Yet, it is becoming ever more apparent that the genuine understanding of these issues is minimal. New partnerships must be forged with professionals accustomed to examining these issues. Cultural and medical anthropologists may be able to offer new insights into the complicated nuances of individual and collective behavior.

Until now, many prevention theories have been reduced to mere sound bites concerning the individual—most notably, the idea that "education is the only vaccine we have against HIV." In an essay on behavior modification entitled "Changing for the Better," HIV/AIDS prevention expert Ronald Valdiserri comments on this interpretation. He writes:

> ...the analogy [of education as a vaccination] always struck me as peculiar. When we receive an influenza vaccination, we don't consciously will our immune systems to produce neutralizing antibodies: it just happens. Nor do we have to remember to use our antibodies against the influenza virus; they are activated automatically. Education, though, is a different kind of health intervention. We can teach people that HIV is transmitted sexually,...but it's possible to know this and still have sex without taking appropriate precautions.[1]

Sexuality does not fit neatly into the health belief model. Passion is less clinical than it is impulsive. Prevention efforts focusing on sexual transmission of HIV must deal candidly with the complications of sexual behavior. This is not the same as the "eroticizing safer sex" models that have proliferated over the past thirteen years. Rather, this approach should build on efforts that support the individual sexual self and identity, and that confront the emotional aspects of sexuality.

Several years ago, SIECUS published a booklet for young people called *Talk about Sex;* we are now adapting and translating it for Spanish-speaking communities. When asked to comment on what may be added to the current version, one member of the advisory committee suggested the concept of romanticism—the emotional aspects of sexuality. HIV/AIDS prevention education overall needs to pay more attention to the emotional and personal difficulties and strengths that either challenge or promote healthy sexual choices. Up to now, prevention initiatives have merely scratched this emotional surface.

Overcoming Reality with Imagination

I have a feeling that one of the most fundamental reasons that questions concerning prevention are emerging at this particular time is that few people would have imagined that this disaster would go on this long. The first *SIECUS Report* article on AIDS appeared in 1982. The title was "What Does AIDS Mean?" It was six paragraphs long. Among the haunting ideas it expressed is a quote from James Curran, then the coordinator of the Task Force on Kaposi's Sarcoma and Opportunistic Infections for the Centers for Disease Control. Curran said, "This obviously doesn't have the proportions of such longstanding public health problems as hepatitis. At least not yet." Thus, Curran, like many early workers in HIV/AIDS, seemed to be feeling some ambivalence—a sense that this was a serious problem, balanced with the near certainty that a solution would be imminent.

As it is becoming more and more apparent that we must prepare for the long haul, it is stunning to realize that the "long haul" extends beyond the darkness that workers have groped our way through over the past thirteen years. Where in the imagination remains the possibility of the light?

But imagine we must. On my desk sits an invitation for a benefit that took place long ago. It says boldly, "Imagine, Demand, and Work for a Cure." Questions to which the answers are already well known will only distract us; unreasonable expectations of prevention efforts will only lead us to conclude that prevention is not working. Imagining might be our most challenging task. Therefore, it should be our focus.

At the Tenth International Conference on AIDS and STDs in Japan this past August, it was striking to repeatedly hear speakers from around the world describe how inspired they feel by the activities in the United States. In addition, it struck me that the challenges faced by educators in Asian and African countries would likely completely discourage the average American worker. Two things became apparent: that as difficult as things may feel in the States, this culture allows for more progressive education than is feasible in most parts of the world; and that in places where the culture is more restrictive, patience and creative programming are what pay off most in the long run.

The long run. The most devastating realization is, of course, that it will never be over. In the last scene of *Longtime Companion,* a kind of dream sequence, all those boys who were by then long gone are running down a Fire Island boardwalk onto the beach, looking so healthy. Imagining such vibrancy alongside the reality of such devastation brings clearly into focus the past and present of HIV/AIDS prevention, and what the future must be.

Reference

1. R. O. Valdiserri, *Gardening in Clay: Reflections on AIDS* (Ithaca, NY: Cornell University Press, 1994): 23.

NEW RESOURCES FROM THE FEDERAL GOVERNMENT

National AIDS Hotline Classroom Calls

The CDC National AIDS Hotline has introduced Classroom Calls, a free service intended to enhance classroom or group discussion about HIV/AIDS. Participants may ask questions about any aspect about HIV/AIDS and how to prevent it; trained specialists provide answers based on the most current information available through the U.S. Centers for Disease Control and Prevention.

Classroom Calls, which require access to a speaker phone for group participation, usually last 15–30 minutes and may be conducted in Spanish and through TTY.

For more information or to obtain copies of a brochure about this service, call the CDC National AIDS Hotline at 800-342-AIDS.

Public Health Service Recommendations on Use of Zidovudine

The publication *Recommendations of the U.S. Public Health Service Task Force on the Use of Zidovudine to Reduce Perinatal Transmission of Human Immunodeficiency Disease* is now available through the National AIDS Clearinghouse. These recommendations were developed on the basis of results from AIDS Clinical Trials Group Protocol 076, which demonstrated that zidovudine administered to a selected group of HIV-infected pregnant women and infected women's infants can significantly reduce the risk of perinatal HIV transmission.

To obtain a free copy of the recommendations, contact the Centers for Disease Control and Prevention National AIDS Clearinghouse, PO Box 6003, Rockville, MD 20849-6003; 800-458-5231. This publication may be reproduced and distributed as extensively as necessary.

REDEFINING HIV/STD EDUCATION

Deborah Schoeberlein
Executive Director, RAD Educational Programs

As the AIDS epidemic continues, it seems clear that the majority of HIV education programs based on traditional educational models have not succeeded in changing the high-risk behaviors of adolescents.[1] As a result, educators are challenged to redefine both the philosophy and the methodology of HIV education. Effective education for the adolescent population must simultaneously reach young people in a meaningful manner and confront the constellation of issues related to AIDS, other sexually transmitted diseases (STDs), high-risk behaviors, and sexuality itself. Feasible and effective HIV/STD prevention education programs are needed to facilitate adolescents' evaluation of their own risks and their subsequent adoption of healthy behaviors.

One approach to providing HIV/STD education with high-quality content and presentation is based upon a partnership between schools and community organizations. The partnership between RAD (Redefining Actions and Decisions) Educational Programs and the Roaring Fork School District in rural Colorado, described here, illustrates this approach.

Partnerships between Schools and Outside Resources

While rural America has experienced such long-standing phenomena as teenage pregnancy and STDs, prevention education seems to have taken low priority, because of the conservative political climate, as well as the social and economic realities of many rural communities. Education and health services for adolescents are often inaccessible; educators are wary of broaching topics that may generate controversy; and schools may assign the task of HIV/AIDS education to teachers who are not adequately familiar or comfortable with the material. Thus, providing better curricula and more staff development training for health educators is simply not enough.

In addition, high-quality content and presentation are relevant only if a school is willing and able to devote time and resources to the provision of HIV/STD education. In an odd break from conventional wisdom, it seems that schools in rural areas are often in a better position to do this than are their urban counterparts. The relative simplicity of establishing an HIV/STD education program in a rural school district allows for time and attention to be focused on all of the challenges present, whereas the complex politics and sheer scale of urban centers often draw attention away from issues of program implementation at the classroom level. Thus, the experience of rural schools offers important lessons about HIV/STD education.

RAD in Rural Colorado

RAD's experience with the Roaring Fork School District RE-1 in the Rocky Mountains of Colorado illustrates a successful partnership between schools and outside HIV/STD education resources. Approximately 2,500 students attend middle and high schools in this district. RAD first worked here informally in 1992, teaching a few classes at the invitation of health teachers who were looking for outside resources in the area of HIV/STD prevention.

The principals became interested in expanding the partnership, in part because of the endorsement of teachers and the obvious interest of the students. Using outside resources also had political appeal: if opposition to HIV/STD education was too great, the school administration could simply refrain from hiring RAD in the future. In addition, the school board eventually voiced support for the use of an outside resource, partly because of the increased comfort level among parents and administrators associated with the use of an "HIV/STD education expert."

The district then contracted with RAD to provide two HIV education sessions per year, starting in the 1993–94 academic year, to each student in five of the six middle and high schools. (The remaining high school had a strong health education program and opted to send a health teacher to be trained to use RAD's techniques on her own.) RAD's classes had an average of twenty-five students and met during regularly scheduled classroom periods (fifty minutes for middle school classes, ninety minutes for high school classes).

RAD provides students with sequential HIV/STD education classes that focus on a variety of related topics. Classes always reinforce the core themes of disease prevention, decision making, and refusal and negotiation skills. Additionally, RAD conducts in-service training for teachers and offers parent workshops before implementing classes.

While RAD instructors see each student only twice, the RAD program may be in a school for a week or more each semester, and this has significant advantages. The presence of RAD instructors increases students' awareness of the importance of HIV/STD prevention. Furthermore, adolescents are highly influenced by their peers on subjects such as sexual decision making and drug use. Therefore, offering a schoolwide program that members of any given social group experience at different times can generate ongoing discussion and heighten awareness of the subject.

Communication-based HIV/STD Education

RAD's approach is based on direct communication between the educator and students. In addition, it facilitates communication between all members of the school community, including parents. HIV/STD education becomes a community issue, not just a topic for certain health classes. Parental involvement is a key element in the program, and the parent workshops both educate parents so that they can be resources for their children, and provide an opportunity for parents to express their concerns and questions, support, or opposition regarding HIV/STD prevention education. In most schools, parents have the option of removing their children from classes if they consider the material inappropriate, and some parents exercise that option. However, RAD's experience suggests that the provision of a parent workshop substantially reduces the likelihood of children's being opted out of HIV/STD education classes.

A combination of outside resources and interested school employees who provide support and information for students can create a successful educational approach to HIV/STD prevention. The outside resource person can provide a sense of anonymity, and consequently emotional safety, for students, as well as serve as a catalyst for ongoing discussion. However, the presence and identification of familiar, permanent, and appropriate school-based resources is critical. Students often require follow-up many days or weeks after the sessions. In addition, reinforcement of the prevention message, from many sources and in many venues, is of great value. The partnership between the Roaring Fork School District and RAD is mutually advantageous: the schools reinforce RAD's programs, and RAD is able to support the efforts of teachers to continue ongoing discussion of issues that may be too politically charged for the teachers to touch on their own.

Interactive HIV/STD Education

Interactive HIV/STD education is based on the philosophy that a successful program must not only teach, but elicit the internalized responses of students to the material presented. It is imperative that HIV/STD education begin with knowledge and skills, because without a concrete context and set of reference points, meaningful discussion of attitudes and behaviors is impossible.

Conventional programs perhaps fail because they do not convey information (knowledge and skills) in a fashion that is relevant to students, and because they do not address adolescents' behaviors or communicate about young people's attitudes in a realistic way. Classes that are too structured—where the teacher sets the agenda and the students can choose to buy in or not, without having the option of participating in creating the agenda—model power imbalances. In contrast, a free-flowing dialogue models communication.

Encouraging students to ask questions increases the likelihood that they will listen to the information a teacher provides. In addition, students will pose the questions *they need to* ask, and they will do so in an order that reflects their priorities. A skilled educator is able to go into the classroom with a variety of techniques, activities, and approaches that can be incorporated into a unique structure that develops during classtime. This may seem challenging, but in fact, it is often much easier to engage in conversation than to impose a lesson plan.

Engaging students intellectually is not enough to make HIV/STD education effective. Rather, students must internalize the multifaceted prevention messages on a variety of levels—emotional, intellectual, and physical. Thus, HIV/STD education must encourage dialogue not just between people, but also between the different aspects of an individual's being.

Although the basic information involved in HIV/STD education is fairly simple, the presentations are often complex. For example, how can teachers effectively demonstrate the interrelationship, direct and indirect, between the use of alcohol and other drugs and the increased risk of HIV/STD transmission? How can educators convey to a child with a history of sexual abuse that abstinence is an individual's rightful choice? How can instructors reinforce the risks associated with unprotected sexual behaviors without presenting sexual activity as synonymous with illness and death?[2] Most important, how can educators provide information and teach skills in ways that become important for the adolescents they serve, and that are acceptable to the adult communities within which the adolescents live?

RAD's experience provides some responses to these questions and philosophical dilemmas. The RAD approach to interactive HIV/STD education has four essential components:

- developing a safe learning environment with clear expectations and implicit respect of students, parents, and teachers;

- weaving core themes and information into a chronology determined by the order of students' questions and comments, thereby honoring students' autonomy;

- incorporating creative activities involving movement that help students connect their mental learning and their physical reality; and

- modeling direct and compassionate communication.

Safe Environment. The question of emotional safety is relevant for students, parents, and teachers, because anyone engaging in an open discussion on HIV/STD prevention will be taking some risk. Part of what makes a class emotionally safe is the balance between structure and flexibility: structure can reduce vulnerability, whereas flexibility encourages confidence and a feeling of investment in the program.

Classes need to be framed in a context that is acceptable to all participants, acknowledging, at the very least, that each person carries a unique emotional history. Beginning a class by spelling out what will, and will not, happen can help diffuse tension about an otherwise threatening subject. In addition, the teacher can explain the health perspective of the class, emphasizing that values and morals will not be taught. Students can preserve their sense of safety by having permission to leave the class and spend the time in designated areas of the school building until they feel ready to be present again. Demanding that students absorb information, possibly against their will, is very different from inviting students to be involved while being respectful of both the importance of the class and the needs of individuals, and has very different results.

Core Themes: Respecting Students' Autonomy. Successful HIV/STD education helps people learn to live with the realities of prevention. Adolescents are often angered by the dangers that surround them and may direct their anger at those people who remind them of the risks in their lives. Many adolescents resent the fact that sexual activity is freighted with risks. Contemporary adolescents compare the negatives associated with sexual behavior today to their somewhat glorified ideas of the sexual revolution of the 1960s. In their comparison, the 1990s version of sexuality is laced with HIV, other diseases, and sexual violence. Somehow, HIV educators must affirm that healthy sexuality is positive, and that protecting oneself is an affirmation rather than a punishment.

RAD defines the core themes of HIV/STD education to include the basics of disease transmission, as well as prevention and risk reduction techniques. In addition, refusal skills, negotiation skills, and communication skills are critical. Finally, focusing on issues related to self-esteem, respect, and personal decision making are essential for an individual to translate knowledge into behavior.

All of these themes can be introduced to young children and can be developed in an age-appropriate manner through ongoing HIV/STD education. A sequential curriculum with consistent presentation styles and booster-style classes that review and reinforce core themes increases student comfort with information. An ongoing program also sends the implicit message that HIV/STD prevention is both a personal and a community issue that demands sustained attention and discussion.

As students get older, their needs change, as does their perception of the relevance of HIV/STD prevention information. For example, discussion of risk reduction techniques such as correct and consistent use of condoms may seem interesting, but unimportant on the personal level, to a sexually inexperienced thirteen-year-old. Three years later, the same individual may have become sexually active and as a result have much higher motivation to learn about condoms and other risk reduction techniques related to sexual behavior. Thus, as an adolescent becomes sexually active, she or he may find greater value in access to prevention information, including instruction in risk reduction techniques. This change in attitude may, in turn, support the likelihood of informed sexual decision making and facilitate the incorporation of risk reduction skills into sexual behavior.

> ***"HIV educators must affirm that healthy sexuality is positive, and that protecting oneself is an affirmation rather than a punishment."***

As adolescents' attitudes and behavior develop, they need increased knowledge and skills proficiency. Information and skills can be taught sequentially in creative and memorable ways that simultaneously establish a knowledge base and set a precedent for future discussions. For example, to teach younger middle school students about the important functions of latex gloves, RAD teachers have the students wear gloves and then, using a felt-tipped marker, draw on the outside of the gloves, simulating blood. The children are fascinated by the gloves and are able to learn about the possible dangers inherent in direct contact between one person's open cut and another person's blood. RAD teachers can also explore various scenarios with the students to emphasize the need for risk evaluation and making commonsense decisions about protection. Finally, the activity can emphasize that the correct use of gloves is a way to show respect for the health and well-being of everyone involved in a risky situation.

For older students who are ready to learn about condoms, this familiarity with the way gloves work as a barrier makes the protective mechanism of condoms easy to understand. Also, the established connection between gloves and respect helps combat the common belief that using a condom could be insulting. Students can see that condoms, like gloves, can provide protection for both individuals, and that both partners share the responsibility to protect themselves and each other.

By itself, knowledge about risk reduction does not immediately translate into behavioral change. Therefore, HIV/STD education must include a high level of reciprocal discussion about why, when, where, and how to use the barriers. Open discussion of risk reduction can reinforce the importance of abstinence from all risky behaviors as a healthy choice, rather than a moral issue. In addition, focusing on topics such as self-esteem and self-autonomy can help to support an individual's confidence in his or her ability to make healthy decisions.

Another example of a core theme that develops with young people as they grow is contained in RAD's Bill of Rights (see box on page 10), which reinforces students' right to make their own choices about their bodies and their health. (The Bill of Rights as presented at the high school level can be modified for younger students.) By affirming adolescents' autonomy, a teacher can gain trust while encouraging young people to believe in themselves.

Interactive Activities. Adolescents generally prefer to evaluate real-life situations for risk rather than be forced to memorize the basics of HIV prevention. For example, the list of fluids that can transmit HIV is much less meaningful to the typical adolescent than is a discussion about identifying the risks inherent in sexual behavior following a party or learning the protocols for responding to an injury on the playing field. Interactive activities, like free-flowing discussions, help convey information in a dynamic manner and often contain clues or key words that can serve as reminders for students in their daily lives.

Interactive activities that teach information about HIV/STD transmission can provide students with an opportunity to gain knowledge not just intellectually but through their experience. For example, in RAD's program, fifth-grade students learn about the effects of HIV on white blood cells by enacting the interplay between the blood cells and the virus: Groups of four students join hands to form a circle, and thereby model a white blood cell. Other students represents HIV and invade the cells. The infected cells die, and the virus is free to invade the remaining healthy cells.

In this activity, students can process information about HIV transmission with a sense of immediacy and personal investment rarely afforded in more conventional programs. The teacher uses the activity to explain how HIV weakens the immune system, and the students participate in an experience that illustrates this concept. In addition, the teacher focuses the students' attention on the importance of preventing HIV.

Interactive activities have a number of advantages. They can shorten the interval between students' intellectual acceptance of information and their behavioral integration of prevention techniques. Also, they may generate laughter or otherwise reduce the tension level surrounding the discussion of sensitive topics. Finally, some elements of interactive activities can be reproduced in other situations, such as among groups of friends, and provide effective tools to help teenagers adopt risk reduction techniques.

Direct and Compassionate Communication. Ultimately, prevention depends on people's ability to accept, internalize, and adopt the concepts, skills, and information presented in comprehensive HIV/STD education programs. School-based HIV/STD education generally provides the primary, and often the only, opportunity for adolescents to learn objective information about these diseases and their prevention. The pure information is critical, but by itself is not enough. Communicating that information in a way that is meaningful and useful for adolescents is the key to successful intervention.

Compassionate communication implies a nonjudgmental attitude and a desire to acknowledge adolescent and adult realities. Because gaining access to adolescents hinges on other adults, educators should communicate with those who have concerns about school-based HIV/STD education. Furthermore, when students hear a compassionate tone, they are more receptive to hearing the content of a statement. In addition, and perhaps most important, compassionate communication models the kind of open discourse that students need to learn in order to express and experience their sexuality in a healthy manner.

Teachers cannot explain compassionate communication. Instead, they should communicate compassionately—by listening to what is being said and responding to all levels of the communication—and hope that students will learn not just from what they say, but from the ways in which they say it.

Evaluation

How can educators know if a particular program approach makes a difference? RAD, like most grassroots organizations, lacks the resources to conduct the kind of longitudinal evaluation necessary to establish its role in behavior change. RAD has used a variety of self-administered evaluation tools, such as presession and postsession questionnaires, postsession evaluations, and evaluations by classroom teachers observing RAD's classes. These evaluation tools have yielded encouraging responses. For instance, student responses have suggested that the RAD program provides valuable information, enhances students' awareness of the risks related to sexual behavior, and increases their confidence in their ability to choose healthy behaviors and to stick to their decisions. At the same time, however, there are limitations to what can be learned from such formats. For example, while RAD has asked students to project their future likelihood of using condoms, it is impossible to verify the actual outcome.

RAD'S BILL OF RIGHTS

The following is an excerpt from RAD's Bill of Rights:

> Your body is your own. You have the right to choose what you do with your body, and this means that you have the right to make choices that will keep you safe(r) and healthy. Sometimes these choices are confusing and making that safe(r) choice often requires commitment. However, you are worth the effort.
>
> In your lifetime, you always have the right to say "no" to sex. You will also have the right to choose to say "yes." This means that it's up to you to decide if, when, where, and with whom you are sexually active. You don't have to do anything with your body that doesn't feel safe to you; no matter who you are with, whether you've done it before, or what you agreed to earlier.
>
> If you say "no" you don't need to justify yourself. You may choose to say why you've made that decision. But, it doesn't have to be "I don't want to because...." —"I don't want to" is enough.

After naming the essential rights described above, RAD's Bill of Rights goes on to explore some of the ways in which people can choose to exercise their rights:

> If you choose to take risks, whether sexually or with alcohol and other drugs, or in other ways, you need to know what the possible consequences might be. For example, if you choose to be sexually active, make that decision as safe as possible—emotionally and physically. Emotional safety means that you and your partner are comfortable with each other and both want to engage in sexual activity. If you feel like you could say "no" and have your statement respected—that's emotional safety. If you feel like you couldn't do that, then you're not in a safe place.
>
> Physical safety is also based on trust, respect and communication. Safe sex only exists in a risk-free, monogamous relationship where both partners are HIV–. Otherwise, the safest choice you can make, from a health perspective, is to not have sex until you reach that safe relationship. But, if you do choose to have sex before you're able to be sure about your partner's HIV status, you need to protect yourselves by using condoms, dental dams, etc.

Perhaps the most important features of RAD's experience are that the subject matter is age-appropriate and appropriately explicit (including discussion of abstinence and risk reduction techniques), and that RAD has enjoyed widespread acceptance and support within schools and communities. RAD's approach to HIV/STD education, which includes programs for youth, parents, and teachers, has been well received by all of these groups. One indication of the level of community support for this program is that approximately 2 percent of students scheduled to receive RAD's programs have been opted out by their parents.

Conclusion

Effective HIV/STD education requires innovation, and innovation has no precedent. RAD believes that partnerships between schools and outside organizations may offer the best option for the provision of truly comprehensive and effective HIV/STD education.

In the classroom, the success of any HIV/STD education program will correspond, in part, to the degree to which students accept the subject matter as personally relevant and subsequently internalize and act upon the presentation's core themes. In RAD's experience, interactive activities play an integral role in facilitating students' integration of knowledge and skills into their behavior and attitudes. Yet, ultimately, the essence of successful HIV/STD prevention education is defined not by information or concepts, but by the presence of direct and compassionate communication between teacher and student, parent and adolescent, individual and individual.

Acknowledgment

The author gratefully acknowledges the contributions of Anne Fitten Glenn and George Stranahan, Ph.D.

References

1. D. Rogers, "Report Card on Our National Response to the AIDS Epidemic—Some A's, Too Many D's," *American Journal of Public Health*, 82 (1992): 522-24.

2. K. Hein, "'Getting Real' about HIV in Adolescents," *American Journal of Public Health*, 83 (1993): 492-94.

AN AGGRESSIVE APPROACH TO TEACHER TRAINING:

A Necessary Ingredient in Preventive HIV/AIDS Education

Elain Edge, M.S.
Educational Consultant, Cutting Edge Associates

During the past few years, as HIV/AIDS prevention education efforts have been concentrating on youth behaviors, teacher training has emerged as an ongoing need. In 1993, the National Commission on AIDS cited a lack of adequate training for teachers and other school staff, and recommended that Congress increase the level of federal resources for training in the sensitive areas raised by HIV/AIDS education.[1] However, this critical need demands attention even if financial support or mandated training does not materialize. If education for youth is to effect behavioral change, teacher training must be a higher priority than it has been in HIV/AIDS education.

As I reflect on my career in teacher training, I realize that many assumptions I have made over the last several years have been false. In what follows, I outline these assumptions, describe how they were disproven, and discuss some of the implications for teacher training.

Assumption: *Most teachers are familiar with basic HIV/AIDS information.* In preparation for facilitating a recent two-day teacher workshop on HIV/AIDS prevention in Iowa, where I used to live, I conferred with a colleague from the state's department of health, who had agreed to present updated medical facts and local statistics at the workshop. We decided it was time to go beyond AIDS 101: after all, we had done countless teacher trainings together in that area, and we thought the teachers who would attend would be ready to learn more advanced teaching strategies. But we had barely begun the first session when one participant interrupted with a question: "What do you mean when you say HIV?" His questions throughout the two days, most of which centered on how he could present material in his industrial arts class, amazed us. Clearly, improved teacher training at the most basic level is a must.

Assumption: *Teachers are not committed to further training.* The same participant disproved this assumption. Every workshop participant is strongly encouraged, but not required, to submit a project reflecting the lessons of the training. I assumed this young man would do a sketchy project at best, focusing on the handling of bloody accidents in the industrial arts classroom. Instead, his project consisted of five lesson plans on HIV/AIDS prevention, beginning with the handling of blood, moving to various modes of transmission, and finishing with role-playing some conversations between partners about safer sexual practices. Not only had he internalized the material discussed in the workshop, he had read the background materials that had been distributed and had incorporated all the information into his lesson plans. In fact, all the workshop participants but one completed projects indicating a commitment to implement improved lessons in their classrooms.

Teachers can and will come through with commitment if they are expected to do so. Teacher training activities should be long enough to warrant at least an hour of college credit, and should include assignments that require participants to synthesize the material and apply it in creative and practical ways.

Assumption: *Most health teachers are becoming comfortable addressing sexuality-related issues.* A teacher center coordinator in charge of health issues asked me to present a six-hour training aimed at increasing educators' comfort level when teaching about sexual issues—my favorite kind of workshop. I was allowed to send her fifteen handouts to be duplicated for participants. When she received them, she called me, panicked. "Elain," she lamented. "There is no way I can use most of your handouts. I would be fired, and you would not be able to do this workshop at all if my administrator were to see the reproductive diagrams, the exercise on recognizing the needs of gay youth, or the condom quiz." In the end, I used most of the material I had planned for the workshop, but not the handouts. And despite some apparent discomfort among the participants, I believe that most came away with a better feeling about covering sexuality-related topics in the classroom. Still, it was evident that several comprehensive health programs avoid covering sexual behaviors because instructors may feel uneasy with the material.

In today's world, knowledge about such sensitive subjects as postponing intercourse, as well as about condom use, is a necessity; teaching youth about sexuality-related issues requires talking to them about these issues. Education programs must not be deterred by the discomfort of some professionals.

Assumption: *By now, caring health teachers realize they cannot provide HIV/AIDS education alone, and are actively enlisting the support of teachers in other curricular areas, helping them to identify and take advantage of teachable moments.* At one workshop, a seasoned health educator from a large school district shared that she alone was responsible for providing HIV/AIDS education; she reached every student with a three-week unit in the required tenth-grade health class. When I remarked that other teachers should be prepared to reach youth in different ways and at different stages of development, she replied, "Oh, that would never work. They just wouldn't do it." Furthermore, she said, the teachers in her district were not prepared to provide any level of HIV/AIDS education, and she did not think they would be open to in-service training covering some of the topics and activities included in the workshop. "They expect this material to come from me," she said. Perhaps—but surely in a faculty of one hundred or more teachers, someone might be interested in helping to reinforce what she was teaching. It is time to create ways for the "experts" in the area to share not only their knowledge, but also the responsibility of reaching young people with more than one shot of HIV/AIDS education.

Assumption: *Administrators are a stumbling block.* I have shared education assessment expert W. James Popham's feeling that school administrators are apathetic and have failed to see the urgency of HIV/AIDS prevention education.[2] But the education programs I have been privileged to conduct with superintendents have disproven that. Rather than spelling out the urgency of the need for education to administrators at training sessions, I have provided relevant materials and asked them to assess the level of need for themselves. As participants examine current statistics and review information on incubation periods, transmission categories, costs of care, and so on, I hear remarks such as, "We don't really have a choice about educating our students."

Maybe the approach of teacher training warrants reconsideration. Maybe school administrators are more receptive to evaluating material on their own than to hearing a lecture. Maybe they learn best in the same ways that students do. Certainly, not all workshop participants go back to their districts and begin explicit prevention education programs, but their comments indicate that they can be supportive of HIV/AIDS education that includes sexuality issues, and that training sessions can help them to think about the possibility in a positive way.

Assumption: *Churches oppose HIV/AIDS education.* When I hear that the churches in a particular area are against educating young people about sexual issues, I ask why. Often, the answer is that clergy think sexual activity should be discussed only within marriage. I know their fears are justified in some cases—but not always. In one workshop, I asked how many church members in the room were willing to let young people die because of withheld information, and no hands went up. At a break, a young woman came to me and said, "Thank you for speaking up about the church. My husband is a Baptist minister, and we want to support factual sexuality information. We get blamed for being anti when indeed we are not."

I agree with the observation of Peter Scales, director of the University of North Carolina at Chapel Hill's Center for Early Adolescence, that educators and clergy have certain points of agreement, including concern about sexually transmitted diseases and adolescent pregnancy.[3] Both schools and churches want children to learn to love and trust, and be able to make responsible sexual choices. No one wants to deny children their cultural and religious heritage, and all who are responsible for educating them want them to develop into caring adults.

"If education for youth is to effect behavioral change, teacher training must be a higher priority than it has been in HIV/AIDS education."

The urgency of preventing HIV/AIDS is too great for schools and churches to waste time and energy arguing about sexuality education. There has never been consensus on many sexual issues, and there may never be, but areas of agreement can be used advantageously. It is time for schools and churches to stop arguing and work together.

Assumption: *Teachers know how to ferret out the truth when presented with conflicting information.* Both during one workshop and in the workshop evaluation, participants expressed confusion about the effectiveness of condoms. One young woman repeatedly questioned my accuracy about condom effectiveness because the statistics I cited differed from what she had read in the newspaper. After explaining the differences between actual and theoretical failure rates, latex and animal-skin condoms, and various studies, I commented that inaccurate or incomplete information is often published because of genuine misunderstanding or to support an emotional feeling. She replied that the article she had read quoted a study by the Centers for Disease Control and Prevention (CDC), so it had to be right. I suggested two ways for her to determine if what she believed was true: she could call the CDC Clearinghouse and ask for the complete article the newspaper had cited; or she could go to the public library, do a computerized search for reports of condom studies, and compare several articles. Another teacher in the group picked up on that idea, and remarked that teachers often do not research issues as well as they should; she was, she said, going to use the idea of a library search to help her students learn about condoms. As psychiatrist M. Scott Peck observes, confusion is a necessary, if painful, stage of attitudinal change, which results when people realize that their previous perceptions may have been incorrect.[4] Perhaps for those who were confused about condom effectiveness, this workshop was the beginning of the process of seeking out more information, or at least of realizing that they needed to reexamine their perceptions.

Doubting adults need to be challenged to distinguish facts from misinformation, and all adults have to be willing to accept the confusion and pain entailed in attitudinal change as new information becomes available.

Conclusion

As HIV/AIDS education proceeds, effective teacher training must continue to be a priority, and professionals responsible for sexuality education must receive appropriate training.[5]

Lobbying efforts for government support of such training for all teachers, and most certainly for health teachers, need to continue. Additionally, schools of education should have required courses on sexuality education. Given the teenage pregnancy rate, sexual harassment and abuse statistics, and the magnitude of the AIDS epidemic, it would be realistic for state governments to mandate sexuality education training for teacher recertification, as they did for human relations several years ago.

Finally, training programs and individual trainers should be able to evaluate the effectiveness of their efforts and willing to adapt their approaches to respond to the various demands of teacher training.

References

1. National Commission on AIDS, *Preventing HIV/AIDS in Adolescents* (Washington, DC, 1993).

2. W. J. Popham, "A New AIDS Agenda," *American School Board Journal,* 180, no. 2 (1993): 39-42; and ——, "Key Points for Evaluators of HIV Staff Development Programs" (Paper presented at the Second Annual Workshop on Research and Development for the Effectiveness of School Health Education to Prevent the Spread of HIV, Chicago, Oct. 11-13, 1989).

3. P. Scales, "Sexuality Education in Schools: Let's Focus on What Unites Us," *Journal of Health Education,* 24 (1993): 121.

4. M. S. Peck, *The Different Drum: Community Making and Peace* (New York: Simon and Schuster, 1987).

5. National Guidelines Task Force, *Guidelines for Comprehensive Sexuality Education: Kindergarten–12th Grade* (New York: Sex Information and Education Council of the U.S., 1991).

"HARD FACTS" POSTERS AND PAMPHLETS

The Bureau for At-Risk Youth has published a series of posters and pamphlets featuring "hard facts" about current topics facing young people, including teenage pregnancy and HIV/AIDS. The posters are designed to provide maximum impact while promoting discussion, prevention, and safety; the accompanying pamphlets contain additional information that support the posters' themes. These materials can be used in the classroom, as giveaways at health fairs, or in prevention campaigns.

For more information or to receive a free buyer's guide, featuring these products and hundreds of other posters, publications, programs, and videos, contact the Bureau for At-Risk Youth, 645 New York Avenue, Huntington, NY 11743; 800-99-YOUTH.

LESSONS FROM THE STREET:
Outreach to Inner-city Youth

Jeanne Kalinoski, M.A., R.N.
Director, HIV Services
Planned Parenthood of New York City

Caitlin Rothermel, M.A.
Senior Coordinator, Institutional Giving
Planned Parenthood of New York City

Today in the United States, approximately 1.5 million young people live on the streets.[1] Most are homeless, having run away from home or been cast out by their families. In large part, these young people hold only tenuous attachments to society; many have never experienced any semblance of interactive, familial life. They generally have limited education and social skills, and they frequently are dependent on drugs, as their parents often were before them. In New York, these teenagers live in neighborhoods where drug use, street sex work, HIV infection, and violence rates are among the highest in the city. Most of them have been victims of or have participated in shootings, stabbings, and gang activity.

Street workers, who represent only a small fraction of prostitutes in the United States, generally earn less money, work under conditions significantly more dangerous and stressful, and have higher rates of drug abuse than other prostitutes. Young street workers are a forgotten population—rarely included in social service planning efforts and outreach, and completely neglected in health care debates. The stigmatization of sex work, homelessness, and drug use, combined with fears of legal reprisals, of being forcibly returned home or delivered into foster care, and of being treated harshly by medical and service providers, makes this population highly resistant to conventional health care and counseling programs.

In many ways, and despite their hard-won survival skills, these teenagers remain unable to take care of themselves—even to the extent of lacking the most basic knowledge of personal hygiene. Many of them are uninformed regarding the practices of safer sex, refuse to believe they need to practice safer sex, cannot afford condoms, or simply refuse to adopt healthy behaviors. They decline typical interventions, and almost never seek services on their own. It was in response to the needs of these young people that Planned Parenthood of New York City launched Project Street Beat in 1988.

The Program

Sex workers, particularly on the streets, are perceived as "reservoirs of infection"—public health risks, who spread HIV, other sexually transmitted infections, and tuberculosis to their clients. It was to curb this "threat" of rampant infection and reinfection that street outreach programs were designed, embraced, and funded with great zeal in the late eighties and early nineties. The expectation, whether stated or not, was that these programs would funnel street youth into medical and rehabilitative programs, convincing them to leave the life of the streets behind for more appealing alternatives.

However, Project Street Beat was implemented in response to the overwhelming and unmet needs of these clients, not in response to the public health outcry. Street Beat is a comprehensive program and, as such, has multiple goals. Its principal aims are to integrate HIV/AIDS education, prevention, and treatment into all facets of its services; and to give clients primary and reproductive health care, counseling, and referrals, as well as needed supplies. Outreach staff strive to identify and serve—not decide upon—the most pressing needs of program clients. This perspective enables Street Beat to achieve its goal in a nonrepressive and nonchastising manner.

Three evenings a week, Street Beat's thirty-one-foot mobile medical clinic—equipped with an examining room, shower, kitchenette, and meeting room—travels the streets of the South Bronx, Brooklyn, and Queens. On other nights, staffed minivans provide outreach, services, and referrals. To initiate contact, Street Beat staff seek out homeless youth, providing on-the-spot counseling and primary and reproductive medical care, as well as material aids such as food; clothing; condoms; and "Dignity Packs," consisting of a toothbrush, toothpaste, comb, soap, washcloth, and other personal care items. These vans are the program's primary method of outreach, and provide the only effective way of contacting and serving this population. Typically, they travel from five in the evening to midnight, stopping at designated locations where people congregate. However, staff regularly adapt this schedule to meet the needs of clients, whose communities are subject to police sweeps and turf wars, greatly affecting the places and hours of day in which clients can congregate.

The program's methods for establishing client-provider relationships are based on the realities of clients' lives, and are therefore not modeled after established, traditional strategies. Street Beat quickly learned that it could not offer discrete HIV/AIDS education and treatment services and expect results. Therefore, the project integrates HIV/AIDS information into every programmatic component. Clients who approach the Street Beat vans for advice, supplies, or treatment also receive HIV/AIDS information. Staff are thus able to conduct ongoing, nonthreatening HIV/AIDS-related discussions—making the issue inescapable, yet not oppressive. This method was specifically designed to convey two messages Street Beat clients do not frequently hear: that their lives have meaning and are worth protecting; and that to protect themselves, they must take personal responsibility.

Integration is key in attempts to reach these clients, who have typically experienced social service agencies as places that do not attempt to seek them out or establish genuine relationships, but rather distribute condoms and advice on a "one-shot" basis. These clients are also considerably less reliable than other underserved populations. Client-provider trust can be established only through repeated connections on the street. To be effective, Street Beat staff must be patient, flexible, and even unorthodox in adjusting to clients' needs. These relationships can be frustrating, both initially and throughout, and emotionally unprepared providers may have difficulty coping with them. (The program helps staff develop their coping skills through support groups and in-service presentations that address the realities of their work.) But outcomes can be rewarding: Street Beat's clients come to understand that the program is a presence that is not going away, and that will provide assistance and comfort they would be unlikely to find elsewhere. Some clients have told Street Beat staff that the connections they have established within the program have been the first they could ever count upon. Project Street Beat is a special program because it strives first and foremost to make human contact and to honor the dignity of individual clients.

A vital component, which ensures that the project can achieve longer-term successes, has been the establishment of Street Beat office sites in each borough in which the program operates. These sites provide case management, group peer counseling, and rap groups. Staff regularly remind clients of the offices' services and are often able to convince clients to take advantage of them. After regular attendance, some clients begin volunteering their time at the Street Beat office. In taking these steps, clients begin coming together with others in a positive way, and honing their social skills.

The Population

In six years' work, Project Street Beat has been able to construct illuminative profiles of discrete client groups. Not all clients are teenagers; some are the "typical" homeless—people of different ages who were doing okay until something in their lives went wrong.

However, Street Beat primarily serves another group of clients, who are enormously distinct from the "typical" homeless. Consider Eddie and Lucinda:

> Eddie is a sixteen-year-old high school dropout with no permanent address. He occasionally spends the night at his aunt's apartment, but usually stays with friends. His mother died of AIDS; his father died of a shotgun wound. Initiated into a gang two years ago, he has been beaten severely and carries a gun. He has experimented with injection drugs and drinks regularly. He does not consider himself an addict. Eddie became sexually active at the age of eleven and has had multiple partners. He never uses condoms. Although he comes to the Street Beat van for food and warm clothes, he is resistant to discussions about risk reduction. He declares that today is all that matters. Eddie does not expect to live to old age, and expects to die violently.
>
> Lucinda, age fourteen, was born in a city hospital; her mother was a sex worker and an addict. Born addicted and with mild brain damage, Lucinda had to remain in the nursery for several weeks. Through her childhood, she was fed erratically and sometimes not at all. Her mother ignored Lucinda most of the time, and regularly brought home men, some of whom were violent toward Lucinda and her mother. Lucinda was also sexually abused on a regular basis by a neighbor. When she started school, Lucinda found that no one noticed whether she went or not. So, for the most part, she did not attend. As a result of this and her extremely limited interaction at home, she developed very poor verbal skills. Lucinda never received any genuine affection, praise for having done something well, or age-appropriate discipline.

Clearly, the Street Beat van—with staff offering microwaved spaghetti, a jacket for the cold weather, and lessons on how to use a condom—is not a solution, but only a small beginning. The initial care

Street Beat provides is 5–15 minutes of comfort, and then clients return to what they have long known. The project has to confront extraordinary barriers as it carefully and creatively works to get clients connected to medical and entitlements systems, and enlists and encourages them to consider issues related to the prevention and treatment of HIV/AIDS.

Resistance to HIV-related Issues

Street Beat clients face some of the same barriers to obtaining HIV testing and treatment as other populations, but they also face some unique obstacles.

Denial. Many Street Beat clients are simply unable to perceive themselves as at risk. They claim to always use condoms, or say they do not share injecting drug paraphernalia. Denial of this sort is a problem among many populations, but it is the norm among Street Beat's clients. Whether project clients are adolescents or adults, their emotional and intellectual maturity frequently does not correlate with their age. Their "perceived perception" is skewed because of their chaotic upbringing, and their residence in the streets continues to compromise their ability to begin the process of normal emotional development. It therefore is extremely difficult to present this material in the context of personal risk and have the message be heard.

Survival. On the street, these clients will do whatever they must to survive, including engaging in high-risk behavior. For example, a sex worker will agree to accept extra money from a client if a condom is not used.

Addiction. A large number of Street Beat clients are drug-addicted. When high, an individual may make inappropriate choices around high-risk behavior. In addition, when clients are high, they often literally cannot hear an outreach worker's voice. Frequently, clients do not even remember what they have done when high. Street Beat's educational efforts are in constant competition with addiction.

Violence. Like Eddie, many of Street Beat's clients do not think they will live to an old age—and AIDS pales in comparison to some of the violence they have seen. Clients have told staff that since they do not think they are going to live long, they see no value in doing "middle-class" things, such as using condoms. Street Beat's offers of health maintenance and preventive care—and the gains to be made through eating well, stress management, and "clean living"—ring hollow to these clients.

Emotional Burdens. Many of Street Beat's clients are ambivalent about the value of taking the HIV test. Most pervasive are feelings of hopelessness and betrayal. Even clients who learn the "rules" of safer sex frequently see no reason to implement them, feeling they have nothing to gain. They have little sense of responsibility to society, and in a sense, this seems only logical, because society has taken so little responsibility for them. Even clients who take the HIV test can expect little in the way of assistance or care from society at large.

When Clients Take the HIV Test

It is frequently difficult to find Street Beat's clients following testing. Therefore, even the relatively basic task of delivering test results can become a long-term process. Furthermore, upon hearing their test result, some clients may not understand its meaning. Or the complex set of resistance issues may emerge, making clients unwilling to take further action. There is also the potential that clients will become angry and act out, increasing the risk to the rest of the client population, as well as to other populations with which they interact.

However, if a client does desire further intervention, the problem travels beyond the scope of the Street Beat sphere. The question becomes, Now what? Hospitals and clinics do not really want Street Beat clients, who cannot pay and are perceived as a drain on scarce resources. Public assistance is of little use to many Street Beat clients, and the inadequacies of the Medicaid system are clear when viewed in light of their needs. Street Beat's homeless clients cannot access Medicaid. They also frequently reject coverage out of hand, as it would require them to provide their full name or other information they do not want to reveal.

These systemic lacks raise a complicated moral dilemma: If there are few comprehensive HIV-related services for Street Beat to refer clients to, what is the benefit of street outreach, testing, and education? What happens when, after telling someone that he or she is HIV-positive, staff cannot offer any connections or assistance beyond the basic primary and reproductive care that the program is already providing? Programs like Street Beat were expected to facilitate street youth's entry into the system. What is to be done when it is impossible to fulfill this mandate? And the question to the public and policy makers is, What will be done to address this public health issue?

To respond in part, Street Beat has forged strong intra-agency linkages with community-based organizations, health care facilities, religious institutions, drug rehabilitation programs, and the like. These linkages constitute the first step in creating coalitions.

A more significant response is needed—street outreach alone is not the answer. Programs such as Street Beat are merely the foundation of what must be a larger structure. Street Beat has been very successful in gaining trust among clients, in delivering its message of HIV prevention and treatment, and in preparing clients to work within the system. But for many clients, Street Beat continues to be all that they have, and the only place they can go.

Street Beat's crucial lesson is that no one program can do it all alone. Multiple programs, working either collaboratively or in tandem, must share their successes and lessons. They must also advocate vigorously, as a body, for the need not only to restructure the health care system, but to direct the health care debate toward the needs of these individuals. Street youth are the orphan children of the entire system and, most likely, the population that will be among the 1–2 percent not served in any proposed 98 percent health coverage plan.

What Street Beat Has Learned

Providing effective HIV/AIDS education remains one of the biggest challenges to outreach programs. The staff of Street Beat, the frontline experts, have learned valuable lessons in promoting risk reduction behavior.

Being Informed. Staff providing HIV/AIDS education cannot be effective if they are inadequately informed. Too often, amid the rush of efforts to get the message out, and owing to the paucity of dedicated, fully trained providers, individuals have become designated as AIDS educators because they have attended the most basic course, cared for a loved one with AIDS, or done volunteer work for "the cause." This background may be useful to them, and to the program they serve, but it must serve merely as the foundation for their ongoing education. Consistent training and reeducation—provided by the agency itself or through outside experts—is essential to ensuring that staff are truly informed and their interventions reliable.

Understanding Clients. HIV/AIDS education strategies need to be tailored to specific populations. It is difficult and destructive for educators to serve clients if they are unfamiliar with their clients' culture and community—or if they are saddled with opposing social attitudes or values, or with personal, unresolved emotional issues. While it may be argued that individuals from the target population are the most effective educators, those who have worked to become comfortable with and knowledgeable about these clients' issues can also be successful teachers.

Being Consistent. The chaos of the inner city erodes clients' lives. For many street youth, the Street Beat staff bring a consistency that they can find nowhere else. They start to listen when the van shows up regularly; staff faces become familiar. This consistency signals caring—and when these vulnerable young people know that someone cares, they may be willing to reexamine their risk behavior.

Giving Something to the Client. No educator can make breakthroughs if clients are hungry, cold, or dirty. Providing Dignity Packs, clothing, and food attends to client's immediate needs. Offering comfort is a way to demonstrate the genuineness of the staff's intentions.

Integrating HIV/AIDS Education. HIV/AIDS education alone significantly benefits individuals who are in need of facts. However, street clients need much more. By weaving HIV/AIDS information throughout many facets of a comprehensive program, Street Beat provides this message on multiple levels. HIV/AIDS education therefore becomes associated with the consistency, comfort, and care that Street Beat provides. Hence, this educational process occurs on the clients' own terms, and in synchronicity with their own efforts to restructure their lives.

Remaining Barriers. Street Beat is an example of effective community-level HIV/AIDS education. However, barriers to reaching all clients remain.

As Eddie's and Lucinda's stories illustrate, HIV/AIDS education cannot break though despair. Fundamental societal changes are needed before these individuals, emotionally crippled by the circumstances of their birth, can accept and benefit from the offer of help.

Furthermore, while the literature is rife with HIV/AIDS-related research, there is a dearth of empirical evidence concerning the target population—for example, data that could help HIV/AIDS educators understand how Eddie can overcome his sense of hopelessness. In addition, more research is crucial if program planners and policy makers are to quantify the factors that make HIV/AIDS education and outreach to this population most effective.

Conclusion

Street Beat was developed in response to client need. As the program has matured, and modifications and expansions have been implemented, this client-driven focus has remained a guiding principle. To be successful, street outreach programs must be willing to address their clients' agendas and time frames by adapting to their needs. They must be willing to accept that programmatic goals, accomplishments, and methods will sometimes run contrary to the interests or expectations of the funding community and society at large. Therefore, they must accept their inevitable, dual responsibility—as educators both of street youth and of the public.

In the midst of programmatic discussion, it cannot be forgotten that Street Beat's clients are individuals, with agendas of their own. If Street Beat and similar programs are to fulfill the range of client needs, the public and private sectors must reevaluate their commitment to these youth. Doors to needed services must be opened, this "forgotten population" must be spoken about, and their futures must be made a collective responsibility.

Reference

1. G. C. Luna and M. J. Rotheram-Borus, "Street Youth and AIDS," *AIDS Education and Prevention,* supplement (Fall 1992): 1-13.

HIV PREVENTION AND OLDER PEOPLE

Gregory Anderson, M.S.W.
Supervisor of Individual Services,
SAGE (Senior Action in a Gay Environment)

In the first decade of the AIDS epidemic in this country, most of the research was aimed at the search for a cure or a vaccine to prevent HIV infection. The last two international conferences on AIDS, in Munich in 1993 and in Yokohama in 1994, have revealed that the focus of research in the 1990s will be on the development of drugs to prolong life in the absence of a cure or vaccine.

What research has gone into the development of education and prevention strategies has targeted primarily younger groups at risk for HIV infection. Even though older adults now account for 10 percent of persons with AIDS in this country, little attention has been devoted to understanding the risk factors for older adults and to developing appropriate outreach, education, and prevention strategies.

The first comprehensive study of risk factors for older adults, conducted by Ron Stall and Joe Catania of the Center for AIDS Prevention Studies at the University of California at San Francisco between 1990 and 1991, was published in the *Archives of Internal Medicine* in 1994. Stall and Catania studied a cross-section of heterosexual and homosexual adults between the ages of fifty and seventy-five, and found those with one or more risk factors for HIV infection—injection drug use, transfusion, history of hemophilia, multiple sexual partners, or a primary partner with one or more risk factors—to be about one-sixth as likely to have used condoms during sexual activity and about one-fifth as likely to have been tested for HIV as a comparison group in their twenties.[1] Clearly, the AIDS prevention message has not reached the older population. To slow the new infection rate among older adults, a well-researched and well-funded message must be formulated that can bring awareness of risk factors and risk reduction to all older Americans.

In a previous *SIECUS Report* article, Karen Solomon of Elder/Family Services and I reported on two models being used to educate older adults in social service settings.[2] Elder/Family Services, in Brooklyn, New York, provides mental health and case management services to people over the age of fifty-five who either are HIV-infected or are caring for someone who is. The agency's case managers have found that individual or family counseling sessions provide a valuable forum in which to integrate AIDS education and risk reduction strategies into older persons' lives. Providing vital HIV prevention information in a context that values cultural and generational beliefs improves the chances that such information can be internalized and lead to a reduction in risk behaviors. Unfortunately, such a model currently reaches only a small number of clients in a handful of agencies.

In 1990, as part of a state-funded program to offer HIV/AIDS forums in publicly funded senior centers, SAGE (Senior Action in a Gay Environment), a New York City–based social service and mental health agency for gay and lesbian seniors, developed a curriculum for educating older adults on HIV/AIDS in congregate settings. During the program's two years of operation, SAGE reached more than 3,000 seniors with up-to-date HIV/AIDS information that carried a strong prevention message. Avoiding many of the myths about sexual behavior among older adults, the SAGE model is particularly effective in communicating the realities of HIV prevention in a nonthreatening and nonjudgmental fashion. Unfortunately, after two years, the state funding was not renewed, and the agency has been unable to find other sources of support for this kind of preventive outreach work. At this time, it is apparent that HIV prevention work for older adults is still considered a low priority for funding. Until the efficacy of such work can be qualitatively demonstrated, it will remain so.

Risk Factors

Stall and Catania's research confirmed that the risk factors for older adults are the same as for younger persons, although they may be distributed differently among older persons.

Injection Drug Use. The literature on substance abuse documents that injection drug use drops off significantly after the age of fifty, but a small proportion of users—presumably, those who have a history of "cautious" use—continue to inject drugs even after that age. Although "cautious" users are relatively unlikely to share needles, they are at risk for HIV infection whenever they do so. Needle exchange programs are effective in lowering new infection rates among injection drug users, but the extent to which older users participate in these programs is not known.

In some cases, needles are shared "accidentally." An incident was reported in New York City involving an older diabetic who, to save money, was reusing her insulin needles. This woman, who was caring for her sixteen-year-old orphaned grandson who was HIV-positive, was infected because her grandson was using her syringes to inject himself with street drugs. Although accidental needle sharing appears to be rare, infection by this means should be avoidable. Many older people still misunderstand the mechanics of HIV transmission, and it is possible that comprehensive information on infection control could have prevented this case of HIV infection.

Transfusion and Hemophilia. Older people are the greatest consumers of blood products in our society. Prior to 1985, when testing of the blood supply for HIV began, many older adults were infected through transfusions. Physicians and other health care providers, unprepared to look for HIV infection in their older patients, misdiagnosed many cases, attributing the early symptoms of HIV infection (fatigue, weight loss, loss of appetite, and swollen lymph glands) to the normal aging process.

An opportunity for HIV prevention was thus blindly passed over. Furthermore, many of the early recipients of tainted blood went on to infect their partners because they had never been provided with information about safer sexual practices. At a time when the gay male community was developing standards for safer sex behavior, the aging community was not targeted even though it was very much at risk. At a time when geriatricians could have been advising their patients of the risks of unprotected sexual activity, many were silent on the subject.

Most of the first generation of older HIV-infected adults have died from the illness by now. Little is known about the infected partners they left behind, but there are stories of older men and women living with shame and fear, many not knowing whether they are infected or not.

Sexual Behavior. The myth that people become sexually inactive as they age has produced dreadful consequences in the age of AIDS. The highest risk for HIV infection for older adults at this time is from sexual behavior, and serious examination of the issues of sexuality and aging has only just begun. Preventing the further spread of HIV in the aging population will require creative strategies based on the realities of the sexual lives of older adults.

As important as it is to recognize that many adults enjoy rich, rewarding sexual lives well into old age, it is also important to understand that aging can bring on significant physiological and psychological changes that can increase an older person's vulnerability to HIV infection. Postmenopausal women experience a gradual drying of the vagina and a thinning of the vaginal wall, which can make a woman more vulnerable to injury during intercourse and, subsequently, more susceptible to infection if her partner is HIV-infected.[3] Older men often experience erectile and ejaculatory problems that may be associated with aging or with other health problems—for example, hypertension and diabetes. Heterosexual men, who have been led to think of themselves as completely invulnerable to HIV infection through vaginal intercourse, may find themselves turning to riskier sexual practices if their penetrative powers decline. I recently spoke with a seventy-year-old widower whose sole sexual pleasure was performing cunnilingus on sex workers. He had never considered the possibility that this activity could put him at risk for HIV, and he was nonplussed when I suggested that he use barrier protection (dental dams) in the future.

"... a well-researched and well-funded message must be formulated that can bring awareness of risk factors and risk reduction to all older Americans."

It is equally important to remember that older adults were socialized at a time when sex was not a household word. Many have demonstrated to me not so much prudishness, but a lack of familiarity with the language of feelings on the subject. What I hear from older adults is that it is difficult to talk about sexual needs and interests with a new partner. A seventy-five-year-old widow described to me the frustration she experienced in negotiating the complexities of sexual activity in a new relationship. Having been married to the same man for more than forty-five years, she was reluctant to discuss the mechanics of sexual behavior—let alone the vagaries of safer sex practices—with her new partner. She had sufficient information about safer sex; she simply did not know how to use it. Today's seniors are very familiar with condoms, but may be out of practice using them and unwilling to bring a discussion of them into the bedroom.

Creating Workable Models for Prevention

The task of helping older people integrate HIV prevention strategies into their lives is enormous. The fundamental premise must be that HIV education is the first step toward HIV prevention, and that every older American is entitled to comprehensive and culturally sensitive information. Risk reduction will take place if older adults are made aware of the risks and are shown ways to prevent infection.

Comprehensive HIV education for older adults can take place in a variety of settings. The individual or family counseling session and the HIV/AIDS forum in congregate settings are two models. But HIV education is not a one-shot deal. Recent research has shown that some gay men, who were heavily targeted in the 1980s, are having trouble maintaining risk reduction in the 1990s.[4] Behavioral change in the area of sexuality will not be accomplished in forty-minute forums. Educators need to be committed to long-term, comprehensive methods.

Service providers in the aging network can perform a vital role by using their community-based agencies to provide HIV information for their clients. City and state health departments, as well as federal-level agencies, could provide technical support and the kinds of high-impact media representations missing so far from the HIV message. Safer sex posters and brochures are everywhere to be found in our society, but rarely do they show aging faces or wrinkled bodies. It is not surprising that older people still do not see themselves in the HIV prevention message.

It has long been clear that sexual health is an important component of an individual's medical picture. For an entire generation of older adults, the problem of discussing matters of sexual health with one's physician has been enormous. In addition, most physicians today have difficulty taking complete sexual histories of their patients, especially when the patients are older than they are. Only in the past twenty years have the nation's medical schools begun to provide students with even rudimentary sexuality education. Nevertheless, the physician's office is an appropriate setting for HIV education. Medical schools and programs for geriatric medical education need to better equip future physicians and other health care providers to deal with HIV, and its prevention, among older people.

Reaching significant numbers of older adults with the HIV prevention message will entail exploring creative venues—the widows' support group at the senior center, the seniors' bowling league, the Golden Age clubs at community centers and churches. Wherever seniors gather, the HIV message must be visible, accessible, relevant, and respectful.

References

1. R. Stall and J. Catania, "AIDS Risk Behaviors among Late Middle-aged and Elderly Americans," *Archives of Internal Medicine,* 154 (1994): 57-63.

2. K. Solomon and G. Anderson, "AIDS and Older People: Two Educational Models," *SIECUS Report,* 21, no. 5 (1993): 13-15.

3. L. Barbach, "The Pause: A Closer Look at Menopause and Female Sexuality," *SIECUS Report,* 21, no. 5 (1993):1-5.

4. New York State Department of Health, AIDS Institute, *Risk of Sexually Transmitted HIV Infection* (Albany, NY, 1993); and W. Odets, "AIDS Education and Harm Reduction for Gay Men: Psychological Approaches for the 21st Century," *AIDS & Public Policy Journal,* 9, no. 1 (1994): 3-15.

CALL FOR PAPERS

For the book *Cross-cultural Perspectives on AIDS Education,* the editor seeks articles on historical, pedagogical, epidemiological, treatment, preventive, legal, economic, cultural, and sporting issues regarding AIDS.

Authors should follow APA style and submit one printed copy and a WordPerfect 5.1 disk. Please address inquiries and submissions to Dr. Davidson C. Umeh, Department of Physical Education and Athletics, John Jay College, City University of New York, 899 Tenth Avenue, New York, NY 10019; phone 212-237-8397; fax 212-237-8901. The deadline for submissions is June 15, 1995.

AIDS IN THE WORKPLACE

Laurel A. Pickering, M.P.H., C.H.E.S.
Associate Director, New York Business Group on Health

In a variety of ways, the American workplace is vulnerable to the consequences of the HIV/AIDS epidemic. Persons aged 15–44, who are at greatest risk for contracting HIV, make up over 50 percent of the U.S. work force, and they spend about one-third of each workday in the workplace. Also, the most sexually active segment of the U.S. population is in the work force.[1] Research by the New York Business Group on Health shows that employers are the most credible source of health information to employees.[2] Nevertheless, well into the epidemic's second decade, HIV/AIDS in the workplace—and ignorance about it—still fosters discrimination, anxiety, and discomfort among employers and employees. Many companies have responded to the epidemic by creating HIV/AIDS policies, training managers and supervisors, or developing educational programs for their employees. Many more, however, have upheld the prevailing view among employers that HIV/AIDS does not affect them.[3]

Next Steps for Companies That Have Not Yet Addressed HIV/AIDS

Companies that have not yet addressed HIV/AIDS should develop an AIDS policy, offer training for managers and supervisors, and provide employees with information to dispel fears and ignorance.

HIV/AIDS Policy. An HIV/AIDS policy outlines a course of action for an organization to follow when an employee has HIV/AIDS. Such a policy should emphasize flexibility and should cover the following:

- *Time Off.* Employees with HIV/AIDS require time off for physicians' visits and illnesses. These needs may vary, and the employer is not expected to pay for all this time. Flexible sick leave and flexible scheduling are important.

- *Job Accommodation.* The 1990 Americans with Disabilities Act includes HIV infection in the definition of disability and requires employers to make "reasonable accommodations." Employers should review each case for job adjustments or reassignments that may help the employee function in the job. This may include permitting the employee to work at home, providing more breaks, arranging job sharing, using labor-saving equipment, or transferring the employee to a position that is less labor-intensive.

- *Confidentiality.* Just as with other medical information, the diagnosis of HIV infection must be kept confidential by the employer. The HIV/AIDS policy should contain a statement regarding confidentiality.

- *Provisions for Caregivers.* Employees who are caregivers of people with AIDS require similar compassion and flexible arrangements.

- *Medical Overview.* Employers may also want to include basic information about how HIV is—and is not—transmitted.

Management Training. Managers and supervisors must be trained to deal effectively with employees who are HIV-infected. It is essential that managers and supervisors be prepared to execute the company's policy and address the effects of an infected worker's presence on productivity and morale of coworkers. Managers who have experienced HIV/AIDS in the workplace have said that it demands much more than what is usually taught in a seminar or training program. When faced with "real people doing real work in real organizations," managers are often unprepared.[4] As a result, businesses often call upon organizations such as Gay Men's Health Crisis in New York City to provide one-on-one counseling for managers who are having problems dealing with an infected employee and coworkers. Although this approach may not be as cost-effective as training managers in a group, it is often a necessary tool.

Educational Efforts. Various educational strategies may be used in the workplace, ranging from distributing informational materials to providing a comprehensive program. Organizations can disseminate information in newsletters, on bulletin boards, in pay envelopes, or in libraries. Comprehensive programs can include a video presentation, a discussion led by a health expert, and backup counseling and referral. Companies often engage an outside organization (such as the American Red Cross) to conduct an on-site program. These programs can be onetime or ongoing.[5]

Next Steps for Companies That Have Already Addressed HIV/AIDS

If an organization has already addressed AIDS in the workplace, through either policy development, manager and supervisor training, or education, it must continue to do so. This is important for two main reasons. First, organizations are constantly hiring new employees, whose levels of knowledge regarding HIV/AIDS may vary. Second, since the AIDS epidemic is many years old, the media have covered it extensively, and AIDS and other health organizations have aggressively distributed the HIV prevention message, many people assume that by now, knowledge of the facts about AIDS is universal. Yet, this is not true, and employers must be careful not to make this assumption. Employees who do not know the basic facts about AIDS may be afraid to express concern, show their ignorance, or ask questions. For those who do have an understanding of AIDS, their fears may override knowledge. Therefore, the employer must continually provide a venue that is safe and encouraging for employees to have their concerns addressed and questions answered.

Activities and Resources

Community HIV/AIDS organizations can help meet the need of employers in their area by providing HIV/AIDS education programs for employees, managers, and supervisors. By contacting area employers, local HIV/AIDS organizations can determine whether the issue has been addressed and offer assistance in providing education. Meanwhile, businesses should call their local HIV/AIDS organizations to get more information on how to educate their employees in order to prevent any disruption in the workplace and facilitate the dissemination of this important public health message.

The U.S. Centers for Disease Control and Prevention (CDC) has developed an initiative known as Business Responds to AIDS (BRTA), whose goal is to encourage HIV/AIDS education in the workplace. One of the cornerstones of the program is a partnership between business and labor, as represented by corporate executive officers and presidents of union and trade associations, respectively. An integral component of BRTA is a resource service housed at the National AIDS Clearinghouse. Experts at the resource service are available to provide materials, community referrals, and other technical assistance. Kits for labor leaders and for managers with information on developing workplace policies, implementing employee education programs, and additional resources are available through this service. The resource service has been shown to facilitate the implementation of HIV/AIDS education programs, by either improving their comprehensiveness or actually "getting them off the ground."[6]

The National Leadership Coalition on AIDS (NLCOA), an alliance of nearly 200 major corporations, labor unions, and other organizations, provides leadership in guiding the workplace response to HIV/AIDS. NLCOA's conferences, publications, and resource center have been a source of information for many employers.[7] One of the Coalition's recent publications focuses on an aspect of HIV/AIDS that employers are beginning to address: accommodation.[8] Now that HIV/AIDS is covered under the Americans with Disabilities Act, employers need to look for ways to keep their infected employees working as long as possible.

Conclusion

The next steps in HIV/AIDS prevention education in the workplace are very much like the first steps. The many companies that have not yet addressed HIV/AIDS must take the first steps to introduce the issue to their employees. Companies that have dealt with this issue must continue to relay the HIV/AIDS prevention message. An infected employee can be very costly to an employer. These costs can be measurable, such as loss in productivity or increase in health insurance costs, or not so measurable, such as declining morale and increased fear and discomfort among employees. Most important, since there is no cure or preventive vaccine, education and the adoption of behaviors that reduce the likelihood of transmission are the best defense against HIV/AIDS. The workplace is an optimal setting for the communication of the HIV prevention message. Using it as such will benefit both employers and society as the fight to prevent the spread of HIV/AIDS continues.

Acknowledgments

The author thanks Laura Long of Gay Men's Health Crisis and Allan M. Huff of Multitasking Systems of New York (an organization that employs and provides job training for people with HIV) for their insight, and Judith K. Barr for her review of and comments on an early draft of this article.

References

1. Centers for Disease Control and Prevention, National AIDS Information and Education Program, *Business Responds to AIDS Program: Background and Rationale* (Atlanta, 1992).

2. J. K. Barr, J. M. Waring, and L. J. Warshaw, "Employees' Sources of AIDS Information: The Workplace as a Promising Educational Setting," *Journal of Occupational Medicine*, 33 (1991): 143-47.

3. J. K. Barr, "Organizational Response to AIDS in the Workplace," *Advances in Medical Sociology*, 3 (1993): 143-64.

4. G. E. Banas, "Nothing Prepared Me to Manage AIDS," *Harvard Business Review*, 70, no. 4 (1992): 26-33.

5. Barr, Waring, and Warshaw, "Employees' Sources of AIDS Information."

6. L. A. Pickering, "Assessing the Effectiveness of an AIDS in the Workplace Reference and Referral System" (Master's thesis, Emory University, Atlanta 1993): 45.

7. J. Monford, "HIV/AIDS Education and the Workplace," *SIECUS Report*, 21, no. 6 (1993): 13-16.

8. National Leadership Coalition on AIDS, *Accommodating Employees with HIV Infection and AIDS: Case Studies of Employer Assistance* (Washington, DC, 1994).

EXTERNAL REVIEW OF CDC'S HIV PREVENTION STRATEGIES: Summary of the Final Report

In February 1993, the Centers for Disease Control and Prevention (CDC) requested that the CDC Advisory Committee on the Prevention of HIV Infection convene outside experts to review five of the agency's key HIV program areas.

The review, which took place between April and October 1993, involved visits by committee members to program sites in eighteen cities, meetings with government and nongovernmental representatives involved with the programs, and committee meetings to discuss program strategies and activities. The following is excerpted from the "General Findings" section of the committee's report to the CDC, issued in June 1994.

The full Advisory Committee's review and discussion of the subcommittees' reports yielded nine common themes that the members viewed as important to highlight:

1. Prevention is necessary and urgent.

HIV infection is an urgent, and unique, prevention challenge because of the virus' virulence, long incubation period, length of infectiousness, grave prognosis, and potential for exponential spread. The epidemic is fostered by a complex interaction of biological, behavioral, and social forces. It is a growing problem in disenfranchised communities that are faced with a multitude of other compelling problems. And it emanates from the most personal and private of individual behaviors—sex and drug abuse. With neither a cure nor a vaccine on the immediate horizon—and with a huge national reservoir of infection—the only promising barrier against the virus is widespread adoption and maintenance of personal behaviors that eliminate or minimize the chances of exposure and infection.

Preventing new HIV infections requires a commitment from all levels of government to the diverse neighborhoods of America. The lack of such a commitment, along with restrictive federal policies, has weakened the prevention effort since the onset of the epidemic—constraining funding, limiting flexibility, discouraging innovation, and thwarting prevention specialists in their efforts to use resources where they would be most effective. Added to this set of problems is the relegation of prevention to a status secondary to that of treatment. Although progress in treatment of those already HIV infected must and will continue, it is not a substitute for prevention....

2. Behavior can be changed.

Both formal research and the practical experience of communities demonstrate that intensive interventions *can* reduce risk behaviors. Relatively little is known, however, about the comparative effectiveness of different approaches to induce desired changes. Despite advances in knowledge in recent years, we are only beginning to understand how to help people make the leap from possessing information about health to changing their behavior on the basis of that information. Nonetheless, given the enormous social and economic costs of the HIV epidemic if permitted to run its present course, even modest behavior changes must be viewed as successful. The essential question—still unanswered—is what *set* of interventions can change *most* people's behavior *most* of the time—*over a lifetime.*

3. Prevention should be guided by science.

Since behavior change is the main prevention intervention for HIV infection, behavioral research must be the foundation upon which the national program is based. Unfortunately, the nation has invested inadequately in prevention research, especially as it concerns human sexuality and drug-use behaviors. Thus, much essential knowledge still eludes us. The key role for CDC is to develop, synthesize, and promulgate scientific guidance for the HIV prevention activities carried out by community organizations and state and local health authorities. This means clarifying goals, definitions, and measures of effectiveness; identifying successful and unsuccessful strategies; and developing and applying quality standards. The task will require considerable strengthening of the science base as well as substantial increases in funding for prevention research.

4. Prevention requires sustained, long-term efforts.

Despite hopes to the contrary, the HIV/AIDS epidemic is not a transitory crisis with a "quick fix." Pressures to come up with fast, easy solutions have left us with a prevention model that is inadequate to address the *lifetime risk* of HIV infection: We must both initiate *and sustain* changes in risk behaviors; we need *generational changes in social norms.* The urgency of the escalating epidemic calls for an acceleration of both the scale and the scope of the national prevention agenda. CDC must move away from the short-term infectious disease control model and instead mount a long-term effort similar to those instituted for smoking cessation and prevention of heart disease....

5. Partnerships and collaboration are key.
Problems with programmatic cohesion both within the federal government and with others involved in HIV prevention...have severely hampered the prevention effort. Several federal agencies in addition to CDC, as well as health departments, non-governmental organizations, corporations, religious organizations, and academic institutions all have parts to play in funding, planning, and implementing prevention activities.... CDC, or some other federal entity, must take responsibility for developing functional alliances, promoting participatory planning, encouraging communication, and ensuring coordination.

CDC's recent initiation of a community planning process for the awarding of HIV prevention grants is a welcome response to some of these problems. But the process will need to be monitored closely to ensure that communities have sufficient time and technical assistance to meet their new responsibilities. There is also the danger that "bottom-up" community planning will lead to abdication of CDC's responsibility to provide needed oversight and scientific guidance. A local organization's deep commitment to HIV prevention and strong community ties does not guarantee it the requisite knowledge and skills to design and successfully carry out a broad, long-term prevention program. The line between support and responsible supervision on the one hand, and arbitrary interference on the other, presents a major challenge for the CDC.

6. Prevention interventions must strike a balance between targeted efforts and efforts to change general community norms.
HIV prevention is complicated by a problematic epidemiologic reality: nearly all Americans are at some risk of HIV infection, but their *degree* of risk varies dramatically. Those charged with carrying out prevention must choose strategies and allocate resources with this uneven risk in mind. There can be no standard formula; we must constantly question whether the right balance is being achieved. Insufficient attention to the highest-risk populations will squander resources and fail to halt the epidemic's spread. Limitation of outreach to *only* those at highest risk will promote a false sense of security, miss some opportunities to prevent HIV infection, and limit public support for national prevention efforts.

7. More funding for prevention is needed.
Excessively limited resources and inappropriate restrictions on their use have hampered HIV prevention efforts. Although CDC's total HIV prevention budget has grown from $200,000 in fiscal year 1981 to $498.2 million in fiscal year 1993, funding for the prevention program was essentially flat over the last 3 years (with an actual decrease in fiscal year 1992). Despite an increase to $543 million in 1994, the level of federal financial commitment to HIV prevention is inadequate to address the overwhelming need for *long-term, sustained, individual-level behavior change interventions for millions* of at-risk and HIV-infected persons. Restrictive policies and Congressional earmarks attached to these funds have further curbed flexibility and prevented the implementation of innovative and important prevention approaches. The Committee recognizes that although HIV prevention is expensive, the alternative—unchecked spread of infection continuing indefinitely—is many times more costly.

8. Stigmatization and discrimination continue to adversely affect prevention efforts.
Despite progress in the development of a caring and compassionate national attitude toward persons with HIV infection and AIDS, ignorance, bigotry, and discrimination still pose obstacles to prevention. A continuing effort to dispel misconceptions about HIV transmission and to protect the confidentiality and human rights of those with or at risk for HIV infection must be an integral part of the national prevention agenda.

9. CDC's organizational structure may be hindering prevention efforts.
CDC's HIV prevention programs are dispersed among ten centers that compete internally for resources; the effort lacks a clear line of authority for policy, programming, and budget.... CDC's main HIV prevention activities are subsumed within the Division of STD/HIV Prevention in NCPS [the National Center for Prevention Services]. Some view this as lessening the perceived priority of HIV prevention, isolating sexual transmission from other modes of spread, and inappropriately imposing the operational model of STD control on HIV prevention. Another key question is how to strengthen the capability to do *good science* in the prevention program. Key activities that *should* be tied to prevention—disease monitoring, epidemiologic studies, laboratory investigation—are situated in the [National Center for Infectious Diseases], which shares neither staff nor programmatic emphasis with NCPS. Broader ramifications at the non-federal level center on fragmented funding streams, barriers to integration, and a piecemeal approach to the work of prevention.

Although CDC's structure has been reviewed more than once over the past several years, the Committee members generally agree that another look is merited.... The CDC Director should seek the participation of affected constituencies—including state and local health departments and community grantees—in considering whether the current structure is optimal for meeting AIDS prevention needs.

SIECUS SALUTES INNOVATIVE YOUTH-BASED PROGRAMS

As part of a cooperative agreement with the Centers for Disease Control and Prevention's Division of Adolescent School Health, SIECUS has established a recognition project to honor programs that conduct effective HIV/AIDS prevention and sexuality education for youth.

The SIECUS Board of Directors chose the winners on the basis of the programs' innovativeness, extent of youth involvement, and quality of HIV/AIDS prevention and sexuality education. All ten winners have sound methods of evaluation and have completed both process and outcome evaluations.

The winning programs are profiled below. Each will receive a one-year SIECUS membership and a $100 voucher for SIECUS publications. For additional information about particular programs, readers should contact them directly.

We offer the winners our congratulations and best wishes for continued success and good work!

- **Adolescent Health Promotion Program**

YouthCare
333 First Avenue, West
Seattle, WA 98119-4103
206-282-1288; fax 206-282-6463
Victoria Wagner, Executive Director

The Adolescent Health Promotion Program provides HIV/AIDS prevention services to youth in detention facilities, drug and alcohol treatment programs, shelters, group homes, drop-in centers, and alternative schools, as well as to youth living on the streets. The program's goal is to provide comprehensive HIV/AIDS prevention services to runaway, homeless, and street-involved youth. The Adolescent Health Promotion Program uses several approaches: direct education, peer education, HIV/AIDS education training for other youth service providers, outreach services, educational materials development, special events, prevention case management, anonymous testing and counseling, and early intervention services. In addition, YouthCare facilitates sessions to help youth enhance the interpersonal skills they need to negotiate, practice, and maintain safe behaviors. Youth are involved in all levels of the design, implementation, and evaluation of programming. YouthCare employs three peer educators, who assist the health educators in delivering prevention services; approximately twenty-five volunteer peer educators assist in materials development and information dissemination.

- **Allentown School District HIV Professional Development for Elementary Teachers**

Allentown School District
31 South Penn Street
Allentown, PA 18105
Ralph Daubert, Director of Community and Student Services, 610-821-2651
Elizabeth Brensinger, HIV Specialist, 610-298-0002

This project seeks to enhance both the quality and the quantity of HIV/AIDS education offered to elementary school students and to ensure that the HIV/AIDS curriculum is appropriately taught in each of Allentown's fourteen elementary schools. Its ongoing training and technical assistance is geared toward increasing the district's long-term capacity to deal with issues related to HIV/AIDS and sexuality. This year, the project will offer training and support to 150 teachers, and will provide technical assistance—including a newsletter, reviews of new curriculum materials, and responses to requests for assistance—to all school district employees.

The project grew partially from requests by elementary school teachers for assistance beyond the mass in-service training they had already received, as well as in response to alarming district statistics regarding pregnancy among students as early as the fifth grade. During the first year of the project, teachers in the five pilot schools underwent training on dealing with issues concerning sexuality and HIV/AIDS education in the classroom. Supplementary materials were provided, including educational videos, a new HIV/AIDS curriculum, student workbooks, and guides for teachers and parents.

- **Coalition for AIDS Peer Education (CAPE)**

2211 East Madison
Seattle, WA 98112
206-328-7719
Jo Ann Henderson, Coordinator

The Coalition for AIDS Peer Education (CAPE) was formed by ten Seattle-area community agencies and organizations to create and support an HIV/AIDS peer education project at the high school level. CAPE member agencies have developed partnerships with schools and social agencies that serve both in-school youth of high school age and out-of-school youth up to the age of twenty-two; participating youth are of a variety of cultural and ethnic backgrounds. The coalition's efforts allow the joint participation of community agencies involved in HIV/AIDS services to reach a broad audience of adolescents in the spirit of cooperation, which minimizes competition and makes a wide variety of services available to young people.

At an annual two-day retreat, CAPE members, experienced peer educators, and community HIV/AIDS educators conduct education training. In addition, a midyear educational session provides an opportunity for further training, information updates, and project and activity reports. The ideas for projects are generated and executed by the young people at each site, and have included peer team teaching in high school classrooms, assembly programs on HIV/AIDS infection conducted by students, community service, a video, a play, and a board game.

Following CAPE's third year in operation, a number of youth were graduating from local high schools with active CAPE programs. Many of those youth wanted to stay involved in HIV/AIDS peer education, and the CAPE graduate program was born. Some of these young adults are brought on staff as paid consultants, in which capacity they are responsible for outside trainings and site maintenance. They go back to the high schools from which they graduated to ensure that the CAPE program remains a viable enrichment program, and they have been responsible for the CAPE model's replication in other school districts.

- **Coalition of Peer Educators (COPE)**
  c/o AIDS and Adolescents Network
  121 Sixth Avenue, Sixth Floor
  New York, NY 10012
  212-724-1110, ext. 2042
  John Won, Chair

COPE is a group of New York City high school and college students, youth advocates, AIDS activists, and educators who are committed to HIV/AIDS peer education. The goals of this coalition, which was formed in 1993, are to raise young people's awareness about HIV/AIDS and methods of HIV/AIDS prevention; to empower young people to educate themselves and others about HIV/AIDS as peer educators; and to serve as a support network across the five boroughs of New York City, sharing resources, training, and technical assistance with young people who are offering HIV/AIDS peer education in their high schools, communities, or community-based organizations.

Foremost among COPE's accomplishments was the organization of a conference last February. Some 175 youth and 75 adults attended the one-day event, which was hailed as the first HIV/AIDS conference organized by young people for young people. In addition, a youth leadership forum was held in May, at which participants discussed, debated, and ratified the Youth Platform, a collection of findings and public health and education policy recommendations compiled by youth at the COPE conference.

- **Mid-Coast School of Technology AIDS Education Team**
  Mid-Coast School of Technology
  One Main Street
  Rockland, ME 04841
  207-594-2161
  Sherman Cramm, Roanne Rooker, Advisors

In the fall of 1990, four students from different vocational schools and an advisor attended a workshop sponsored by the Maine Department of Education. During the drive home, the students expressed concern that vocational students needed a targeted HIV/AIDS program. They developed a peer education program focusing on HIV/AIDS prevention education and abstinence from drugs and alcohol. While concentrating their efforts on other high school students, the AIDS Education Team has also conducted presentations for middle school students, school board members, parents, health care workers, and teachers. A program is being developed for elementary school students. The project has united students from many schools, with various vocational goals; therefore, youth studying auto mechanics, truck driving, and health occupations all work together to accomplish their goal.

- **Nobody's Fool: Dating, Love, Sex and AIDS**
  Planned Parenthood of Central Texas
  PO Box 1459
  Waco, TX 76703
  817-754-2391
  Pamela Smallwood, Education Coordinator

Nobody's Fool is an annual conference for girls and boys entering grades 5–9. Objectives include promoting communication about sexuality between young adolescents and their parents; fostering communication among adolescents; and increasing awareness as to how dating, relationships, sexual issues, and STDs, including HIV/AIDS, affect their lives. The half-day conference is held on a weekday and has taken place each summer since 1990, with 400–700 participants attending each year. The conference participants are divided by age and gender and are involved in educational activities focusing on important subjects relevant to young teenagers: puberty; dating; relationships; peer pressure avoidance; teenage pregnancy; and STDs, including HIV/AIDS. A team of experienced sexuality educators teaches each session. The day's events include lunch and entertainment.

This conference has broad-based community support. It had thirteen underwriters in 1994, and eight nonprofit organizations provided volunteers for the workshops and administrative support. Registration costs five dollars, and scholarships are available. Additionally, volunteers from local churches provide transportation. One innovative aspect of this project is a youth-designed T-shirt and conference packet. The T-shirts have become popular around the county.

- **Sexual Health Advocate Training Program**

Rutgers University
Rutgers Student Health Service
Department of Health Education
Hurtado Health Center
11 Bishop Place
New Brunswick, NJ 08903
908-932-7710
Fern Goodhart, Director of Health Education

This program provides peer education and training around a variety of sexual health issues. Interventions include team-led seminars in residence halls, celebration of National Condom Week (with a series of exhibits and events) and World AIDS Day (with a variety of programs, panels, and concerts), theatrical skits and guerrilla theater in dining halls and on buses, and special projects (in high schools, the community, and on campus). Students are involved in all aspects of the program's activities, including the training of new volunteers.

This project has been sustained and strengthened for thirteen years. Student interest has shaped its growth, and has allowed it flexibility and resiliency as sexual health needs have changed. The Sexual Health Advocate Training Program teaches others how to amplify and respect the voice of youth by recognizing their authority and providing a safe and supportive environment for them to demonstrate their leadership.

- **Students for Safer Sexuality**

Waynflete School
360 Spring Street
Portland, ME 04102
207-774-5721
Chris Hall, David Vaughan, Pam Wright,
Faculty Advisors

Students for Safer Sexuality (SFSS) is a peer education program designed to train eleventh and twelfth graders to be key agents in the delivery of sexuality education, HIV prevention, and communication skills programs. Participants are trained to lead discussion groups, present skits and information, and help improve communication and decision-making skills. Students involved in the program have gone on to lead programs for middle school students, high school peers, and parents, and have made presentations at other schools and a variety of conferences. SFSS advocates abstinence or postponement of sexual involvement, alternatives to intercourse, and use of protection against pregnancy and STDs. Students were involved in the design and implementation of this program from the very start. They are responsible for determining the direction of the program, what presentations will take place, and who will conduct them. SFSS demonstrates the importance of giving youth the respect and responsibilities they need to make a difference.

- **Teen Peer Education Program**

AIDS Center of Queens County
97-45 Queens Boulevard, Suite 1220
Rego Park, NY 11374
718-896-2500
Luis Melendez, Teen Peer Education Coordinator

The Teen Peer Education Program of the AIDS Center of Queens County is committed to providing HIV/AIDS educational presentations by and for youth. Youths aged 15–19 are trained to lead HIV/AIDS prevention presentations in schools, youth organizations, and other neighborhood locations. In addition, the peer educators publish a newsletter and resource directory, sponsor rap sessions and monthly trainings, and write and perform skits and role-plays. After sixteen hours of training, peer educators receive a stipend for every presentation they lead. The program flourishes because of the teenagers' imagination, motivation, and ability to create different approaches for educating their peers.

- **Teens Teaching Teens: Just Say Know**

Southern Tier AIDS Program
122 Baldwin Street
Johnson City, NY 13790
607-798-1706
Barbara Coyle, Director of Education

Through Project STOP (Students Teach Other Peers), the Southern Tier AIDS Program provides extensive training for HIV/AIDS peer educators, and technical assistance to rural schools interested in peer education. Participation of community and school members enhances the program's development. Trained student educators work to stop the myths surrounding HIV/AIDS, the fear of people living with HIV/AIDS, unsafe sexual behaviors, and behaviors that may lead to increased risk for HIV. The project started out in one school district, and has expanded to thirteen districts, addressing the specific needs of each. Projects may include workshops, AIDS Awareness Week, newsletters, and volunteer work.

This project is entirely peer-based in its design, training, and implementation. College and high school students work together to train high school peer educators, and community agencies collaborate with the program. Project STOP demonstrates that energy, dedication, and commitment from youth can accomplish significant change with limited resources.

FROM THE EXECUTIVE DIRECTOR

SURVEYING THE "DEFINITIVE SEX SURVEY"

Debra W. Haffner, M.P.H.

SIECUS Report readers have no doubt seen the extensive press coverage given the new report on sexual behavior in the United States. *Time* and *U.S. News & World Report* ran cover stories; the *New York Times* reported the results on the front page.

What most captured the reporters' attention was the news that married adults have sexual relations more often and are more satisfied with their sexual relations than unmarried people, and that most married people say they are monogamous. The press also highlighted the finding that only a small proportion of American adults identify themselves as gay or lesbian.

I highly recommend that SIECUS members read the entire study report, which is available in a popular version[1] and in a scholarly form, running more than 700 pages.[2]

This study, based on interviews with a national probability sample of more than 3,400 men and women aged 18–59, is clearly the most complete picture we have ever had about the sexual behaviors and attitudes of American adults. The authors, the University of Chicago (where the research team was centered, and which published the scholarly version of the report), and the private foundations that supported the survey after the Congress voted to defund it are to be commended for their persistence and scientific rigor. It is unfortunate, however, that the funding restrictions kept this from being a much larger study, which would have allowed for generalizable results about key population groups, as well as collecting information about older adults.

Key Findings

The survey depicts an American public that is considerably less sexually active than many had believed. Americans are about equally divided among those who have sexual relations with a partner at least twice a week, a few times a month, and a few times a year or not at all. Almost half of single men and slightly more than half of single women have had few or no sexual experiences during the past year. The majority of Americans have had one sexual partner during the past year; slightly more than one in ten have had none.

The data confirm the impression that Americans reaching sexual maturity since the late 1960s differ significantly in their premarital behavior from older adults. Younger Americans began intercourse earlier, married later, and have had more sexual partners than their parents. But marriage is a great leveler. Regardless of sexual attitudes, premarital sexual experience, religious or ethnic background, or where they live, married adults display remarkably similar sexual behavior patterns. The vast majority of married people report that they are monogamous, and most are physically and emotionally pleased with their sexual relationships with their spouses.

Another, more unsettling picture of sexuality in America that can be found here has received little media coverage. The findings indicate that many adults are not sexually healthy. One-third of women are not interested in sexual activity. Almost one-quarter of women have been forced to have sexual relations during their adult lives, most often by their committed partner. Just under one in five men and women were sexually abused as children. A history of sexual abuse seems to have especially pernicious effects. Among other sexual problems, women who have been subjected to sexual abuse are more likely than others to be unhappy, to have more than ten lifetime sexual partners, to lack interest in sexual activity, and to be unable to have orgasms; they are less likely to find sexual activity pleasurable.

Significant differences emerge in how men and women perceive sexuality. Men are much more likely than women to engage in recreational sexual behavior and to be interested in a variety of activities; they are less likely than women to be monogamous, and have more partners, on average. Women are much more likely than men to say that their first intercourse was a result of peer pressure, that they do not consistently have orgasms, and that they have never masturbated.

Perhaps the sharpest contrast is that although 22 percent of women say that a male partner has forced them to have sexual relations, only 3 percent of men say they have ever forced a women. Clearly, men and women have very different understandings about what constitutes consensual sexual behavior. Men also appear to have greater access to sexual partners than women, particularly as they age: Almost six in ten single men aged 45–59 have had a partner in the last year, compared with only about one-third of women. In fact, six in ten single women in this age group have had no partner during the past twelve months.

The most troubling aspect of the report may be the authors' conclusion that "there is not and very unlikely ever will be a heterosexual AIDS epidemic in this country."[3] The authors convincingly argue that the 83 percent of American adults 18–59 who have had either one partner or no partner during the last year face little risk of exposure to HIV, unless this partner is exposed by sharing injecting drug needles. The finding that most American adults have sexual relationships with people very much like themselves is cited as evidence against widespread transmission.

The authors do a real disservice in the popular version of the book by emphasizing that "it is all but inconceivable that infected members of middle-class Americans will start an epidemic going in the general population."[4] Who is a member of the general population, and how many people does it take to make an epidemic? The authors seemingly ignore certain facts, such as the 110 percent increase in the number of women with AIDS and the 95 percent increase in heterosexual cases between 1991 and 1993.[5]

A number of other problems are based on the research itself. First, the researchers did not study adolescents or people over age fifty-nine, two groups who may engage in behaviors that increase the risk of infection. Second, by emphasizing the prevalence of monogamy, they ignore the behaviors of a significant minority of people. According to this research:

- More than four in ten American adults have had five or more partners. An estimated 13 million have had twenty-one or more partners since age eighteen.

- One in six Americans have had a sexually transmitted disease.

- One in five Americans have had a new sexual partner in the past twelve months—25 percent of men and 15 percent of women. Some 9 percent have had a onetime sexual relationship; 12 percent have had a sexual relationship that lasted less than two months. The more partners one has had, the less likely they are to be known well, the less likely they are to be from the same social networks, and the less exclusive the relationships are likely to be.

- Condom use is quite low. Of people who have had three or more partners in the past three years, only 20 percent always use condoms with their primary partner; 40 percent do so with their secondary partner. And while knowledge of AIDS is high, fewer than half of those surveyed said that using a condom is a very effective way to prevent HIV.

I fear that this report will herald a return to talk about "risk groups" for HIV. The authors report in the popular version of the study: "AIDS is, and is likely to remain, confined to exactly the risk groups where it began: gay men and intravenous drug users and their sexual partners."[6] In one radio interview I did about the study, the interviewer said, "So the good news is that people can stop worrying about AIDS."

I wanted to scream. Clearly, HIV/AIDS prevention messages need to remain the same. No, everyone is not at equal risk, but everyone who has sexual intercourse—of any kind—with a partner with an unknown serostatus is taking a chance. Unquestionably, more, not less, condom use is needed. In fact, the survey found that generalized HIV/AIDS information efforts have made a difference: One-third of adults have changed their sexual behavior because of AIDS. The more sexual partners people have had (over their lifetime and in the past year), the more they have changed their behavior.

I agree with the authors that HIV/AIDS education programs need to be targeted to specific populations, and that perhaps less attention should go to "general population" messages. Interestingly, it seems that in order not to offend that "general population," many prevention programs avoid addressing such groups as gay men and lesbians, adolescents, and injecting drug users. HIV/AIDS information and education programs need to target those with multiple partners and those with partners who engage in risky behaviors. Further, as the researchers note, "AIDS is becoming endemic in poor neighborhoods, among drug users and their sexual partners, where behavior has changed little and where society has averted its eyes from the multiple problems of these populations."[7]

These survey results undoubtedly will be used to support a wide range of political beliefs about the role of sexuality in American life. Social scientists are familiar with the axiom, Statistics don't lie, but people lie with statistics. These findings already are being misused. It is incumbent upon those of us in the sexuality education community to help the public understand the data and to use them to evaluate and plan public health programs. Start by reading the book. Let SIECUS know your reactions. We will publish your views as space permits.

References

1. R. T. Michael et al., *Sex in America: A Definitive Survey* (Boston: Little, Brown and Co., 1994).

2. E. O. Laumann et al., *The Social Organization of Sexuality: Sexual Practices in the United States* (Chicago: University of Chicago Press, 1994).

3. Michael et al., *Sex in America,* 216.

4. Ibid., 214.

5. CDC Surveillance Service, personal communication, Oct. 25, 1994.

6. Michael et al., *Sex in America,* 216.

7. Ibid., 217.

THE DROP-IN GROUP: AN AIDS RISK AND PREVENTION PROGRAM FOR THE MENTALLY ILL

Massachusetts Department of Health, JSI Research, Solomon Carter Fuller Mental Health Center, and Dr. Fuller Institute, 24 min., 1993.
Distributed by the Dr. Fuller Institute, 47 Halifax St., Boston, MA 02130. $195 (purchase); $50 (rental).

This urgently needed and first-of-its-kind video, with its accompanying pamphlet, is aimed at professionals involved in HIV prevention training for people with chronic, severe mental illness. The video could also be useful as an introduction to the topic for people who have such disabilities.

In the video, Stephen Brady, director of research and training at the Solomon Carter Fuller Mental Health Center, and Rita Martin, AIDS coordinator for the Massachusetts health department, discuss the training program; the video also shows parts of a session. Six instructors (including Brady and Martin) present information to the group. It is not clear if a session typically involves so many instructors.

Brady begins the video by explaining that he organized this weekly drop-in group after seeing several people with chronic mental illness die of HIV/AIDS. The increased vulnerability of people with severe mental illness is a key issue, and I wish his presentation included illustrative data. People with mental illness, AIDS educators, and mental health clinicians need to know, for example, that extremely high rates of HIV infection—from 5 percent to an astounding 16 percent or more[1]—have been found among selected groups of individuals with mental illness in large cities in Europe and the United States. In fact, mental health professionals may need to prepare to address HIV infection as yet another source of prejudice against people with mental illness when the general public learns of these high rates of infection.

This concise yet comprehensive video covers several important points. One is the need for confidentiality as a routine part of training. Also, there is a discussion of the bias against seeing people with disabilities, especially chronic mental illness, as sexual beings. Such "disability awareness" is crucial for social and sexuality training for people with any disability.

The pamphlet *The Drop-in Program*, which comes with the video, provides an opportunity to review the instructors' recommendations at greater length. It offers an overview of why such training is useful, outlines the points it should include, and provides a sixteen-page script to guide a session.

I had a few reservations about this training package. First, in the era of "people first," when diagnoses are supposedly secondary to the affected people, the constant use of the phrase "the mentally ill," as opposed to "people with mental illness," is jarring.

A more substantial concern is that the discussion is very focused on knowledge; it is vague about approaches to changing attitudes and even vaguer about calls to action. Studies of HIV prevention education suggest that simply improving knowledge will not necessarily change behavior. Direct training, including practice assignments, focus on short-term behavioral goals, and improvement of social skills, is a crucial complement to knowledge-based initiatives. My work in HIV training with people who have chronic mental illness, physical disabilities, or developmental disabilities suggests, for instance, that activities such as having people go out and buy condoms, try condoms on themselves or their sexual partner, or carry condoms around for a week can help effect long-term behavioral or attitudinal changes.

Finally, an assessment of the program's impact would have been useful. Research has shown that programs for individuals with serious mental health problems do not always succeed in improving knowledge, let alone in changing attitudes. This is a critical issue, which needs to be addressed by trainers, since if education has no impact, it is merely another leisure-time activity, not a lifesaver.

Reference

1. H. K. Lee, S. Travin, and H. Bluestone, "HIV-1 in Inpatients," *Hospital and Community Psychiatry*, 43 (1992): 181-82.

Reviewed by Geoffrey Garwick, clinical psychologist, Ramsey County Mental Health Center, St. Paul.

THE HIV TEST: WHO SHOULD TAKE IT? WHAT DOES IT SHOW?

Human Relations Media, 25 min., 1993.
Distributed by Milner-Fenwick, 2125 Greenspring Drive, Timonium, MD 21903. $200.

HIV testing has been a delicate subject since its inception in 1985. Concerns regarding client confidentiality and the very utility of the results have generated considerable confusion and frustration among consumers. As a result, many people who could benefit from testing have refused it. Meanwhile, events such as Magic Johnson's disclosure of his HIV status have driven people who are at low risk to flock to testing centers with little or no concept of what the test means or how the results can affect their lives.

Human Relations Media's *The HIV Test: Who Should Take It? What Does It Show?* offers important information to all those who may be taking an HIV antibody test, as well as to individuals who may have decided against the test for the wrong reasons. It is also an appropriate training tool for patient educators. This well-produced video offers a comprehensive look at the key issues surrounding HIV testing and counseling, including insightful discussions about HIV infection and AIDS, testing methodology, and psychological reactions to a positive test result. The video does an exemplary job of providing vital information that allows for informed decision making about whether HIV testing is a sensible option.

The video combines on-camera narration, personal testimony, and graphics to deliver its messages. Information is presented in accessible language, without excessive use of medical terminology. When scientific vocabulary is introduced, terms are well explained and concepts fully clarified. The script is carefully constructed to emphasize probability and possibility, rather than offering general statements regarding HIV transmission, disease progression, and test results. Although the segment on transmission risk is brief, the information it provides is accurate and clearly distinguishes the reality of transmission through sexual contact and needle sharing from the myth of transmission through casual contact.

Counseling professionals, as well as

persons with HIV, offer personal testimony about testing and reactions to positive results. The producers are to be commended for assembling a diverse group of individuals. By including a wide ethnic and racial mix, as well as both men and women, the producers subtly emphasize the vital point that HIV infection and the need for appropriate counseling and testing are not confined to any one population.

A particular strength of the video is its in-depth analysis of the key questions an individual should ask before taking the test. Among the issues covered are the cost of the test (free testing through health departments or community clinics is suggested), parental consent for minors, and the distinction between confidential and anonymous testing. As regards the necessity of pretest and posttest counseling, the video offers a clear message: "If the place [you have contacted] does not offer counseling, look for a place that does."

The sole shortcoming of this otherwise excellent production is one that is increasingly common in HIV/AIDS prevention materials: the omission of explicit references to risks among gay and bisexual men. With the exception of a shot of two men walking down a street together, the video fails to acknowledge the continuing elevated risk of transmission among men who have sexual relations with other men. Of the three individuals who deliver personal statements about living with HIV, two are heterosexual women, and the third is a heterosexual man who is a former injection drug user. While efforts to inform the "general population" of their possible risk for HIV infection are certainly commendable, the producers of this video do a disservice to their audience by failing to specifically address the population that, in many areas, continues to account for the highest prevalence of HIV infection and AIDS.

Reviewed by Jeff Natter, M.P.H., an AIDS consultant and former education manager at the Northwest AIDS Foundation, Seattle.

GARDENING IN CLAY: REFLECTIONS ON AIDS

Ronald O. Valdiserri
Ithaca & London: Cornell University Press, 1994, 107 pp., $16.95

One might pick up Ronald O. Valdiserri's *Gardening in Clay: Reflections on AIDS* because the title is so intriguing. Once begun, this collection of short essays is difficult to put down—especially for people whose lives are saturated by the effects of the AIDS pandemic.

Inspired to put thoughts to paper as a result of his twin brother's struggle with AIDS, Valdiserri, the author of *Preventing AIDS: The Design of Effective Programs,* takes a decidedly personal turn with this collection. He weaves together anecdotes from his childhood, his perspective as a pathologist and educator, and his beloved gardening all to comment on how AIDS has affected our society's collective life.

Although essays typically seem to be the vehicle of an observer rather than a participant, these essays are the work of a man who is capable of commenting on life while being immersed in it. He writes: "Analogy has always seemed to me a good way to think about complicated issues; such comparisons often generate new ideas. But some of the analogies that come to mind when I think about the tangle of medical, public health, and social circumstances associated with the AIDS epidemic have been pretty strange" (p. 36). The strange and the mundane are held up, examined, and made poignant by this metaphorical thinking.

Twenty-six essays make up this collection. My favorites include "Weeds"; "Epidemiology of Anger"; "Patience"; "Down There"; "My Father's Bakery"; and "Gardening in Clay." I look forward to using these in trainings for sexuality and HIV/AIDS educators. To begin a values and attitude assessment, for example, I will read the following excerpt from "Down There," an essay about sexuality, which pays special attention to homosexuality. Valdiserri begins by relating a story about his grandmother and her memory of learning about sexuality. She tells him:

> When I was a young girl, Nona (as we called my great-grandmother) took me and my sisters into the parlor and asked us to pretend that there was a large hole hidden under the carpet. "Now, if you don't know anything about that hole and you fall into it," she told us, "it would be *mala fortuna* but it wouldn't be your fault. But if I told you about the hole and then you fell into it, it would be your own fault." (p. 62)

Valdiserri goes on to point out what he calls society's "cultural adolescence" concerning matters sexual, observing that many adults have yet to achieve an "adult level of understanding and acceptance" (p. 63). He moves from the personal to the cultural skillfully and with great subtlety. In fact, if one were to read some of these essays out of context, the true subject matter might be difficult to discern. For example, "Gardening in Clay," the deeply moving final piece, never mentions AIDS, but illustrates the triumph of slow and steady work and determination, and—most important—hope.

At this point in the pandemic, hope may be difficult to achieve, yet it is essential. In his preface, Valdiserri writes: "[My brother's] illness and death and the loss of other friends and colleagues have changed my feelings about life and my notions of fulfillment. I find that I cannot see things in the same way anymore....I hope that readers will recognize in [these essays] my firm conviction that the AIDS epidemic is not a uniformly negative event. What we learn from it has the potential to make us better people and enrich our society" (pp. ix–x).

Without indulging in excessive sentimentality, Valdiserri offers his readers the gift of hope. My copy of this book will soon be dog-eared, as I plan to use the essays to guide my work, and to look back at them in particularly weary times.

Reviewed by Carolyn Patierno, director of program services at SIECUS.

This issue of the *SIECUS Report* was funded under the Centers for Disease Control and Prevention cooperative agreement no. U62CCU 2011 28-06. SIECUS is grateful to the CDC Review Committee: Sandra Gilkes, acting deputy assistant director, Youth Outreach Unit, New York City Department of Health; James Holmes, M.P.H., instructor, Community Health Education Department, Hunter College School of Health Sciences; Ronald Moglia, Ed.D., director, Human Sexuality Program, Department of Health Studies, New York University; Sharon Mottley, project director, National Urban League; John Vogelsgang, Ph.D., consultant, National Council of Churches; and Ellen Wahl, senior scientist, Education Development Center.

HIV/AIDS: RECENTLY REVIEWED RESOURCES

A YOUTH LEADER'S GUIDE TO BUILDING CULTURAL COMPETENCE

Advocates for Youth

Addressed to youth group leaders, teachers, and other youth-serving professionals, this training guide defines cultural competence as a "life-long learning process of expanding horizons, thinking critically about issues of power and oppression and acting appropriately." The focus is on African-American and Latino cultures and their particular issues around HIV/AIDS education. 1994, 76 pp.

Advocates for Youth, 1025 Vermont Avenue, NW,
Suite 200, Washington, DC 20005; 202-347-5700.

AFFIRMING PERSONS—SAVING LIVES. AIDS AWARENESS AND PREVENTION EDUCATION: GRADES 5–6

William R. Johnson and Cynthia A. Bouman

The authors consider ages ten and eleven the time of optimum receptivity to HIV/AIDS prevention education. Written in Christocentric language, this curriculum uses sexually explicit terminology to teach children to identify behaviors associated with increased risk of HIV infection. 1993, 58 pp.

United Church Board for Homeland Ministries,
Division of the American Missionary Association,
700 Prospect Avenue, Cleveland, OH 44115-1100;
216-736-3800.

INTEGRATING THE NEEDS OF WOMEN AND CHILDREN: ADDRESSING PERINATAL DRUG EXPOSURE AND PERINATAL HIV INFECTION

National Association of County Health Officials

Countering the trend to pit fetal and women's health interests against one another, practitioners, administrators, community representatives, and clients from model programs promoting the health of women and children met in 1993 to discuss barriers to providing integrated services. Covered topics are funding, programmatic setting, bureaucratic and regulatory restraints, community culture, and politics. 1994, 57 pp.

National Association of County Health Officials, 440
First Street, NW, Suite 500, Washington, DC 20001;
201-783-5550.

EMPLOYEE ATTITUDES ABOUT AIDS—A NATIONAL SURVEY

National Leadership Coalition on AIDS

Participants in this survey were asked to share their concerns about HIV/AIDS, their views on how HIV-positive employees would and should be treated in the workplace, and their awareness of HIV/AIDS initiatives their employers have taken in the workplace. One conclusion the researchers draw is that many employees do not have accurate information about the legal rights and medical condition of people with HIV. 1993, 28 pp.

National Leadership Coalition on AIDS, 1730 M Street,
NW, Suite 905, Washington, DC 20036; 202-429-0930.

AIDS: EFFECTIVE HEALTH COMMUNICATION FOR THE 90S

Scott C. Ratzan, Editor

Health communication is the area where the scientific community intersects with "humanistic and ethical experts in the communicating arts in crafting effective rhetorical messages and campaigns." In this volume, the elements of a preventive approach to public health, analyses of HIV/AIDS media coverage and prevention campaigns, and an AIDS Action 2000 Plan are laid out. 1993, 268 pp.

Taylor & Francis Publishers, 1900 Frost Road,
Suite 101, Bristol, PA 19007-1598; 215-785-5800.

STDS AND HIV: A GUIDE FOR TODAY'S YOUNG ADULTS. INSTRUCTOR'S GUIDE

William L. Yarber

This curriculum addresses sexually transmitted disease (STD) and HIV health messages. Following the Learning Domains philosophy, it offers a discussion of implementation and lesson units, complete with worksheets and test questions, which include rehearsals of STD and HIV preventive behaviors. The lesson units include "Resisting Negative Peer Pressure," "Sexual Responsibility," and "Getting Condoms." 1993, 98 pp.

American Alliance for Health, Physical Education,
Recreation and Dance, 1900 Association Drive, Reston,
VA 22091; 800-321-0789.