

THE FUTURE OF HIV/AIDS PREVENTION PROGRAMS

Learning from the Experiences of Gay Men

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As the HIV/AIDS epidemic enters its second decade, education remains the key tool for effectively preventing HIV transmission. To date, widespread adoption of safer sexual behaviors has been evident among gay men. The apparent success of HIV/AIDS prevention programs that have targeted gay men is unprecedented in the history of public health campaigns.¹ In spite of this remarkable achievement, there is still no guarantee that behavioral changes continue over time.

It is axiomatic in health education that initiating health-motivated behavioral change is far easier than maintaining new behaviors in the long term. HIV/AIDS prevention programs targeted to gay men have focused primarily on the skills needed to successfully adopt safer sexual behaviors. Until recently, scant attention has been paid to reinforcing behavioral changes over time or teaching the skills needed to cope with situations that increase the potential for unsafe sexual behaviors to occur. As gay men become more and more acclimated to life in the age of AIDS, many initial messages about safer sexual behaviors — couched in simplistic phrases such as *on me, not in me* — must be replaced with a set of ongoing, holistic statements that not only reinforce safer sexual behaviors, but also support a person's identity, culture, and especially, beliefs and values. In the absence of this type of ongoing support, the likelihood of sustaining any new behaviors on a long term basis, particularly sexual behaviors, remains tenuous.

For many health-protective behaviors, such as those associated with weight loss, abstinence from alcohol, adherence to a low-cholesterol diet, or smoking cessation, widespread community support is available. Behavioral change in these areas is likely to be viewed as an achievement and reinforced with approval. Compared to a generation ago, smoking is now socially unacceptable to a large proportion of the

population, and as a result, smoking cessation programs are held at workplaces, churches, and community centers. Exercise and healthier diets are often encouraged by peers and the media.

Similar support for safer sexual practices needs to be readily available. Certainly for gay men, there is no widespread, visible support from mainstream society that safer sexual behaviors should be congratulated, supported, or even acknowledged. Instead, forces work against gay men and deny male-to-male sexuality. Newspaper and television stories, gay-bashing, and government apathy tell gay men that society would rather judge their sexual orientation than give them support for meaningful change.

In the absence of ongoing positive reinforcement for safer sexual behaviors, patterns of unsafe sexual behaviors among gay men are likely to increase. Indeed, several recent reports indicate that for some gay and bisexual men, a reversal from low-risk to high-risk sexual activity is on the rise.^{1,2,3} A 1989 report noted that 15.6% of the 453 men participating in the UCSF AIDS Behavioral Research Project, had engaged at least once in high-risk sexual behaviors from low-risk sexual behaviors.⁴ Another report classified 16% of 517 gay and bisexual men who made a commitment to never practice unprotected anal sexual intercourse as relapsers because they had done so in the last year.⁵

Relapse Prevention Models and Behavioral Change

So-called relapse from safer sexual behaviors has not been explored as extensively as relapse to addictive behaviors. *Relapse prevention* from addictive behaviors "is a self-management program designed to enhance the maintenance stage of the habit change process. The goal of relapse prevention is to teach individuals who are trying to change their behavior how to anticipate and cope with the problem of relapse. In a very general sense, relapse refers to a breakdown or setback in a

person's attempt to change or modify and target behavior.⁶ The model of relapse prevention in the area of safer sexual behaviors can borrow from the literature on relapse from addictive, habitual, or compulsive behaviors. But before we adapt the relapse concept to unsafe sexual behaviors, there must first be careful examination and exploration of whether or how it can apply.

Since much of the relapse literature focuses on addictive behaviors, there is a danger of similarly labeling unsafe sexual behaviors. By grouping them in a category reserved for behaviors deemed health destructive, we give the false impression that engaging in sexual behaviors is harmful. We must be cautious of using the term relapse to label those sexual behaviors deemed unsafe without first testing the relapse prevention model in the context of behaviors that are not addictions per se. We also need to recognize that so-called high-risk sexual practices are not inherently unsafe; what makes them unsafe is the ever-present risk of infection.

For example, breathing — a normal function inherently vital and not expected to be a risk to life or good health — may present serious risk of increased morbidity and premature mortality. An activity pursued specifically for improving health, such as exercise, becomes a health risk when normal breathing becomes difficult due to poor air quality levels in some areas, especially during the summer. Individuals need to adjust their activities to the level of hazards, actual or potential, in the environment, for the body's systems to function safely, and support efforts to make the environment cleaner and safer for everyone.

"The traditional view of relapse is a negative one, associated with addictive behaviors; it connotes behaviors that are typically beyond the individual's control and health-destructive in most situations, and it engenders a sense of all-or-nothing failure."

In a similar way, the growing sexually transmitted disease (STD) epidemic of the last two decades has challenged us to look for vaccines that will make human beings and our potentially hostile environment more compatible. Unlike environmental hazards to healthy lung function, which are largely human-made, STDs first emerged from the biosphere, and their spread has been influenced by human patterns of habitation, behavior, etc. By knowing about the plethora of sexually transmitted pathogens, individuals can adapt the way they behave sexually to avoid these — largely unseen — hazards. The health educator's task is to provide the knowledge and to help people develop the skills needed for adopting and maintaining safer sexual behaviors.⁷

Using the term relapse to indicate a return to sexual behaviors which present a serious risk of exposure to HIV, may give the erroneous impression that the sexual behavior itself — rather than a virus — is the cause of

infection. It also prevents health educators from discussing sexuality and choices about sexual behaviors in a positive and life-affirming manner. The constant barrage of negative moralistic judgments about sexuality, particularly gay sexuality, from the media and conservative groups devalues both the validity of sexual activity between two men, and the lives of gay men. The traditional view of relapse is a negative one, associated with addictive behaviors; it connotes behaviors that are typically beyond the individual's

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control and health-destructive in most situations, and it engenders a sense of all-or-nothing failure.⁸

Due to its connotation with disease, the term relapse threatens to alienate the very people HIV/AIDS prevention efforts are attempting to reach, i.e. all sexually active people, and gives the impression that sexual activity — particularly between two men — is a behavioral compulsion that needs treatment. We have yet to isolate and compare various groups of gay men who have engaged in high-risk behaviors after adopting low-risk behaviors. How are decisions made concerning sexual behaviors and on what are they based? Are these behaviors out of the individual's control, as traditional views of relapse behavior indicate, or are they a result of negotiation between partners — a skill that has been a part of primary risk-reduction efforts from the very beginning. In other words, are gay men, in various situations and circumstances, making a mutual decision not to use condoms? Is unsafe sexual behavior a choice or a compulsion? Relapse theory in itself presents a narrow view of the complicated and little understood realm of sexual behaviors, particularly with regard to sexual decisionmaking. While it is not disputed that a return to high-risk behaviors is a reality, the many issues that account for this trend have not been studied convincingly.

Prevention programs modeled on more recent models of relapse, such as Marlatt's cognitive-behavioral relapse prevention model, define relapse as a "violation of a self-imposed rule or set of rules governing the rate or pattern of a selected target behavior."⁹ The challenge for HIV/AIDS educators is to test the model with behaviors that are not predicated on the medical/disease model and establish a set of guidelines or skills which will help the individuals maintain new, healthier behaviors. Of particular value will be the focus on individual instances of unsafe sexual behavior, including the situations in which they occur and the events which lead to those situations.

It is more appropriate to view episodes of high-risk sexual behavior as lapses, rather than relapses. Relapse implies a pattern of behavior, whereas lapse infers an instance of behavior at a single point in time. We have no reason to believe that the majority of gay men are adopting ongoing patterns of unsafe sexual behaviors over a period of time. The relapse model's negative and self-blaming message, which attributes unsafe sexual behaviors to an inability to control one's own behaviors, undermines efforts to support healthy behavioral change.

In addition, publicly using relapse as a way to label current trends in the sexual behaviors of gay men, has added a threat to the gay community in the form of moral judgment and accusation from those who believe that sexual activity outside a traditional married heterosexual relationship is sinful. For example, an editorial in *The New York Post* stated, "The ongoing expenditure of billions of dollars by the federal government to fight AIDS, and the extraordinary efforts on the part of scientists to understand and treat the disease, will be to no avail if those who are most at risk willfully engage in the very practices that promote its spread."¹⁰ Following the release of research on

The National Relapse Prevention Network Offers Support for Ongoing HIV/AIDS Prevention Programs

The very success of safer sexuality education programs and campaigns for gay and bisexual men has resulted in a misperception that the HIV/AIDS prevention needs of gay and bisexual men have been fully addressed. As a result, funding for ongoing HIV/AIDS prevention programs that support the maintenance of behavioral changes may become more difficult to obtain. HIV/AIDS organizations need to stress the importance of continuing these efforts even while funds are needed for other populations that have not been so adequately reached.¹¹ Nonetheless, some funding has continued to be awarded for relapse prevention programs.

Created in June 1990 through a grant from the American Foundation for AIDS Research (AmFAR) to the San Francisco AIDS Foundation, the National Relapse Prevention Network's mission is to promote collaboration and information exchange among HIV/AIDS organizations in the United States in order to initiate more demonstration prevention programs and research on so-called safer sex relapse behaviors and prevention approaches. The network already boasts 140 members from national and community-based organizations, extending beyond the United States to Canada, Australia, and the Netherlands. Earlier this year, 35 representatives from participating organizations met in San Francisco to set a national agenda for this issue. A report documenting this historic meeting is currently being written.

For more information about The National Relapse Prevention Network, write to Wayne Blankenship, The San Francisco AIDS Foundation, P.O. Box 426182, San Francisco, CA 94142-6182.

relapse, a Chicago news commentator issued a particularly venomous editorial, stating, in part, that because "as many as one-third of practicing homosexuals in San Francisco have reverted to unsafe sex," society need not continue increasing its commitment to fighting AIDS. This editorial also stated that society was already doing far more than enough."¹¹

What Researchers Tell Us

What are the factors which contribute to high-risk sexual behaviors? Various studies suggest that rationalizations such as a partner's HIV-antibody status, being too turned on to stop, being in love, stress, depression, embarrassment, a partner's request, low self-esteem, or an inability to formulate a positive gay identity, all may be determinants of lapses in safer sexual behaviors.^{12,13} Although these determinants have been frequently identified, researchers need to focus on understanding how they actually impact on the sexual decisionmaking process and what needs to be done to eliminate their negative effects.

Recent research studies have found relationship status to be significant: men in mutually monogamous relationships had unprotected anal intercourse more

THREE HIV/AIDS PREVENTION PROGRAMS DEVELOPED BY GMHC

House of Latex

The *House of Latex* is an innovative form of HIV/AIDS prevention education designed to meet the needs of a particular subculture of the gay community indigenous to the East Coast. The House Community is a social network that almost exclusively comprises people of color. Its roots go back to the 1940s drag queen balls held in Harlem. House members include butch and femme queens, transvestites and transsexuals, biological females, and recently, straight men. House gatherings in the past tended to mirror debutante balls in which older drag queens would introduce their *daughters* to society. Today's balls are more competitive events where modeling techniques, wardrobe, dance skills, and male/female authenticity are judged. A documentary about life in the House Community, "Paris is Burning," has received critical acclaim and national distribution.

Each House has its own identity and its own name. Originally, most of the names were borrowed from the couturier houses of Paris such as Armani, Chanel, and St. Laurent. Many Houses currently choose names that reflect their own style and personality, such as Penda'vis, Jadu, Ultra-Omni, and Xtravaganza. Most, if not all, have a *mother* and a *father*, and their *children* find the support network they may not have access to in their families and communities. Belonging to a House is not only a means of acceptance, but also allows members to express themselves in unique ways. By attending the balls, house members have an opportunity to show off their wardrobe, looks, and self-identification, and perhaps to win a trophy or cash prize.

With its *House of Latex* — as in latex condoms — Gay Men's Health Crisis is able to fit a corp of volunteers in among the House crowd. Highly visible and entertaining interventions meld with the particular theme of each ball, while brochures about HIV/AIDS prevention and testing, buttons, condom packs, and a safer sex message are presented unobtrusively. Thus, awareness of the need for safer sexual behaviors combined with information and resources is integrated into a specific community.

"Noche de Ronda"

"Noche de Ronda" (Night of Serenades), a play written by Pedro Monge Rafols, is a recent component of GMHC's efforts to reach the gay Latino community. A take-off on Mart Crowley's hit "The Boys in the Band," the play is a risqué comedy about a gay Latino man who has invited some close friends over to celebrate his birthday. He tries to give them the impression of being perfectly carefree, enjoying sexual relations, and looking forward to many more birthdays, when, in fact, he has taken the HIV-antibody test and is afraid of the results. Amidst an atmosphere of witty remarks, camp, and sexual innuendos, the anxieties and fears of being diagnosed HIV-positive are heightened by concerns about the possible rejection by friends, the lack of information about HIV/AIDS, and the breakdown of family ties. The characters discuss safer sex, fidelity between lovers, confronting parents with homosexuality, gays versus straights, and trust in relationships. The play effectively addresses the realities and concerns surrounding HIV/AIDS faced by the gay Latino community. "Noche de Ronda" can be sponsored by community groups and has been performed for both target and general audiences.

"Keep It Up"

Since 1988, GMHC has received significant funding for its new prevention workshop, *Keep It Up!*, from the Robert Wood Johnson Foundation, New York City Department of Health, Paul Rappaport Foundation, and New York City AIDS Fund. The *Keep It Up!* workshop is specifically targeted for gay and bisexual men who have experienced problems in maintaining safer sexual practices.¹⁴ Preprogram screening limits the workshop to men who engage in safer sexual behaviors with a high degree of consistency yet occasionally engage in unsafer behaviors, and men who have reverted to unsafe behavioral patterns after a period of engaging in safer sexual behaviors. High-risk behavior usually occurs in a situation-specific setting. What constitutes a high-risk situation varies from person to person; some situations, such as relationship-specific settings, frequently present insurmountable barriers to successfully maintaining safer sexual behaviors.

Based on relapse prevention literature, this workshop first identifies high-risk situations that influence sexual behaviors and then teaches alternative coping skills for effectively handling these situations. Rather than focusing on how to resist unsafe sexual behaviors, the workshop examines the situations where unsafe sexual behaviors typically occur. This allows participants to examine ways in which previously learned skills for following safer sex guidelines may be insufficient. Participants analyze the events that lead to their own high-risk situations, and identify how decisions were made which resulted in unsafe sexual behaviors. They divide into smaller groups to discuss ways in which the steps leading to unsafe sexual behaviors can be changed, and list options and resources available to help fortify their commitment to engaging in safer sexual behaviors, such as garnering community support and attending assertiveness-training workshops. Ongoing walk-in support groups are also offered on a biweekly basis, which gives interested participants an opportunity to further discuss issues of concern raised during the workshop.

The curriculum developed as a result of this workshop is currently being evaluated under a two-year research grant provided by the Health Services Improvement Fund. The results of this evaluation will hopefully offer further insight into the complex issues surrounding the maintenance of sexuality- and health-related behavioral change. Upon completion of the study, the curriculum of *Keep It Up!* will be available for use by HIV/AIDS service providers and educators.

For more information about these and other HIV/AIDS Prevention Programs, contact: Gay Men's Health Crisis, 129 West 20th Street, New York, NY 10011, or call the GMHC Hotline: 212/807-6655, TDD 212/645-7470.

frequently than men in any other relationship category, including nonmonogamous relationships and men outside a primary relationship. In general, men in any kind of relationship were more likely to have engaged in unsafe sexual behaviors than men who were not.^{2,5,12}

The misleading and dangerous recommendation that abstinence from sexual behaviors outside a monogamous relationship — whether heterosexual or homosexual — can be a viable means of protecting oneself from exposure to HIV is particularly problematic, given the results of these studies and the fact that the meaning of monogamy varies from culture to culture. For example, in a focus group of gay men conducted by Gay Men's Health Crisis (GMHC), a participant referred to his long-term relationship as monogamous even though he had sexual interactions outside the relationship. Monogamy in this case was an emotional commitment to a partner, not necessarily an exclusively sexual one. If not addressed sufficiently, this type of message can lead to an increased risk of exposure.

Social support for safer sexual practices, or the lack of it, is often cited as a determinant of relapse.¹⁵ One study found that the level of attachment to the gay community predicted, to some degree, adherence to safer sexual practices.¹⁶ The three levels of involvement studied were gay community involvement, an indication of a political and cultural attachment to the community; social engagement involvement, as defined by men who were only socially involved in the community; and sexual engagement, representing attachment limited to sexual interactions only. Men who had a high degree of involvement in the gay community were most likely to adhere to safer sexual practices. Such attachment may not be possible for gay and bisexual men living outside more visible, highly politicized gay communities. For these men, healthy behavioral change must be reinforced by personal networks, which for some may only comprise casual, anonymous partners.

In the absence of a widespread cultural context in which safer sexual behaviors become the only accepted means of sexuality, the onus for adopting and maintaining healthy behavioral change will remain firmly planted on the shoulders of the individual. A culture that adopts safer sexual behaviors as not only acceptable, but preferable to unprotected sexual behaviors in all situations, at all times, must extend well beyond established coastal communities of gay men. The challenge is thus to generate a culture which accepts and encourages safer sexual behaviors for all people, regardless of sexual orientation, socioeconomic status, age, ethnic origin, religion, or any other social or political descriptor.

Understanding Informed Sexual Decisionmaking

Changes in the way gay men perceive their risk of HIV infection present serious implications for the future of HIV/AIDS prevention programs for all communities. When HIV/AIDS organizations first began delivering safer sex workshops to the gay community, the HIV-antibody test was not as commonly utilized as it is today. Therefore, an important message delivered during safer sex workshops was *assume all partners*

are HIV-positive. This focused on the specific sexual behaviors that have a higher risk for infection, such as unprotected anal intercourse. The premise was that following these safer sex guidelines would reduce the risk of exposure to HIV regardless of a partner's HIV-antibody status. Now gay men are more sensitive to the limitations of the safer sex guidelines and less confident about how safe safer sexual behaviors with an infected partner may be. Also, as more and more gay men take the HIV-antibody test, the gay community becomes more sensitive to the implications of sexual activity when partners have different HIV-antibody statuses.

"Demanding information about a potential partner's health status may not seem inappropriate to some, yet it is obvious that using this information to determine another's acceptability as a sexual partner has the potential to divide all communities affected by HIV."

Participants in GMHC's safer sex maintenance workshop have suggested it is more acceptable to engage in safer sexual behaviors with someone whose HIV-antibody status is unknown, even if they may actually be positive, than to engage in safer sexual behaviors with someone who has tested positive. These men say that the safer sex guidelines do not address the many subtleties of sexual behavior and thus do not provide them with enough assurances to feel confident about avoiding exposure. When asked to reevaluate the standard safer sex guidelines and to add more personal ones, participants agreed almost unanimously that disclosure of HIV status, whether positive or negative, should be part of informed sexual decisionmaking.

Demanding information about a potential partner's health status may not seem inappropriate to some, yet it is obvious that using this information to determine another's acceptability as a sexual partner has the potential to divide all communities affected by HIV. And in the absence of more precise information concerning transmission, the likelihood that that information will be a rationale for engaging in unsafe sexual behaviors will certainly increase. Personals in gay publications, such as "HIV-negative seeking same" or "Positives only need apply," indicate that opposing factions of gay men, based on those who have the virus and those who are virus-free, is becoming a reality.

Bridging the gap between HIV-positive and HIV-negative individuals needs to be a priority for organizations who serve an already AIDS-aware gay constituency. It is also important to emphasize the need for partners of like HIV-antibody status to engage in safer sexual behaviors. Although same-serostatus partners may believe they pose little or no risk to each other, a seropositive person faces the possibility of re-infection or infection with a different strain of the virus, and it is possible that an infected seronegative person could seroconvert at any time.

Developing Safer Sex Guidelines

Many HIV/AIDS organizations, municipal health departments, and state and federal health agencies have adopted a set of safer sex guidelines. These guidelines are successfully teaching people about safer sexual practices. However, anecdotes reported by GMHC's safer sex workshop participants indicate that these guidelines are no longer sufficient for answering questions about the precise risk of certain activities. For example, many safer sex guidelines initially promoted monogamy as a viable means of avoiding exposure to HIV. It has become evident since then, however, that engaging in unsafe sexual behaviors with one long-term partner can be the cause of exposure leading to infection, while the consistent practice of safer sexual behaviors with multiple partners can be health-protective. Though some people believe that choosing monogamy is morally superior, for others it is but one equally valid choice among many.

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To date, safer sex guidelines have oversimplified risk. Although now there is a clear picture of what behaviors expose an individual to HIV, the ability to predict with any amount of certainty the likelihood that infection will result from that exposure is not available. As a result, many gay and bisexual men are now seeking levels of comfort with risk-taking that challenge established safer sex guidelines. Sexual activity has been viewed as either safe or unsafe, which may be appropriate in the context of exposure to HIV, but not regarding HIV infection. We can be fairly confident of which behaviors expose an individual to HIV: unprotected anal, vaginal, or oral sexual contact with a partner who is already infected with HIV. However, this view does not hold fast when considering the risk of infection that follows exposure. Unfortunately, researchers have not investigated the differential risk of infection among sexual behaviors. So even the informed individual may be relatively uninformed, considering the decisions s/he must make.

Most sexual activities are neither 100% safe nor absolutely unsafe, but lie somewhere along a *safe to unsafe sexual behaviors continuum*. It is up to the individual to make informed decisions on where along this continuum s/he is comfortable with accepting risk. Individuals must view the guidelines not as rules of behavior, but rather as measures taken to prevent exposure during sexual activities. For example, anal sexual intercourse is the same act with or without condom use. The sexual act itself has not changed; instead, the way in which an individual views and carries out the behavior has been modified, and has resulted in a healthy behavioral change.

Moreover, there is no guarantee that transmission of HIV will not occur as a result of a low-risk activity.

The assumption that oral sexual contact is low risk, for example, does not mean that oral sexual contact presents no risk. Sexuality and HIV/AIDS education must now address the uncertainties about virus transmission and include information that will contribute to informed choices. As stated in the Tucson AIDS Project's philosophy on education, "Safer sex educational efforts should incorporate messages which validate and reaffirm healthy sexual expression for individuals...should be directed toward informing people about the methods and efficiencies of HIV transmission. People should be encouraged to use information about transmission and to understand there are choices to be made. Whatever choice they make should be one that incorporates their value system as well as the information about transmission. An essential...is empowering people to take responsibility for their own protection. The responsibility for risk reduction does not rest with the Project or the educator, it rests with the individual."¹⁷

Supporting Positive Behavioral Change

HIV/AIDS prevention education needs to present the tools necessary for informed decisionmaking to occur. For example, despite the almost universal recommendations to use condoms, unprotected oral sexual contact remains a highly-engaged-in activity for gay men.¹⁸ Thus, many gay men have made the decision to engage in a sexual behavior that may expose them to HIV, leading to an unsure risk of infection. How great a risk is not known.

Various agencies and groups have, based on the limited knowledge available, classified the risk associated with unprotected oral sexual contact. For example, "minimal-to-low risk" (Canadian AIDS Society), "high-risk" (U.S. Centers for Disease Control), "possibly safe" (Columbus AIDS task Force), "dangerous" (Charlottesville AIDS Task Force), "safe, under certain conditions" (Buro GVO, the Netherlands), and "safe" (Queensland AIDS Council, Australia). With such lack of consensus about the level of risk, a variety of responses can be expected from individuals seeking a green light to engage in oral sexual behavior.

A culture of fear around HIV transmission has been created so that people who perceive themselves at risk for HIV infection are expected to make an absolute decision to practice safer sexual behaviors in every instance for the rest of their lives — which is certainly preferable to engaging in behaviors which may lead to HIV infection. However, this all-or-nothing expectation fails to recognize the scope and progression of behavioral changes necessary to inhibit HIV transmission. Careful measures need to be taken to support those changes throughout the continuum of behaviors, especially in the midst of an epidemic.

When individuals falter in their efforts to consistently refrain from engaging in specific sexual behaviors that carry a high-risk of exposure to HIV, we must be careful not to burden them with added negative messages. By combining an understanding of the issues surrounding safer sex and behavioral change, with the means for ongoing support for individuals to adopt and maintain

new behaviors over time, HIV/AIDS prevention campaigns can instill a sense of control over sexual behaviors and decisionmaking that is life-affirming.

While it is important to recognize the continuing problem of adherence to safer sexual behaviors, it is a mistake to attribute that problem exclusively to relapse. There are many complicated issues involved in sexual decisionmaking that are as yet not completely understood. Categorizing large and diverse groups of gay men as *relapsers* whenever unsafe sexual behaviors occur, simplifies the issues surrounding the decision to engage in unsafe sexual behaviors and may complicate the search for an effective solution. A priority for HIV/AIDS prevention programs is to understand how gay men make decisions about their sexual behaviors, how they view safer sexuality in the context of their whole life experience, and where along the sexual decisionmaking continuum learned skills and coping mechanisms become inadequate and positive behavioral change needs to be supported.

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ATTENTION HIV/AIDS EDUCATORS

SIECUS ANNOUNCES A CALL FOR MATERIALS

SIECUS is collecting HIV/AIDS teaching strategies, guidelines, and syllabi in order to publish a compilation of resources which will provide educators with new ideas and approaches and encourage information sharing among HIV/AIDS educators. Information about this resource will be distributed to SIECUS members and HIV/AIDS agencies nationwide. According to a membership survey we conducted in May of 1989, 75% of our membership is involved in HIV/AIDS education.

Now, 10 years into the HIV/AIDS epidemic, as we hear more about *HIV/AIDS saturation*, it is important that we infuse our programs with new vital energy and enthusiasm. If you have developed any type of educational resource, we encourage you to submit it by **December 15th, 1991**. Submissions may include examples of teaching activities, syllabi for courses, outlines, tips for conducting specific lessons, state and/or local guidelines for HIV/AIDS educators, and group strategies.

All contributions will be greatly appreciated and will foster a rich and diverse collection, with examples of submissions included in the resource. Please do not hesitate to send an informal or brief outline of your work. These are actually the type of materials that we are seeking. We need to hear as many voices, approaches, and philosophies as possible. You will be contributing to a resource that can greatly enrich existing programs. This publication is not intended to be a formal collection of comprehensive materials. Rather, we envision a gathering of information from individuals who are involved in HIV/AIDS education. However, if your agency has published an extensive resource that you would like to submit for review, please feel free to send materials for possible inclusion in a bibliography or as a recommended resource in the *SIECUS Report*.

According to our agreement with the U.S. Centers for Disease Control, an advisory committee will review all materials to ensure that they adhere to CDC guidelines. Please direct submissions to: Carolyn Patierno, Director, National AIDS Initiative, SIECUS, 130 West 42nd Street, Suite 2500, New York, NY 10036. (We will not be able to return the materials that we receive.)

UNDERSTANDING AND SUPPORTING HEALTHY BEHAVIORAL CHANGE

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In dealing with the threat of HIV infection in the lives of our clients and students, health care professionals and educators face that same conundrum that challenges us about so many of the major health care problems of the day — *if only they would recognize the dangers of their current behaviors — if only they would recognize our wisdom and stop doing those risky things!* We shake our heads and throw up our hands in frustration. We have no doubt that the primary weapon against the transmission of HIV is education that promotes and influences healthy behavioral change.

We know that the risk of exposure to HIV can be lessened by choosing to engage in specific behaviors: using condoms or latex dams to avoid contact with blood, semen or vaginal secretions; abstaining from sexual intercourse; and for intravenous drug users (IVDUs), no longer sharing needles and other drug paraphernalia or lessening risk of exposure by using bleach to clean needles and paraphernalia between shared uses.

However, experience has clearly demonstrated that the simple provision of facts or promotion of abstinence is not enough. Human beings tend to be resistant to behavioral change in general, and when faced with changing sexual and drug-use behaviors, a stubborn resistance to behavioral change may emerge, which is directly related to specific characteristics shared by these behaviors. Sex- and drug-related experiences — which involve the powerful appeal of sensations that alter the experience of one's life — may serve as expressions of power and identity; they have become a medium of exchange in many people's lives, and invoke mixed messages of approval/censure from the media and society.

Behavioral changes witnessed in the last decade, in areas such as restricted cigarette smoking in public places or stronger sanctions against driving while intoxicated, appear to be the result of the unusual concurrence of multiple voices speaking a single message — a coalition of caring and concerned individuals and organizations, including health, social service and education professionals, governmental agencies, and visual and print media — which provided harmonious support for the adoption of new standards and values regarding these behaviors.

Eventually, people began to respond positively to repeated exposure to the consistent presentation of these attitudes/values, so that some reduction in these behaviors has been observed. But the lethality of HIV infection makes us impatient with the slow, evolutionary pace of previous behavioral change processes. What can we do to effect behavioral change *now*?

Reframing the Concept of Risk-Taking

A first step is to reexamine and reframe our perception of our clients' behaviors. We frequently define behaviors based on our evaluation of what constitutes risk-taking for them. In fact, the behavioral changes we encourage our clients to adopt often feel much more *presently risky* to the client than continuing the current risk-taking behaviors. For example, when we suggest the introduction of condom use into clients' sexual relationships to reduce the risk of exposure to HIV, clients' fears may include the risks of losing their relationship, inviting a rejection or even a violent reaction, and appearing to doubt the exclusiveness of a relationship or their partner's honor.

"An understanding of the situational value and priority of behavioral change needs to be combined with an understanding of the conditions and strategies that will maximize the possibility of such change occurring."

In different communities, condom use carries a variety of social and cultural implications which can make their use problematic and/or unacceptable: an indication of promiscuity, an interference with fertility, and a threat to the assumption that trust is present, in many relationships. For women and adolescents in particular, the suggestion to use condoms to prevent exposure to HIV may ignore the reality of their lack of power in sexual decisionmaking. When sexual behaviors and drug use are linked, an individual's attempts to control or change that situation can become immediately risky in ways that clearly overshadow our warnings of potential infection.

If the client feels that the costs of behavioral change

exceed the benefits, our encouragement of this change may go unheard and may actually be irresponsible, if not undertaken with explicit recognition of the client's perception and pragmatic support for managing the hoped-for change in the context of the client's daily life and personal and social needs. An understanding of the situational value and priority of behavioral change needs to be combined with an understanding of the conditions and strategies that will maximize the possibility of such change occurring.

Behavioral Change is Most Likely to Occur When:

The client gains a new awareness and insight and perceives the significance this has in her/his life. The awareness of the implications of behavioral change may not be new, but is accompanied by a new realization that s/he is not immune to the potential consequences of her/his behaviors.

Consider how a close and personal brush with a behavioral consequence can motivate action, i.e., a teenager's death in a drunk driving accident inspires other teens to become activists against drunk driving, or a friend's diagnosis of breast cancer convinces a woman to have a mammogram. The effectiveness of HIV/AIDS education programs is increased by the inclusion of HIV-positive individuals as presenters, particularly those perceived as peers by the program's targeted population, precisely because that individual's inclusion creates the opportunity for the recognition of personal significance.

The client has the opportunity to examine not just the benefits of the behavioral change, but also the costs of making that change. Rather than failing to change due to inadequate awareness of the benefits of that change, individuals are more likely to fail due to the positive rewards of continuing the current behavior and/or the real or imagined costs of ceasing it.

For example, few smokers today can be unaware of the risks of smoking or the potential benefits of stopping. Yet if a smoker does stop, s/he must deal with the painful loss of the effects of the drug nicotine and the easy availability of an activity which initially relaxes, facilitates social situations, suppresses appetite, and provides a physical outlet for anxiety. For IVDUs, in addition to the physical reaction to withdrawal, stopping drug use may leave them without friends, without a shield against recognizing the pain and poverty of their existence, without a readily available source of income, and faced with confronting life's problems and challenges without drugs.

Dialogue with clients about behavioral change can begin with questions about what they perceive will be most difficult for them, and what concerns them most about trying to make the change. We can listen carefully to their perception of the obstacles and possible negative consequences of the change attempt, and thereby focus on problem-solving approaches to help them integrate new behaviors in real life situations. And we can hear when our agenda for new behavior is inappropriate in light of the severity of difficulty or the consequences they anticipate.

The client has ready access to any necessary tools

and services, the opportunity to develop and rehearse needed skills, and ongoing support for behavioral change. The chance to observe and practice new skills, particularly communication skills, in a safe and non-threatening environment can enable the client to develop a sense of competence — the belief that s/he can successfully make the behavioral changes.

Rehearsal, using role-play, can be a valuable problem-solving approach. For example, if a client wants to share her/his HIV status with a partner but is afraid of doing so, we might suggest acting out the imagined exchange. Reversing roles — having the health care provider role-play the client and the client role-play the other person in the exchange — can maximize the value of this strategy. The client is under less pressure, with less expectation that s/he should know the *right* thing to say, while we have the opportunity to model some possible statements and responses. Clients also frequently gain insight into the other person through this technique, as well as a sense of what it feels like to hear or speak from the other's perspective. By observing how the client plays the other role, we may become aware of possible reactions which could shape the outcome of such an exchange in actual situations or even make it unwise to attempt the exchange; we might then need to explore alternatives to the original behavioral change process being considered.

The client makes a provisional try which is perceived by her/him as more positive than negative. When the initial try is deemed successful by the client, s/he is certainly more likely to try again. However, initial tries often fail or are painful to execute.

We can help reframe that experience by considering the initial success, the first and essential step toward change, as the client's recognition of a moment when an attempt might have been risked, or the fact that s/he now defines the old behavior as *failure*. If the client is genuinely supported in a realistic expectation of the possibility of failure — while the attempt itself is applauded as a success — the chance that the client may begin to integrate the change, or brave further attempts at changing, is greatly enhanced.

We Can Support Behavioral Change By:

Recognizing, supporting, rewarding, and affirming all changes and efforts towards change. Too often, we and our clients recognize success only when the ultimate goal has been achieved, rather than celebrating all the incremental steps inherent in successful behavioral change. People seldom move from 0% to 100% compliance. Behavioral change can be presented with the shared awareness that it often happens in a one-step-at-a-time fashion. We can help clients identify what all the steps might be and anticipate the potential stumbling blocks. Our understandable impatience with the gradual nature of the process of human behavioral change cannot circumvent its inevitability; our genuine acceptance of that truth can allow much greater honesty in supporting clients through the process.

Problem-solving, instead of chastising, around failures. As the behavioral change progresses, we often continue to focus on the failures. For example, we tend

Behavioral Change Can Be Supported By:

- *Recognizing, supporting, rewarding, and affirming all changes and efforts towards change.*
- *Problem-solving, instead of chastising, around failures.*
- *Being available for ongoing support and/or identifying and assisting with other resources for support.*
- *Focusing on the positive benefits of the changes made, while allowing for mourning of past behavior.*

to ask *why?* questions, specifically about behaviors which we judge as negative and would prefer the client to abandon, such as, "Why do you keep having sexual intercourse without condoms?" or "Why have you missed another appointment?" While ostensibly designed to get at underlying motivation, this approach creates defensiveness, diminishes the client's ability and willingness to use us as a resource in problem-solving, and mistakenly assumes that revelation of the *why* will be the motivator for change. *Why?* questions that focus on success can be much more effective. When a client reports using condoms only once in five sexual encounters, an affirmation of that success, e.g., "That's a terrific start!" can be followed by a question, "Why do you think you were able to make it happen that time?" to help surface the dynamics of their success. We can follow that up with an exploration of what was different in the other encounters that hindered condom use for the client. This is the beginning of effective problem-solving.

Being available for ongoing support and/or identifying and assisting with other resources for support. The success of self-help groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), etc., demonstrates the power of ongoing support, particularly when peers provide that support to one another. While we may not always consider ourselves to be our clients' peers, our relationship with them is important, and our support can be a tremendous addition to the other support sources in their lives.

The peer support group approach to promoting and maintaining behavioral change and the model described in this article differ in the following ways: the confrontational style so characteristic of AA-type programs works because it occurs in the context of a peer relationship, and there is a specific, shared experience of the behavior being changed that gives credibility to the power of the confrontation. Such similarity is not a prerequisite to a valuable and valued relationship, however without that common experience or a long-term connection between provider and client, confrontation is a less valid and less effective

approach, which can keep a positive therapeutic relationship from ever developing.

Focusing on the positive benefits of the changes made, while allowing for mourning of past behavior. We can encourage comparisons of before and after change, affirm the strength and courage needed for change, and remind the client of the wisdom of the process which brought him/her to the point of change. At the same time, it is essential to be willing to hear, and to encourage the client to share, the pain of change. It would be a mistake, in our satisfaction over the client's new behavior, to overlook the tremendous pull of what was for the client familiar, safe, and comfortable, even if *risky*.

Conclusion

Ideally, our goal is to create a relationship in which our clients are willing to risk using us as a resource in their own change and growth. This is indeed a risky step — allowing us to know their personal needs, fears and failures — that is likely to happen only if our clients feel they are not being judged and are able to trust. Our greatest challenge, then, is to be willing to change our own behaviors and expectations about the success of our work, and reframe our definition of success.

We need to be able to relate to our clients with healthy detachment from ourselves — not detachment from our clients — and let go of the assumptions that our success is defined by their decisions and actions, that we are supposed to be able to *fix it*, and that our clients' failures are our failures as well. These assumptions create anger, resentment, and frustration in us, because our clients become the embodiment of our own inadequacy. When they become a source of such pain for us, genuine caring for our clients is blocked. However, when we can separate our success from their behaviors, and return to them the responsibility for behavioral change which was never ours to begin with, then we are free to be truly available to them. Perhaps the most important idea we can bring to the work of supporting healthy behavioral change is that *we do not change our client's behavior, the client does*.

Author's Note: The following sources were useful in the writing of this article:

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HIV/AIDS AUDIOVISUAL RESOURCES

A SIECUS Guide to Selecting, Evaluating, and Using AVR

In the past ten years, hundreds of audiovisual resources (AVRs) have been produced to provide HIV/AIDS information. AVRs take many forms, such as posters, films/videos, audio-cassettes, promotional buttons, anatomical models, and subway, bus or wallet cards. This SIECUS Guide to Selecting, Evaluating, and Using AVRs has been created to address those films and videos which can provide useful and uniquely effective components for existing or new educational programs. A plethora of AVRs exists and presents a challenge for the educator or clinician interested in using this medium. Selecting an effective and appropriate resource is as important as utilizing it wisely. The following are guidelines for selecting and evaluating AVRs. This guide is divided into two parts: a selection and an evaluation tool.

WHY THE NEED FOR AVRS

At this point in the HIV/AIDS crisis, people involved in the ongoing educational process are being challenged to re-energize and develop innovative approaches to HIV/AIDS education, which are needed more now than at any other time in the history of the age of AIDS. The most ideal education program is one that offers a variety of approaches. One of the most dynamic teaching tools is the AVR.

AVRs offer both educators and audiences an opportunity to comment on a third element or party. Therefore, there is a level of safety inherent in using AVRs that may be more difficult to establish using other educational techniques. This is especially important considering the difficulty many people have discussing HIV/AIDS, sexuality, illness, death, and drug use.

AVRs may be used to introduce a topic that people are uncomfortable discussing. Asking groups to comment on what they have just seen is a good way to trigger discussion because of its immediacy and (if resources are chosen appropriately) viewers are able to identify with characters. This personal identification also allows for more affective education to take place.

AVRs provide an opportunity to witness new ideas and approaches, discuss them, and then model those that appear to be replicable.

HOW TO SELECT THE AVR THAT'S BEST FOR YOU

There are many AVRs available with a broad spectrum of audiences in mind. Like any educational tool, in order to be effective it must speak directly to the target audience. It should be noted that this appropriateness is often best achieved when the educational resource, in this case the AVR, is produced by members of a particular community for that community.

The first step in choosing an AVR is to identify the audience that will be viewing it. Relevant questions that would help make this determination are included in the AVR Checklist included in this guide.

Once the educator has identified the target audience, the following questions should be taken into consideration:

- What do you want the target group to learn from the material?
- Is the information relevant for the target group?
- Does it reflect the values, lifestyles, and culture of the target group?
- Does it reflect their concerns?
- Will the target group understand it?
- Does it use their language or language that is familiar to them?

- Are the referrals current and appropriate for the target group?
- Does the AVR direct the target group to an easily accessible, appropriate source for more information?

Content

It is important when choosing an AVR to consider the content carefully. There are subtle and not-so-subtle issues that you might want to consider.

SIECUS has outlined five goals for HIV/AIDS education that are useful to keep in mind when reviewing resources that are intended for use with young audiences. HIV/AIDS education should: eliminate panic and misinformation, encourage the delay of sexual involvement, provide sexually active teenagers with the information and resources they need in order to protect themselves from exposure to HIV and other sexually transmitted diseases (STDs), inform about the hazards of drug use, and encourage compassion for people who are living with HIV and AIDS.

As with effective HIV/AIDS curricula or educational programs, AVRs which address the three learning domains will probably lead to the best results. By encompassing cognitive (factual information), affective (attitudes/values and feelings), and behavioral (skills development) aspects, the AVR will offer the greatest potential for supporting healthy life options among its viewers.

For all audiences, regardless of age, consideration should also be given to whether or not the AVR promotes and encourages healthy behavioral change and its maintenance in order to reduce the risk of HIV infection. Does it present the skills needed in order to affect behavioral change? Is it practical for the target audience? Is the material explicit enough to deliver its message without offending the target audience?

Values clarification is a significant component of HIV/AIDS education materials. In terms of AVRs, if viewers are clear about the values that are offered within a given resource, they may become more clear about their own values. This clarification is important as it will guide individuals in their decisions concerning risk reduction. It is imperative that educators remember that although we each must clarify our own values, one should never assume that everyone shares those same values. Effective HIV/AIDS education is more likely to happen in an atmosphere in which participants feel they are not being judged.

Sexuality is another content area that needs to be considered. Sexuality is a natural and healthy part of living. Unfortunately, in this time of rapidly growing rates of HIV and other STDs, education and prevention efforts usually present sexuality in the context of disease. AVRs that present sexuality in a positive light should be sought out. In addition, it would be useful if viewers were presented with a concept of sexuality that encompasses its physical, social and emotional aspects.

WHERE TO FIND AVRs

Sometimes it seems overwhelming to know where to look for AVRs. There are many organizations or agencies which develop, distribute and provide technical assistance and referral information about AVRs. The list below highlights ten organizations or agencies to contact for specific guidance and help:

- **American Foundation for AIDS Research (AmFAR)**, 1515 Broadway, Suite 3601, New York, NY 10036; 212/719-0033. *Produces a useful information resources directory, Learning AIDS, which annotates available AVRs.*
- **Combined Health Information Database, AIDS School Health Education Subfile**, accessed via BRS professional database, 1-800/345-4277; hard copies available from the Centers for Disease Control, NCCPHP, Division of Adolescent School Health, MS K-31, 1600 Clifton Road, Atlanta, GA 30333; 404/488-5372. *Offers comprehensive information on many resources, including AVRs.*
- **ETR Associates/Network Publications**, PO Box 1830, Santa Cruz, CA 95061-1830; 1-800/321-4407 or 408/438-4060. *Distributes AVRs as part of its catalog holdings.*
- **Gay Men's Health Crisis, Video/Education**, 129 West 20th Street, New York, NY 10011; 212/337-1950. *Produces and distributes AVRs.*
- **National AIDS Clearinghouse**, PO Box 6003, Rockville, MD 20849-6003; 1-800/458-5231. *Distributes selected AVRs and provides technical assistance and referral information.*
- **National AIDS Hotline**, 1-800/342-AIDS.
- **NOVA Research Company (National AIDS Demonstration Research Project/ National Institute on Drug Abuse)**, 4720 Montgomery Lane, Suite 210, Bethesda, MD 20814; 301/986-1891. *Produces an excellent annotated guidebook on current AVRs.*
- **Planned Parenthood Federation of America, Education Department/LINK**, 810 Seventh Avenue, New York, NY 10019; 212/261-4628. *Distributes AVRs as part of its catalog holdings; provides technical assistance and referral information.*
- **San Francisco AIDS Foundation**, PO Box 426182, San Francisco, CA 94142; 415/861-3391 (Materials Department). *Distributes AVRs as part of its catalog holdings.*
- **Sex Information and Education Council of the U.S. (SIECUS)**, 130 West 42nd Street, Suite 2500, New York, NY 10036; 212/819-9770, fax 212/819-9776. *Provides technical assistance and referral information.*
- **State and local health departments**. *Often distribute AVRs and provide technical assistance and referral information.*

Up-To-Date Information

Although it is difficult to keep abreast of new HIV/AIDS information, it is important that educators carefully check for the most current information available. This includes information on transmission issues, surveillance, treatments, policies relating to testing, discrimination, and immigration, as well as appropriate resources.

This will take some leg work that is absolutely necessary, as it is imperative that people receive the most up-to-date information possible. Most people are not exposed to an adequate amount of HIV/AIDS education. If information that they do receive is outdated, it results in a grave disservice to both professionals and their target audiences.

There are many AVRs that were produced several years ago, yet remain worthwhile resources. If a resource contains some outdated information, but is otherwise

excellent, you have the option of stopping or pausing the video at those points in order to clarify and present updated information. It is best to use this technique while the issue is still fresh in viewers' minds. You might also want to prepare a handout that will provide the updated information.

Realistic

Viewers need to be able to identify easily with the characters or the narrators in the video. Are the characters people that the audience can empathize with and understand? Do the characters behave in a realistic manner? Also involved in the question of realism is the quality of the performances, because if roles are badly performed, viewers may be distracted by them and not pay attention to the information being presented.

(Continued on page 18)

RECOMMENDED AVR's

Some Examples of SIECUS Staff Favorites Among AVR's for children...for teens & young adults...for all adults...for professionals...

Although there are many excellent AVR's available today, the following is a sample listing of AVR's recommended by SIECUS staff. In some AVR's, terminology and/or information may have changed since their release date; however, the consistently accurate messages about HIV transmission remain. This listing does not constitute a SIECUS endorsement; nor does the listing imply that these are the only AVR's recommended for certain target audiences. Instead, it is designed to offer suggestions for specific AVR's to consider for your unique needs. These AVR's are a reflection of what SIECUS staff believe to be useful, appropriate, and effective AVR's in preventing the further spread of HIV infection and addressing the complex issues in this continuing era of HIV/AIDS — with facts, sensitivity, dignity, and compassion.

Thumbs Up for Kids (pre-school)
AIMS Media, 6901 Woodley Avenue, Van Nuys,
CA 91406-4878; 1-800/367-2467. VHS/\$250,
16mm/\$135.

Teen AIDS: In Focus (teens/young adults)
San Francisco Study Center, PO Box 425646,
San Francisco, CA 94142-5646; 1-800/484-4473.
\$115, plus \$3 postage/handling (p/h).

AIDS-Wise, No Lies (teens/young adults)
New Day Films, 121 West 17th Street, Suite
902, New York NY 10001; 212/465-8210. VHS/
\$250.

Don't Forget Sherrie (teens/young adults)
American Red Cross, Modern Talking Picture
Service, Inc. 5000 Park Street North, St.
Petersburg, FL 33709; 813/341-5763. VHS/
\$19.95, Beta \$24.95.

**Sex, Drugs and AIDS: What You Need to
Know** (teens/young adults)
Select Media, 74 Varick Street, 3rd floor, New
York, NY 10013; 212/431-8923. VHS/\$295,
each additional tape/\$189; 16mm \$400.

**The Subject Is AIDS: The Message Is
Abstinence** (teens/young adults)
Select Media, 74 Varick Street, 3rd floor, New
York, NY 10013; 212/431-8923. VHS/\$295,
each additional tape/\$189.

Vida/Are You With Me?/Seriously Fresh
(teens/young adults)
Select Media, 74 Varick Street, 3rd floor, New
York, NY 10013; 212/431-8923. VHS/\$65 per
title, plus \$10 p/h for first title, \$5 p/h each
additional title.

**It Can Happen to You: Adolescents and
AIDS** (teens/young adults)
Ohio Department of Health, AIDS Activities
Unit, 35 East Chestnut Street, Columbus, OH
43215; 614/644-1838. Free of charge.

AIDS: Changing the Rules (young and older
adults)
Schmid Laboratories, Inc., Sales Department,
PO Box 4703, Sarasota, FL 34230; 1-800/827-
0987. Free of charge.

The Complete Guide to Safer Sex (adults)
Multi-Focus, Inc., 1525 Franklin Street, San
Francisco, CA 94109-4592; 1-800/821-0514.
VHS/\$29.95, plus \$3 p/h; Guide/\$6.95 plus \$2
p/h; video and guide/\$31.95 plus \$5 p/h.

**Her Giveaway: A Spiritual Journey with
AIDS** (adults)
Indian Health Board of Minneapolis, Inc.,
AIDS Video, 1515 East 24th Street, Minneapo-
lis, MN 55404; 612/721-7325. VHS/\$112.

Mending Hearts (adults/everyone)
Carle Medical Communications, 510 West Main
Street, Urbana, IL 61801; 217/384-4838. VHS/
\$295.

**Saving a Generation: Successful Teaching
Strategies for HIV Education in Grades 4-12**
(teachers/professionals)
Select Media, 74 Varick Street, 3rd floor, New
York, NY 10013; 212/431-8923. Two VHS
videocassettes and teacher's guides/\$95.

We Bring a Quilt (everyone)
NAMES Project, PO Box 14573, San Francisco,
CA 94114; 415/863-5511. VHS/\$20.

THE SIECUS AUDIOVISUAL RESOURCE CHECKLIST

NAME OF REVIEWER _____

DATE REVIEWED _____

NAME OF AUDIOVISUAL _____

YEAR AVR RELEASED _____

PRODUCER/DISTRIBUTOR _____

ADDRESS _____

TELEPHONE _____ FAX _____

PURCHASE PRICE _____

RENTAL FEE _____

Brief summary about the contents and major point(s) of the AVR:

TARGET AUDIENCE

Please check all that are appropriate:

This is best suited for:

- ☐ children ☐ early teens ☐ late teens ☐ young adults ☐ mid-life adults ☐ older adults
- ☐ women ☐ men ☐ mixed audience
- ☐ professionals ☐ consumers
- ☐ communities of color: If so, note the community _____
- ☐ lesbians ☐ gay males ☐ heterosexuals ☐ bisexuals

CONTENT/APPROACH

- | | | |
|---|------------------------------|-----------------------------|
| Are young people encouraged to delay sexual involvement? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Is information on protection provided for sexually active people? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Is compassion encouraged for people living with HIV/AIDS? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Does this AVR provide a forum for values clarification? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Is sexuality presented in a healthy and positive light? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
-

INFORMATION

- | | | |
|--------------------------------|------------------------------|-----------------------------|
| Is the information current? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| accurate? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| clearly stated/understandable? | <input type="checkbox"/> yes | <input type="checkbox"/> no |

Items that require updating:

PRESENTATION OF INFORMATION

- | | | |
|--|------------------------------|-----------------------------|
| Is it sensitive to the values and culture of the target group? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
|--|------------------------------|-----------------------------|
- Does it address the three learning domains?
- | | | |
|----------------|------------------------------|-----------------------------|
| a) cognitive: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| b) affective: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| c) behavioral: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
- Does it present attitudes that are:
- | | | |
|--------------------|------------------------------|-----------------------------|
| racially unbiased? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| non-sexist? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| non-homophobic? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| non-heterosexist? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| non-judgmental? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
- | | | |
|---|------------------------------|-----------------------------|
| Does it describe risky behaviors and not risk groups? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
|---|------------------------------|-----------------------------|
-

TECHNICAL ASPECTS

- | | | | | |
|---------------------------|-------------------------------|-------------------------------|-------------------------------|------------------------------------|
| The sound quality is: | <input type="checkbox"/> poor | <input type="checkbox"/> fair | <input type="checkbox"/> good | <input type="checkbox"/> excellent |
| The acting quality is: | <input type="checkbox"/> poor | <input type="checkbox"/> fair | <input type="checkbox"/> good | <input type="checkbox"/> excellent |
| The narration quality is: | <input type="checkbox"/> poor | <input type="checkbox"/> fair | <input type="checkbox"/> good | <input type="checkbox"/> excellent |
| The visual quality is: | <input type="checkbox"/> poor | <input type="checkbox"/> fair | <input type="checkbox"/> good | <input type="checkbox"/> excellent |
-

What do you like most about this AVR?

What do you like least about this AVR?

Are there any omissions? If yes, please identify.

GENERAL RATING:

☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent**

Additional comments:

IDEAS FOR USE:

When presenting this audiovisual:

- ☐ use video in its entirety
- ☐ only present following section(s):

- ☐ stop after following sections, for discussion/questions and/or clarification:

(Continued from page 13)

Visual Appeal

An AVR is most interesting if a variety of visual approaches are utilized. Techniques may include the use of graphics, animation, dramatic scenes, interviews with people living with HIV/AIDS or professionals working with people living with HIV/AIDS, etc. If the video is not engaging visually, chances are it will not maintain the viewer's attention.

Pricing Information

Costs for AVRs can be very expensive, which is another reason to choose carefully and to inquire about other options. Some distributors offer rental and/or preview fee options in addition to a purchase price. For example, purchase prices may range from \$65 to over \$300 on the average.

Community Input

Some communities may require an approval mechanism for the clinic or school administration to implement before HIV/AIDS resources are selected and used. This process actually offers an opportunity for different segments of the community to provide input for programs which can benefit from the influence of diverse viewpoints and the assistance offered to the programs. These groups work best when they represent as broad a cross-section of the community as possible.

TIPS FOR HOW TO USE AVRs IN AN EDUCATIONAL SETTING

Always preview any AVR before showing it to your audience, even to a review committee. There are several ways that an AVR can be utilized within an educational setting:

- It may be viewed from beginning to end and then discussed;
- Parts may be viewed if there are sections that are most relevant, or if time does not permit viewing in its entirety, and
- It may be stopped at strategic points in the film or video in order for discussion to take place or to clarify information.

- Often a discussion or facilitator's guide accompanies the AVR and can be a necessary addition to the process after showing an AVR.

Remember that an AVR is not a stand-alone; that AVRs are one component of the educational process; that AVRs usually require skilled facilitation and careful planning if they are to be used with success.

In summary, these are recommended criteria for desirable attributes of an AVR related to HIV/AIDS:

- Sex-positive and life-affirming in its tone and its messages
- Avoids "risk groups" and describes risky behaviors
- Culturally sensitive and appropriate
- Empowers choice among its viewers
- Emphasizes what we do know about HIV/AIDS
- Usable in digestible learning bits
- Not overly ambitious or broad in scope
- Affordable, accessible, and available
- Promotes compassion for people living with HIV/AIDS
- Presents positive role models
- Target audience is well-defined
- Technically acceptable
- Factual content and terminology are current and accurate
- Devoid of the "isms" and "phobias" that encourage fear, anxiety, and prejudices
- Addresses the three learning domains: cognitive, affective, behavioral
- Upbeat, entertaining, and humanly moving, whenever possible

Developed by Carolyn Paterino, director of SIECUS' National AIDS Initiative and Patti O. Britton, deputy director of Program Services. For further information, please contact Carolyn Paterino at: SIECUS, 130 West 42nd Street, Suite 2500, New York, New York 10036, 212/819-9770, fax 212/819-9776.

AIDS 101 Is Not Over Yet

Carolyn Patierno

Director, National AIDS Initiative

When, at a recent SIECUS staff meeting, we all thought a *View From the Field* column would be interesting, the idea was especially intriguing to me because I love a good story. I enthusiastically embrace this tradition, not only because I think it is interesting, but also because I think it is a great educational tool.

In light of what I believe is the most challenging issue facing HIV/AIDS educators, I would like to recreate the most vivid training experiences that I've had in the past several months.

I am in my fifth year of HIV/AIDS work, specifically, in education and training. Recently, I met with an individual involved in a field whose members felt they were not affected by the HIV/AIDS crisis. Of course, since then they have found that they *are* intimately affected. This woman asked me for some technical assistance as she was about to take her first plunge into HIV/AIDS education. Soon after we began our discussion, I began to realize that although she had assured me that she had a high level of HIV/AIDS knowledge, she, in fact, had very little. I launched into the information that is often referred to as *AIDS 101*. Mid-way through outlining the means of transmission, the difference between HIV and AIDS, and the stages of disease, a not-so-little voice in my head screamed, "Why isn't this part over yet?!" As I shared this story with colleagues it became clear that this was a common experience for HIV/AIDS educators. Apparently, quite a few of us are walking around hearing these screaming voices saying, "Why isn't this part over yet?!"

In actuality, we do know why every person in this country is not fully informed of this important information. What I find disturbing is that while it is true that many individuals do not have this information, many, like the woman I spoke with, believe that they do. Many people feel *AIDS-saturated*, as though they have heard it all. What I'd like to focus on is the growing frustration that many HIV/AIDS educators are experiencing in light of the growing apathy that they are up against.

I have been working with museum educators, as more museums are now featuring the work of artists living with HIV/AIDS and showing exhibits that deal with HIV/AIDS. There was an exhibit at one of the museums, whose title clearly indicated that its topic was HIV/AIDS. Each of the works vividly portrayed the harrowing realities of the epidemic. I met with the educators of this museum to help prepare them for school-age groups that would be viewing the exhibit. I decided to begin by talking with the group about fear: to identify their fears surrounding the issues of illness, sexuality, homosexuality, death, drug use, etc. I first acknowledged that HIV/AIDS is a difficult issue to discuss, and then I framed the question broadly by

asking what some of their concerns have been when bringing groups of school-age children through the museum's exhibits. In general, the participants talked about their fear of museum and school administrators, and, more specifically, parents. I affirmed that these were certainly legitimate concerns, but I wanted to go a step further and talk about the gut responses they had when dealing with the difficult issues that HIV/AIDS brings up. I sensed some resistance in the room and asked what that was about. Most participants claimed that they were not uncomfortable at all when talking about HIV/AIDS. I took a deep breath and pressed on. I asked if I could assume, then, that they were all comfortable talking about illness, sexuality, homosexuality, death, and drug use? Finally, one participant blurted out, "I can't even *think* about these issues! I'm so worried about what I can or cannot say and how the museum administrators, parents, and teachers will respond that I steer clear of AIDS altogether!" My response was to feel my whole body drop, and I asked, "What *do* you talk about? And please, don't tell me brush stroke, color and texture." He slowly nodded his head, "Yes."

No wonder there is still a need for *AIDS 101* when so much fear still exists! For those educators who are struggling with what they can or cannot say, I'd like to offer a suggestion. Perhaps it is time that our education efforts become more activist in nature. I know that in some circles, the word *activist* is a loaded one, which conjures up images that make people feel uncomfortable. However, activist also means *active*, or taking control and responsibility for what you feel is important. It means relating HIV/AIDS to the politics of poverty, racism, homophobia, and sexism. It may also mean sharing our grief and loss. Finally, it means using anger in the most positive way as a motivator. How can HIV/AIDS educators help but feel angry? Yet, instead of letting this anger either fester or manifest in destructive ways, we can use it honestly and constructively. Perhaps if our educational efforts embraced the anger that this crisis inspires by its very nature, we would offer a more engaging educational experience that reaches more people. There is also a good chance that we might have more satisfying personal experiences.

I realize that what I am proposing — a more activist educational approach — will perhaps make educators and activists alike somewhat nervous. I sense this because, in meetings that I have attended recently, I have felt a sense of tension when educators are identified with activists. Similar tension has surfaced when I have met with activist colleagues regarding education issues. It seems that the question has become, "Which side of the left is more right?" (i.e., "correct"). This mistrust has created a destructive chasm between those in the streets and those in clinics, classrooms, and training centers. It is a chasm that must be bridged in order to reach the majority of Americans who feel they know all there is to know, yet, desperately run from mosquitoes. With a more united front, there is a greater potential for collective voices asking "Isn't this part over yet?" to see that light at the end of the tunnel.

STATEMENTS OF SUPPORT FOR SEXUALITY AND HIV/AIDS EDUCATION

SIECUS applauds the efforts of the United States Conference of Mayors, the National Association of Counties, and the American School Health Association, all of whom have courageously advocated for the rights of young people — for comprehensive and nonbiased sexuality and HIV/AIDS education. Their excellent statements of support are contained in the following resolutions:

RESOLUTION ON GAY AND LESBIAN YOUTH IN SCHOOLS

- WHEREAS, the educational system in the United States traditionally has been expected to provide instructional and support programs which meet the needs of diverse groups within the student population and to discourage discrimination against individuals based on group membership; and
- WHEREAS, of the millions of young people between the ages of 10 and 20 in the United States, a significant number are believed to be predominantly or exclusively homosexual; and
- WHEREAS, research indicates that sexual orientation may be established before birth or is developed between the ages of three and nine; and
- WHEREAS, the report of the Secretary's Task Force on Youth Suicide states that gay teenagers are two to three times more likely to attempt suicide; and
- WHEREAS, in a recent study of lesbians and gay men by the National Gay Task Force, one-fifth of the females and nearly half of the males reported they were harassed, threatened with violence, or physically assaulted in high school or junior high school because they were perceived to be lesbian or gay; and
- WHEREAS, unlike other oppressed minorities, gay youth often do not have the support of family and peers;
- THEREFORE, BE IT RESOLVED that the American School Health Association believes that school personnel should demonstrate respect for the dignity and worth of all students; and
- BE IT FURTHER RESOLVED that the Association believes that all young persons should have an equal opportunity for quality education regardless of their sexual orientation; and
- BE IT FURTHER RESOLVED that curriculum materials, teaching strategies, and school policies that do not discriminate on the basis of sexual orientation should be implemented in schools; and
- BE IT FURTHER RESOLVED that sexual orientation should be addressed in the sexuality component of a comprehensive health instruction curriculum; and
- BE IT FURTHER RESOLVED that school personnel should discourage any sexually-oriented deprecating, harassing, and prejudicial statements injurious to students' self-esteem; and
- BE IT FURTHER RESOLVED that every school district should provide access to professional counseling by specially-trained personnel for students who may be concerned about sexual orientation.

Approved by the American School Health Association, October 1990.

Editor's Note:

A useful periodical was inadvertently omitted from *Sexuality Periodicals for Professionals: A SIECUS Annotated Bibliography*, which appeared in the June/July 1991 issue of the *SIECUS Report*.

Family Life Matters is published three times a year by the New Jersey Life Network for Family Life Education, and includes information about how to help young people understand their sexuality, postpone sexual activity, and avoid pregnancy, HIV/AIDS, and other sexually-transmitted diseases. *FLM* also contains information about sources of assistance, new classroom materials, and the latest research in the field. *New Jersey Network for Family Life Education, School of Social Work, Building 4087, Livingston Campus, New Brunswick, NJ 08903; 908/932-7929. Subscription rates: One year/\$10, two years/\$19, three years/\$28.*

RESOLUTION ON HEALTH/SEXUALITY EDUCATION FOR YOUTH

WHEREAS, more than half of American teenagers have had sexual intercourse and face significant health risks; and
WHEREAS, each year over one million teenagers become pregnant, one in seven teenagers contract a sexually transmitted disease (STD), and one in five hundred students on college campuses are infected with HIV; and
WHEREAS, forming a sexual identity is a key developmental task of adolescence; and
WHEREAS, adolescents require accurate information about sexuality, opportunities to explore their values in supportive environments, and encouragement for responsible decisionmaking; and
WHEREAS, responsible adolescent sexual relationships, like those of adults, should be consensual and nonexploitive; and
WHEREAS, adolescents should practice precautions against unintended pregnancies and STDs, including HIV/AIDS,

NOW, THEREFORE, BE IT RESOLVED, that the U.S. Conference of Mayors endorses the provision of comprehensive sex education to adolescents as endorsed by U.S. Surgeon General C. Everett Koop in 1986; and
BE IT FURTHER RESOLVED, that the Conference of Mayors supports education about abstinence, sexual limit-setting and resisting peer pressure that is designed to support adolescents in delaying sexual intercourse until they are ready for mature sexual relationships; and
BE IT FURTHER RESOLVED, that the Conference of Mayors supports comprehensive sex education that includes information about pregnancy, sexually transmitted diseases and HIV/AIDS, and which provides information, access and/or referral on methods to avoid pregnancy and prevent contracting STDs, including HIV/AIDS.

Adopted by the U.S. Conference of Mayors, June 1991.

HEALTH STEERING COMMITTEE RESOLUTION ON HEALTH/SEXUALITY EDUCATION FOR YOUTH

WHEREAS, more than half of American teenagers have had sexual intercourse and face significant health risks; and
WHEREAS, each year over one million teenagers become pregnant, one in seven teenagers contract a sexually transmitted disease (STD), and one in five hundred students on college campuses is infected with HIV; and
WHEREAS, forming a sexual identity is a key developmental task of adolescence; and
WHEREAS, adolescents require accurate information about sexuality, opportunities to explore their values in supportive environments, and encouragement for responsible decisionmaking; and
WHEREAS, responsible adolescent sexual relationships, like those of adults, should be consensual and nonexploitive; and
WHEREAS, adolescents should practice precautions against unintended pregnancies and STDs, including HIV/AIDS,

NOW, THEREFORE, BE IT RESOLVED, that the National Association of Counties (NACo) endorses the provision of comprehensive sexuality education to adolescents as endorsed by U.S. Surgeon General C. Everett Koop in 1986; and
BE IT FURTHER RESOLVED, that NACo supports education about abstinence, sexual limit-setting, and resisting peer pressure that is designed to support adolescents in delaying sexual intercourse; and
BE IT FURTHER RESOLVED, that NACo supports comprehensive sexuality education that includes information about pregnancy, STDs and HIV/AIDS, and which provides information, access and/or referral on methods to avoid pregnancy and prevent contracting STDs, including HIV/AIDS.

Adopted by the National Association of Counties (NACo), July 1991.

PATHFINDERS AWARDS

Call for Nominations

The National Partners, a consortium of national organizations working with the U.S. Centers for Disease Control to combat the HIV/AIDS epidemic, are calling for nominations for the first annual *Pathfinders Awards*. The purpose of the awards is to recognize the individuals who have made unique and vital contributions in the fight against HIV/AIDS.

HIV/AIDS challenges all sectors of society — government, the health care industry, corporations, unions, schools, the voluntary sector, and the religious community. Addressing HIV/AIDS requires compassion and reexamination of sensitive political, religious, ethical, and cultural values.

The organizations which form the National Partners are: American Federation of Labor and Congress of Industrial Organizations, George Meany Center for Labor Studies; American Federation of State, County and Municipal Employees; American Red Cross, Office of HIV/AIDS Education; Americans for a Sound AIDS/HIV Policy; Foundation of Pharmacists & Corporate America for AIDS Education; Hispanic Designers, Inc.; National Hispanic Education and Communications Projects; KCET Television; National Association of Broadcasters; National Association of People with AIDS; National Council of La Raza, NCLR AIDS Center; National Conference of State Legislators; National Education Association, Health Information Network; National Leadership Coalition on AIDS; National Minority AIDS Council; National Native American AIDS Prevention Center; National Urban League; Service Employees International Union; Sex Information and Education Council of the United States; and U.S. Centers for Disease Control.

The National Partners have witnessed the many personal acts of courage, wisdom, and sacrifice in our respective HIV/AIDS efforts. The *Pathfinders Awards* will honor those outstanding men and women who, through their commitment, have pioneered creative and sustained responses to the epidemic. Many of these heroic individuals have thus far received little or no public recognition for their efforts.

We hope you will participate by nominating individuals who have made a difference in the age of AIDS. Please fill out the attached nomination form and return it by December 15, 1991 to: Pathfinders, 1730 M Street NW, Suite 905, Washington, DC 20036, or call 202/429-0930.

Individual *Pathfinders Awards* will be announced at a national press conference with corresponding press events in each recipient's community in early spring 1992.

NOMINATION FORM — PATHFINDERS AWARDS

Nominee

Nominated by

Name:

Name:

Organization:

Address:

Address:

Phone:

Phone:

1. Give a brief description/history of the nominee's involvement in the HIV/AIDS epidemic.
2. Describe major accomplishment(s) and unique aspects(s) of the nominee's work.
3. Describe changes(s) in the community as a result of the nominee's involvement in the HIV/AIDS epidemic.

Submit by December 15, 1991 to: Pathfinders, 1730 M Street NW, Suite 905, Washington, DC 20036.

HIV/AIDS

RECOMMENDED RESOURCES

ADOLESCENTS, AIDS AND HIV: RESOURCES FOR

EDUCATORS (Volume VI, 1991, 16pp., 8½x11 booklet) is an annotated bibliography of print and audiovisual materials for HIV/AIDS education and prevention, published by the Center for Population Option's National Adolescent AIDS and HIV Prevention Initiative. Informative annotations provide a diverse representation of HIV prevention education materials that specifically address the needs of adolescents. "Age-specific educational materials are critical to efforts to control the further spread of HIV among adolescents. These materials must contain accurate information and help dispel the myths and misinformation that cloud the realities of HIV infection. Provided in the context of comprehensive HIV prevention education, these materials should also encourage behavioral change that will prevent adolescents from becoming infected with HIV." *Resources for Educators* is distributed to educators and health care professionals across the country. *Center for Population Options, 1025 Vermont Avenue, Suite 210, Washington, DC 20005; 212/347-5700. Available free of charge.*

AIDS/HIV AND CONFIDENTIALITY: MODEL POLICY AND PROCEDURES

(1991, 122 pp., 8½x11 book) developed by the American Bar Association (ABA) Commission on the Mentally Disabled and Center on Children and the Law, address issues of confidentiality pertaining to AIDS-related information affecting persons with HIV/AIDS and those who care for them. The book provides step-by-step guidelines for developing and implementing a confidentiality policy with an understanding that making HIV/AIDS information available to professionals also involves protecting the privacy of persons infected with HIV. Author Sharon Rennert, director of the ABA's AIDS and Developmental Disabilities Project, writes in the introduction: "Confidentiality, as it relates to [HIV], continues to be a primary concern of individuals with the disease, as well as to the diverse programs, agencies, and institutions that provide them with services and benefits....Why should there be a special confidentiality policy for HIV infection? One reason concerns the potential consequence of unwarranted disclosure — discrimination....Respecting a person's right to privacy — the right to decide who receives personal information, and how it may be used — requires that those privileged to have access to such information maintain its confidentiality." The resource includes sample consent forms, a medical overview of HIV/AIDS, and a list of Protection and Advocacy agencies nationwide. *Sharon Rennert, American Bar Association, AIDS/DD Project, 1800 M Street NW, Washington, DC 20036; 202/331-2282. Price: \$25, plus \$3.95 postage/handling.*

AIDS HEALTH PROMOTION EXCHANGE (1990, 16pp., 8½x11 newsletter,) published by the World Health Organization, Global Programme on AIDS (GPA), Health Promotion Unit, with the Royal Tropical Institute (KIT) in The Netherlands, is an information newsletter that includes articles, programs, GPA news, and news from different countries, evaluation notes, and a global bulletin board as well as graphics. *For subscriptions, write to: World Health Organization, Distribution and Sales, 1211 Geneva 27, Switzerland. Available free of charge to organizations and individuals directly involved in promotion for HIV/AIDS prevention, who*

are unable to pay for a subscription. Price: annual subscription/\$16. Printed in English, French, and Spanish.

AIDS IS ALSO AN INDIAN PROBLEM was prepared by the Native American AIDS Advisory Board, through a grant to the California Rural Indian Board, Inc. from the California Department of Health Services. Attractively designed by Tina Laronne Kohler and David Ipinia, this clearly written pamphlet offers basic information on HIV/AIDS to Native Americans "in every area of the United States — on reservations, rancherias, pueblos, villages, in cities and in rural areas." Pertinent to conventional traditions, it highlights the need to be aware that "sharing of blood as in ceremonial flesh offerings or blood brother initiations can pass the AIDS virus." They sensitively advise at the end: "Learn how to care for and protect people with AIDS." Lists the National Indian AIDS Hotline: 1-800/283-AIDS. *California Rural Indian Health Board, Inc., 2020 Hurley Way, Suite 155, Sacramento, CA 95825; 916/929-9761.*

AIDS PRACTICE MANUAL: A LEGAL AND EDUCATIONAL

GUIDE (Third edition, 1991, 600 pp., 11½x11½ looseleaf binder) published by the National Lawyers Guild AIDS Network in conjunction with AIDS Law Project of Pennsylvania, Gay Men's Health Crisis, and Whitman-Walker Clinic. This clearly written educational manual offers expert guidance and analysis of the wide range of legal issues raised by the HIV/AIDS epidemic. Chapters include: Practical Aspects of AIDS Litigation; Medical and Public Health Overview of HIV Infection; HIV Antibody Testing; Personal and Estate Planning; Future Care of Children; Public Assistance Programs; Debtor's Rights; Insurance and Employee Benefits; Employment Discrimination; Housing Discrimination; HIV/AIDS and Prisons; Child Custody; and Immigration. Appendices listing State HIV Laws, State Handicap Discrimination Laws, Model Voir Dire Questions, and Resource Lists of Legal and HIV/AIDS Organizations offer useful information. A comprehensive treatment of key issues raised by the HIV/AIDS epidemic, the manual provides practical assistance appropriate for the legal community, HIV/AIDS organizations, and individuals affected by HIV/AIDS who wish to learn more about the legal and policy aspects of HIV. *National Lawyers Guild AIDS Network, 558 Capp Street, San Francisco, CA 94110, 415/824-8880. Price: \$95 (includes postage/handling), \$60 for community-based HIV/AIDS groups, 10-day trial offer available.*

AMERICAN SOCIAL HEALTH ASSOCIATION, a leader in the fight against sexually transmitted diseases since 1913, operates two toll-free hotlines to give basic information to the general public: the National AIDS Hotline (1-800/342-AIDS) and the National STD Hotline (1-800/227-8922); the Herpes Resource Center — a network of 100 local support groups around the country which offers a hotline (919/361-8488), publishes *The Helper*, the quarterly journal of the Herpes Resource Center, which produces videos on herpes common concerns — *Common Sense, The Truth About Herpes*, an audiocassette *Management of Herpes*, and published the book, *The Truth About Herpes* by Stephen Sachs, MD (\$13.50); and produces a series of 9x4 foldover pamphlets on symptoms, testing, treatment, and prevention for the major STDs, written in a question-and-answer format: *Questions and Answers About AIDS, Questions and Answers*

Recommended Resources (continued from page 23)

About Herpes, So Your Partner Has Herpes, Questions and Answers About STDs, Some Questions and Answers About Genital Warts, Some Questions and Answers About Chlamydia, Some Questions and Answers About NGU, Some Questions and Answers About PID, Women and Babies; and Condoms, Contraceptives and STDs. Catalog available. American Social Health Association, PO Box 13827, Research Triangle Park, NC 27709; 919/361-2742.

KIDS WANT TO KNOW ABOUT AIDS (1989, 9pp., 5x8 booklet) written by Marcia Blair with illustrations by Brian Medeiros. An easy-to-read, illustrated booklet which introduces the topic of HIV/AIDS for grades 1 to 3 by identifying and demystifying HIV through comparison with a cold or flu virus. Examples of ways "you can't get AIDS" are listed to counteract commonly held myths children may encounter when learning about the AIDS virus and how it is contracted: "You can't get AIDS...from sneezes and coughs...from hugs or kisses or handshakes...from sharing food or drinks...from using bathrooms or drinking fountains...from playing or going to school with someone who has the AIDS virus." The booklet's straightforward and reassuring presentation of the facts allays young children's fears about HIV/AIDS and how it relates to them. *National AIDS Information Clearinghouse 1-800/458-5231. Price: single copy/\$1, bulk rates available.*

LATINA AIDS ACTION PLAN AND RESOURCE GUIDE (1990, 195pp., 8 1/2x11 guide) "Latinas are organizing to reverse the trend of AIDS in women," states Irma C. Maldonado, project director. Since 1988, HDI Projects (National Hispanic Education and Communications Projects) has been involved in HIV/AIDS education and prevention. In 1989, they established a National Education Leadership Council of Latinas, a group of committed women leaders in the fields of health, education, medicine, and the media, who reflect the diverse ethnic and socioeconomic backgrounds of the Latino population from across the United States and Puerto Rico. The council's mission is to bring national attention to Latinas and HIV/AIDS by providing leadership and building partnerships that will empower communities with requisite knowledge, skills, and strategies to promote physical, social, mental, and emotional well-being. They recently developed a national action plan for Latinas and AIDS, and their work represents a major effort to draw attention to the diverse concerns of Latinas and their specific recommendations for action. The plan identifies "threshold" guidelines for effective education and prevention, and covers the critical issues that must be addressed in order to have successful prevention education programs and policies that will empower women, based on respect for both culture and language. U.S. Surgeon General Dr. Antonia Novello said: "Women play a crucial role in combatting AIDS in their communities. As primary health educators and caregivers in the family, women are key to raising awareness about HIV infection and AIDS. The *Latina AIDS Action Plan and Resource Guide* is a valuable and timely resource for cities, communities, and individuals committed to effective health strategies." Supported with funds from the U.S. Centers for Disease Control (CDC), the resource describes model programs and organizations that provide HIV/AIDS services to Latino communities, and includes a bibliography targeting Latinas and children, a listing of HIV/AIDS testing and counseling sites, and federal and state HIV/AIDS hotlines. Spanish translations of the major sections are included. A valuable resource for individuals, community-based organizations, state and federal agencies, and others working or involved with HIV/AIDS education and prevention. *HDI Projects, 1000 16th Street NW, Suite 504, Washington, DC 20036, 202/452-0092. Price: \$15.*

PARTNERS IN HEALTH (Second edition, 1990, 64pp., 8 1/2x11 paperback) by Beverlie Conant Sloane of Dartmouth College. "For college students — a proven resource with straight talk about sexuality, birth control, and reproductive health." Refreshingly contemporary, candid, and straightforward, this book provides detailed information on how to: decide about becoming sexually active or remaining abstinent; prevent an unintended pregnancy; and avoid sexually transmitted diseases, including HIV/AIDS. Illustrated with reproductions of art from the great masters, the publication is designed to reach readers on two levels: cognitive and effective. Conant Sloane says, "Problem solving, communication skills, and decisionmaking tools translate knowledge into behavior change." Includes a listing of resources and covers: making a decision to become sexually active; the basics of anatomy and conception; contraception and protection; pregnancy; female and male reproductive health; sexually transmitted diseases; and "You're on Your Own But Not Alone." *Printed Matter, Inc., PO Box 15246, Atlanta, GA 30333; 404/377-3927.*

PEOPLE OF COLOR AGAINST AIDS NETWORK (POCAAN) offers a number of useful 4x8 1/2 foldover pamphlets: "I Don't Need to Wear One of Those" ("Yo No Necesito Usar Uno de Esos"); "OK, But Next Time You Have to Wear One" ("Muy Bien, Pero la Proxima Vez Te Tienes Que Poner Uno"); "Hey Man, Let Me Use Your Works" ("Oiga, Hombre, Dejeme Usar Su Jeringa"). POCAAN is a multiracial educational coalition which provides training about HIV infection; develops and adapts educational materials aimed at Latino, black, Asian/Pacific Islander and Native American communities; works with existing HIV/AIDS programs on issues pertaining to people of color; and coordinates programmatic efforts of community-based organizations. POCAAN works with the leaders within the community and encourages their leadership and visibility in the effort to empower communities of color, and provides HIV/AIDS education and information to church groups, migrant health councils, health care students and providers, local school employees, community service organizations, adult and juvenile corrections facilities, and shelters. A comic book, "AIDS News" and a series of three pamphlets and a poster entitled "Famous Last Words" are available in English and Spanish; a pamphlet entitled "AIDS in the Black Community"; brochures in seven Asian languages, and three fotonovelas in Spanish. "Can Indian Kids Get AIDS?" a pamphlet developed by Seattle Indian Health Board, United Indians of All Tribes Foundation, and Puget Sound Service Unit, describes what HIV/AIDS is and how it is transmitted, the risky behaviors that spread HIV/AIDS, and alcohol and HIV/AIDS. "Are Indians At Risk for AIDS?" is an excellent pamphlet that discusses risky behaviors and answers the questions: Are Indians at risk for AIDS? What is HIV/AIDS? Can you tell if someone has HIV/AIDS? How do you get AIDS? *People of Color Against AIDS Network, POCAAN, 1200 South Jackson, Suite 25, Seattle, WA 98144; 206/322-7061. Prices: comic books, \$.25 each; brochures, \$.15 each; fotonovelas, \$.25 and \$.15 each.*

STRAIGHT TALK: A MAGAZINE FOR TEENS ABOUT AIDS (1990, 37pp., 9x12 magazine) is an excellent resource for teenagers and parents. Developed by United Auto Workers-General Motors (UAW-GM), National Joint Committee on Health and Safety. The title of included articles are: The Facts About AIDS; I'm 17 and I Have AIDS; AIDS and Drugs; What You Should Know; AIDS in Hollywood; Team Rap; People Like Me; Talking to Your Parents About AIDS; Out in the Street; What We Know (And Don't Know) About AIDS; and The Big Words. *Custom Publishing, Rodale Press, Inc., 33 East Minor Street, Emmaus, PA 19098. Price: \$.75 per copy or \$37.50 per carton of 50.*

SIECUS NEWS

NATIONAL GUIDELINES FOR SEXUALITY EDUCATION

PUBLISHED: In October, SIECUS published *Guidelines for Comprehensive Sexuality Education: Kindergarten Through Twelfth Grade*. Developed by a national task force which included representatives from the American Medical Association, March of Dimes Birth Defects Foundation, National Education Association, National School Boards Association, and U.S. Centers for Disease Control, the guidelines present 36 topics for a comprehensive sexuality education program. The National Education Association has endorsed the guidelines. The publication of the guidelines was featured in more than 50 newspapers nationwide, and was reported in more than 24 radio and television newscasts. An editorial in *The New York Times* supported the guidelines' effort: "Educating children about sexuality and its implications is, quite literally, vital to their future....What kids plainly need is straight talk about sex." Copies of the guidelines are available from SIECUS for \$5 (plus 15% postage/handling).

HIV/AIDS TRAINING WORKSHOPS: As part of our cooperative agreement with the Centers for Disease Control, SIECUS will sponsor three train-the-trainer workshops developed specifically for HIV/AIDS trainers and outlined in SIECUS' training manual, *Communication Strategies for HIV/AIDS and Sexuality: A Workshop for Mental Health and Health Professionals*. For more information, contact Carolyn Patierno, director of SIECUS' National AIDS Initiative.

SIECUS TRAVELS: During the summer, SIECUS staff presented speeches and workshops in Washington, DC; Greenwich, Connecticut; New Orleans, Louisiana; Phoenix, Arizona; Indianapolis, Indiana; and Newark, New Jersey. This fall, we will be speaking in Alaska, Arizona, Georgia, Louisiana, Minnesota, Nebraska, New Jersey, Pennsylvania, and Vermont. Call us for a speaker for your next annual meeting or conference.

SIECUS AND THE MEDIA: In recent months, SIECUS has been featured in over 20 print media, including *Newsweek*, *USA Today*, and the *Washington Post*. Our staff has appeared on CNN's *Sonia Live*, a three-part series on NBC's *Today*, and several programs on local television stations.

NEW SIECUS BOARD MEMBERS: SIECUS welcomed five new members to the Board of Directors: Dr. Patricia Shreiner-Engle, Associate Professor, Ob/Gyn and Reproductive Sciences and Psychiatry Departments, and Director of Psychological Services, Department of Ob/Gyn, Mount Sinai Hospital; Mary Guess Flamer, Educational Program Specialist, New Jersey Department of Education; Cory Richards, Senior Vice President, The Alan Guttmacher Institute; Trish Moylan Torruella, Director of Education, Planned Parenthood Federation of America; and Susan Vasbinder, Human Sexuality Education and Training Consultant, Philadelphia College of Osteopathic Medicine. At their September

1991 meeting, the Board of Directors elected Lorna Sarrel as Vice President and John Robbins as Treasurer for the next three years.

SIECUS BOARD MEMBERS RETIRE: Three members of SIECUS' Board of Directors retired at the September 1991 meeting: Peggy Brick, a board member since 1986 and Vice President since 1988; Dr. Richard Cross, a board member since 1984, a member of the Executive Committee, and SIECUS Acting Executive Director during a six month period in 1988; and Laura Resnikoff, Treasurer since 1988. They will be missed.

SIECUS EXECUTIVE DIRECTOR CHOSEN AS CHAIR-ELECT: Debra W. Haffner has been elected chair-elect of the Population and Family Planning Section of the American Public Health Association (APHA), which has more than 1,000 members who annually select a chair of the section. The chair-elect is responsible for planning the population and family planning program for the 1992 APHA Annual Meeting.

SIECUS WISHES TO THANK Janet Jamar for her outstanding contributions to SIECUS during the past four years as Director of Publications and Editor of the *SIECUS Report*. We wish her well in her new ventures.

NEW FALL LIBRARY HOURS: The Mary S. Calderone Library will be open on Tuesdays, Wednesdays, and Thursdays from 1pm to 8pm; and on Fridays from 9am to 1pm.

SIECUS STAFF

Executive Director
Debra W. Haffner

Deputy Director, Program Services
Patil O. Britton

Office Coordinator
Elliot J. Cohen

Director, Finance and Administration
Joseph DiNorcia

Director, National AIDS Initiative
Carolyn Patierno

Executive Assistant/Development Associate
JoAnne B. Periera

Director, Library Services, Mary S. Calderone Library
James L. Shortridge

Library Assistant
Laura Steele Clapp

Managing Editor, SIECUS Report
Elizabeth Wilber

A SIECUS BOOK REVIEW

COME SIT BY ME

Margaret Merrifield, MD & Heather Collins

Toronto, Ontario: Women's Press, 1990, 30 pp., \$6.95.

Come Sit by Me is an excellent book about understanding and dealing with HIV/AIDS that is written for children ages 4 to 8 and their caregivers.

The story concerns Karen, a preschooler who is sad to see the summer holidays end because now she has to go school. Her parents are gentle and concerned, and her father says, "You'll be happy to see your friends and maybe there will be new friends to play with." Sure enough, when Karen arrives at school, two friends greet her with, "Karen, come sit by me!" Karen also learns that she has a new classmate named Nicholas.

That night, she tells her mother about her day and says, "I had fun playing. I had a really good nap. I didn't have to take a time out. Nicholas isn't my friend yet." The days get colder and Karen tells her family that Nicholas has been sick and that she misses him. "He's my best friend now," she says sadly. And then, one night at the dinner table, she asks, "What's AIDS?"

Nicholas has AIDS. One of her classmates is not allowed to play with him anymore because of his illness and this confuses Karen. Her Mom explains the disease to her in a straightforward and clear manner. She answers Karen's questions and reassures her that she won't "get AIDS" by hugging him, or by playing or eating together.

Karen is happy and continues her friendship with Nicholas until some of the other children's parents do not allow their children to play with Karen because she plays with Nicholas. Her parents get very upset and organize a meeting where everyone learns about HIV and AIDS and talks about the disease. This meeting makes everything okay — the parents feel

good, and the children feel good. The following day, when Nicholas arrives at school, the children all call to him, "Nicholas, come sit by me!"

Because all the issues raised are neatly resolved in the end through mutual cooperation between sensitive and rational people, the conclusion of *Come Sit By Me* feels somewhat like a fairy tale. However, the book's overall message is that knowledge, care, and compassion can foster better communication among families and communities. The book is a good example of how HIV/AIDS education should work.

The illustrations are appealing and beautifully executed. The author captures the playful and inquisitive spirit of this age-group well, and gives the characters diverse ethnic and racial backgrounds.

Following the story, a section is included with information for students, parents, teachers, and caregivers about HIV and AIDS, which answers commonly asked questions about HIV infection and transmission, summarizes what kind of information children are able to understand, and lists Canadian HIV/AIDS resources. "This section is written to help you, as educators and caregivers, to understand AIDS so that you can provide children with some practical answers to the many questions about this disease. Children model parents' and teachers' behavior. That is why you must put aside your fears or indifference and learn about AIDS. If you can answer your children's questions about AIDS in a direct and honest way while they are young, they may discover you as a good source of information later on as well."

No home with young children, school, church, or youth-serving agency should be without this useful book.

Reviewed by Carolyn Patierno, director, SIECUS' National AIDS Initiative.

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Conference and Seminar Calendar

CLINICAL CARE OF THE AIDS PATIENT, December 9-10, 1991. San Francisco, California. Contact: University of California San Francisco, Postgraduate Programs, 521 Parnassus Avenue, C405, San Francisco, CA 94143-0656, 415/476-5808.

SEXUAL ATTITUDE REASSESSMENT (SAR) FOR PROFESSIONALS, January 16-17, 1992 (Orlando, Florida); January 18-19, 1992 (Miami, Florida). Led by William R. Stayton and Susan Vasbinder. Approved by the American Association of Sex Educators, Counselors, and Therapists (AASECT) for 14.0 CEUs. Contact: Stacey Green, Coordinator, 987 Old Eagle School Road, Suite 719, Wayne, PA 19087, 215/971-0700, fax 215/971-0144.

HIV/STD UPDATE, January 22-24, 1992. Baltimore, Maryland. Sponsored by the Baltimore Health Department, STD/HIV Prevention Training Center; Health Education Resource Organization; and Johns Hopkins University Medical School. Contact: Harriette Lowery, Baltimore Health Department, 303 East Fayette Street, Baltimore, MD 21202, 301/396-4448, fax 301/625-0688.

THE EIGHTH NATIONAL SYMPOSIUM ON CHILD SEXUAL ABUSE, February 17-21, 1992. Sponsored by the National Children's Advocacy Center and the American Professional Society on the Abuse of Children. Von Braun Civic Center, Huntsville, Alabama. Will provide training and applicable models for professionals from various fields as well as volunteers working in the area of child sexual abuse. Workshop topics will include: Play Therapy, Adult Survivors Treatment, and Cross-Cultural Sensitivity. Contact: Marilyn Grundy, National Children's Advocacy Center, 106 Lincoln Street, Huntsville, AL 35801, 205/533-5437, fax 205/534-6883.

AMERICAN COLLEGE HEALTH ASSOCIATION'S HIV/AIDS CAMPUS-BASED REGIONAL WORKSHOPS: "Campus Challenges in the 90s," and "Preparing Teachers: Issues in Teacher Education," March 2-3, 1992 (Pittsburgh, Pennsylvania); **"Peer Education: Getting Started,"** April 6-7, 1992 (Detroit, Michigan). Sponsored by ACHA in cooperation with the U.S. Centers for Disease Control. Will enable health educators, physicians, nurses, and administrators to initiate or revitalize HIV/AIDS education efforts, effectively integrate related health issues, and develop new skill-building exercises that promote behavioral change. Free of charge; early enrollment recommended. Contact: American College Health Association, 1300 Piccard Drive, Suite 200, Rockville, MD 20850, 301/963-1100.

SOCIETY OF SEX THERAPY AND RESEARCH'S (SSTAR) ANNUAL MEETING, March 19-22, 1992. Chateau Champlain Hotel, Montreal, Quebec. Contact: Peter J. Fagan, PhD, Scientific Program Chair, SSTAR 1992, 550 North Broadway, Suite 114, Baltimore, MD 21205, 301/955-6318.

THE SOUTHEASTERN WOMEN'S STUDIES ASSOCIATION'S 16TH ANNUAL REGIONAL CONFERENCE, "CELEBRATING FEMINISMS AND THE DIVERSITY OF WOMEN," March 12-15, 1992. Held in conjunction with the Second Annual Florida Statewide Conference on Gender and the 20th Anniversary Celebration of the USF Women's Studies Program. Will celebrate advancements and changes

in the field of Women's Studies. University of South Florida, Tampa, Florida. Contact: Laura D. Ellenburg, Director, Division of Conferences and Institutes, University of South Florida, 4202 East Fowler Avenue, LLL 012, Tampa, FL 33620-8700, 813/974-2403, fax 813/974-5421.

NATIONAL COALITION OF HISPANIC HEALTH AND HUMAN SERVICES ORGANIZATIONS' (COSSMHO) NINTH BIENNIAL NATIONAL HISPANIC CONFERENCE ON HEALTH AND HUMAN SERVICES, March 26-29, 1992. Chicago, Illinois. Contact: Paula Marie Read, Conference Coordinator, COSSMHO, 1030 15th Street NW, Suite 1053, Washington, DC 20005, 202/371-2100.

FOURTH SAGER SYMPOSIUM IN LESBIAN/BISEXUAL/GAY STUDIES, "CONSTRUCTIONS OF LESBIAN/BISEXUAL/GAY IDENTITIES IN THE POPULAR MEDIA," March 27-29, 1992. Call for papers examining mass communication media, such as daytime talk shows, televangelism, magazine advertising, talk radio, and investigating the construction of a lesbian/bisexual/gay identity, by November 20, 1991. Swarthmore College, Swarthmore, Pennsylvania. Contact: Daniel Smartt, Sager Fund Advisory Committee, Art Department, Swarthmore College, 500 College Avenue, Swarthmore, PA 19081-1397, 215/328-8119.

SOCIETY FOR THE SCIENTIFIC STUDY OF SEX (SSSS) ANNOUNCES 1992 REGIONAL MEETINGS: Eastern Region Annual Conference, April 10-12, 1992. Sheraton University Hotel, Philadelphia, Pennsylvania. Contact: Herb Samuels, CUNY LaGuardia, 31-10 Thomson Avenue, Long Island City, NY 11101, 718/482-5742. **Western Region Annual Conference, "Sexual Diversity,"** May 1-3, 1992. Will explore sexual diversity in areas of sexual behaviors, cultural norms and attitudes, individual ideas about perceptions of sexuality, physiological variations, and sexual paradigms. Rickey's Hyatt House, Palo Alto, California. Contact: Joani Blank, PO Box 2086, Burlingame, CA 94011, 415/342-2536. **Midcontinent Region Annual Conference**, June 12-14, 1992. Big Rapids, Michigan. Contact: Robert Friar, Biology Department, Ferris State University, Big Rapids, MI 49307, 616/592-2542.

ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSIONALS' (ARHP) FIRST ANNUAL CLINICAL CONFERENCE ON SEXUALLY TRANSMITTED DISEASES, "STD UPDATE '92: NEW IDEAS, NEW TESTS, NEW TREATMENTS," May 15-17, 1992. This national scientific meeting for physicians and other health care providers will focus on clinical aspects of STD diagnosis, management, and prevention and present current clinical diagnosis, treatment and prevention modalities for STDs, including upper and lower genital tract disorders, HIV, and HPV. Washington, DC. Contact: Martha Pidal, STD Update, ARHP, 2401 Pennsylvania Avenue NW, Washington, DC 20037-3826, 202/466-3825.

14th ANNUAL GUELPH CONFERENCE ON SEXUALITY, "SEXUALITY: NEW VISIONS," June 15-16, 1992. Will examine current issues in human sexuality, counseling strategies for sexual problems, and teaching approaches in sexuality education. Guelph, Ontario. Contact: Division on Continuing Education, University of Guelph, Guelph, Ontario N1G 2W1, Canada, 519/767-5000, fax 519/767-0758.