

NASTAD^{HIV} Prevention Community Planning Bulletin

November 1996

Focus on Spousal & Partner Notification

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The provision requires that states take "administrative or legislative action to require that a good faith effort be made to notify a spouse of a known HIV-infected patient that such spouse may have been exposed to the human immunodeficiency virus and should seek testing." Other recent legislative proposals have also addressed partner notification activities, particularly mandating such efforts.

CDC invited HIV/AIDS and STD directors, community representatives, researchers and other experts from across the country to a meeting on October 17-18 to examine the role partner notification plays in STD and HIV/AIDS treatment and prevention programs, as well as to begin discussion of what "a good faith effort" will be for spousal notification.

During presentations on the background and history of partner notification programs, speakers noted that partner notification has been used in STD control for decades.

Contact tracing, as it was called until recently, was implemented during and after World War II, initially in the fight against syphilis, and for bacterial STDs.

Although the process of partner notification is a standard practice in STD programs, and those who implement these programs believe it is a valuable tool, a number of participants at the CDC meeting pointed to what they saw as a lack of research on the effectiveness of these programs.

In a review of the partner notification science base, Dr. Richard Rothenberg of the Department of Family and Preventive Medicine at Emory University said "Somehow we neglected to see if this works for 40 years." He said that most pre-1980 reports contain little analyzable data, and stressed the need to look more deeply into the data gathered from contacts.

The arrival of AIDS, Dr. Rothenberg said, brought the issue of effectiveness to the forefront, resulting in "polemics" between the proponents of partner notification and the opponents. "Neither was encumbered by data," he said.

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Community Planning Calendar

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November 17-21, 1996

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NASTAD member Wendy Craytor of Alaska presented AIDS directors' perspectives on the objectives of partner notification and implications for HIV/AIDS programs. She reviewed some of the recent history of these programs, differences between STDs and HIV which affect partner notification activities, and the wide range of approaches and experiences with partner notification in HIV/AIDS programs.

Craytor stressed that such activities need to be voluntary and confidential in nature, and tailored to the organizational context as well as the nature of the epidemic in each area.

Dr. King Holmes, Director of the Center for AIDS and STD at the University of Washington, presented an overview of public health objectives for partner notification activities, and how those activities may be incorporated within the basis steps of STD/HIV prevention (*please see document included in attachments*).

Speaking on community viewpoints, Mike Shriver of the National Association of People with AIDS asked, "What makes this issue so visceral for so many of us?" He listed a number of reasons for what he perceives as a failure of collaboration on this issue between infected/affected groups and public health agencies: a lack of clarity as to the purpose of partner notification; political considerations; and a historical mistrust in some communities of public health departments.

States are required by the CDC to have some form of partner notification for HIV cases. A number of AIDS directors at the meeting stressed the importance of keeping partner notification a voluntary process: not only is it next to impossible to force someone to reveal their

sexual partners, but the overall process requires a collaborative relationship which cannot effectively be mandated. Disease intervention specialists and STD directors participating in the meeting noted that their partner notification programs successfully function on a voluntary basis.

The success of partner notification programs for HIV often depends on how the program is presented to and perceived by the communities affected by the program. Minnesota, for example, has developed a partner notification program for gay men that presents the process as a "service" they can access after testing. Oftentimes, an individual who tests positive may be reluctant to contact past sex partners and, given effective counseling and referral services, may be relieved to have someone else deliver the news in a professional manner.

A number of states have taken similar approaches. AIDS directors in attendance stressed the importance of working with the communities to make these programs effective. As partner notification is both a primary and secondary prevention intervention, community planning groups can play an important role in assessing the effectiveness and priority of these programs.

One issue raised during the meeting was the difference between STD and HIV/AIDS partner notification "models." While the processes and models can be similar, the desired outcome can be quite different.

With current medical technology, when intervention workers contacts a person exposed to a bacterial STD such as gonorrhea or chlamydia, they can offer effective treatment and cures for the disease.

For a person infected with HIV, there are no such offerings. Although new treatments have offered much to hope for in recent months, they are not a cure. And while STDs still retain some aura of stigmatization in most communities, the potentially enormous stigma of HIV/AIDS still causes great fear in those who are infected.

These factors require that HIV partner notification programs focus on numerous issues, from treatment

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options to referrals for a range of supportive services to handling shock and fear.

With the emergence of the spousal notification requirement, issues surrounding partner notification most likely will continue to be raised throughout the coming months. With this in mind, it is important for AIDS programs, state health departments, CPGs, STD programs, epidemiologists, researchers and others to work together to assess the desired outcomes from, and effectiveness of, HIV/AIDS partner notification programs within HIV/AIDS prevention programs.

Community Planning & HIV Prevention at the National Skills Building Conference

Written by Miguel A. Miranda, Community Planning Coordinator for the State of Florida Department of Health. NASTAD thanks Miguel for this story.

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The sessions offered included African Americans and HIV/AIDS, AIDS Ministries, AIDS Education in Schools, HIV Prevention Community Planning, Peer Programs, Grantwriting, Board Development, and many others. Conference sessions ranged from 100 to 300 levels of instruction to meet the various needs of people with different work and educational backgrounds. The use of a university model to organize the various sessions gave participants the option of selecting a major such as

fundraising, financial management, organizational development, people development and program planning. Minors were also offered in communications, marketing, computer technology and public policy.

One of the most rewarding sessions I attended was "HIV Prevention Community Planning...BASICS," coordinated by Mary Willingham of CDC. Though I was familiar with the information presented, the opportunity to network with people in other states working on community planning was invaluable. Representatives from New York, Mississippi, Tennessee, Florida and many other states were in attendance, as well as Norm Fikes from the CDC. Many of us used this opportunity to discuss issues and concerns we are currently facing, share ideas for the future and identify current community planning needs. Overall, it was refreshing to hear that other programs are identifying and overcoming many similar growing pains.

Another session which offered information specific to community planning and prevention was "Developing Effective, Theory Based HIV Prevention Programs," presented by E. Duane Wilkerson of the Washington State Department of Health. This overview of behavioral theories provided a concise explanation of the major behavioral theories in use today. Although a required component of the prevention plans developed through community planning, behavioral theories are at times difficult to understand at the direct service level. Mr. Wilkerson provided a rare opportunity to compare and contrast multiple behavioral theories and apply them to real life exercises.

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I would like to express my gratitude to the conference organizers for their forethought and sensitivity and congratulate them for an excellent conference.

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NASTAD applauds the work of Gerald and others who have made important contributions to HIV prevention community planning while also dealing with HIV disease themselves. NASTAD feels it is important to honor this work and recognize the impact their lives have made on all of us.

Adolescents and School Based HIV Prevention

Peer Education in Juvenile Detention Facilities

Statewide and regional HIV prevention community planning groups (CPGs) and state health agencies are having to meet the challenge of reaching youth in high risk situations by using a variety of skills, techniques, and programs. In order to reach adolescent populations most at risk, AIDS directors and CPGs have planned a number of viable projects for reaching this target population. One such population are adolescents who have been placed in juvenile correction centers. Adolescents in these centers often have substance abuse problems. Moreover, individuals engage in same-sex sexual activity without the use of condoms inside detention facilities, increasing the risk of transmission of HIV and other sexually transmitted diseases.

In Tulsa, Oklahoma, the HIV Peer Education Program for Incarcerated Juveniles was established in response to increasing concerns about the incidence and transmission of HIV in correctional facilities. The program is designed to maximize prevention messages for youth incarcerated at the Rader Treatment Center to decrease the risk of HIV/STD infection. The State Health Department's HIV/STD Service, in collaboration with the Oklahoma Juvenile Justice System and the Tulsa American Red Cross, developed this program.

The goal of the program at the Rader Treatment Center is to train peer educators who will serve as positive role models by sharing information, clarifying facts, answering questions, facilitating referrals and providing educational outreach designed to teach fellow inmates the basic concepts of HIV prevention. Specifically, the peer educators explain what steps to take in order to prevent contracting HIV disease or transmitting it to partners while incarcerated or upon release. To identify peer educators for the program, a selection criteria was used

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Once selected, the peer educators met one afternoon each week for ten weeks with educators from the State Health Department and the American Red Cross facilitating *Students Teaching AIDS to Youth* (STAY). The STAY curricula provides accurate HIV/STD information and uses appropriate language and vocabulary level for adolescents. Instructors assess participants' knowledge level and personal effectiveness in asking open-ended questions, and ability to present factual information in a supportive and nonjudgmental style. Participants learn the history of AIDS, HIV/STD prevention facts, techniques for building a healthy relationship, alcohol/drug effects on the brain, relapse prevention, sexual negotiation skills, factors that constitute a functional family, how to be an effective peer educator, and how to utilize tools for successful prevention education. In addition, the effects of drugs, alcohol, family dysfunction and childhood abuse are addressed in relationship to low self-esteem and its impact on the transmission of HIV and other STDs. The curricula was augmented with alcohol/drug tapes and other films and literature provided by the Oklahoma State Department of Health, the Tulsa Community AIDS Partnership, and the Red Cross. Peer educators are trained not to give advice nor to be counselors. In addition, participants are given a written exam and demonstrate their skills by leading classes with accurate peer education presentations at the end of the ten week program.

Process evaluations have indicated that both the young men and the detention facilities were pleased with the peer education program. For example, a juvenile who had participated in the program and was later placed in a halfway house in Oklahoma City called the AIDS office at the State Health Department and indicated that he was giving a presentation to his peers and requested HIV/STD pamphlets. Also, the detention facilities have requested

additional peer education programming, further validating the program's success.

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All youth between the ages of 12-18 who have contributed to the fight against HIV/AIDS in their community are encouraged to apply. Applications must be postmarked by Wednesday, December 4, 1996; fax, e-mail, or computer on-line applications will not be accepted. A National Advisory Panel, consisting of youth and adults, will make final selections. They will meet in January, and awardees will be notified by February 1, 1997.

To receive a *Caring Counts Award* application, please contact the National AIDS Fund; 1400 I (Eye) Street, NW; Suite 1220; Washington, DC 20005-2208; phone - (202) 408-4848.

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NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS

444 North Capitol Street, NW, Suite 706 Washington, DC 20001-1512 FAX 202-434-8092 PHONE 202-434-8090

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