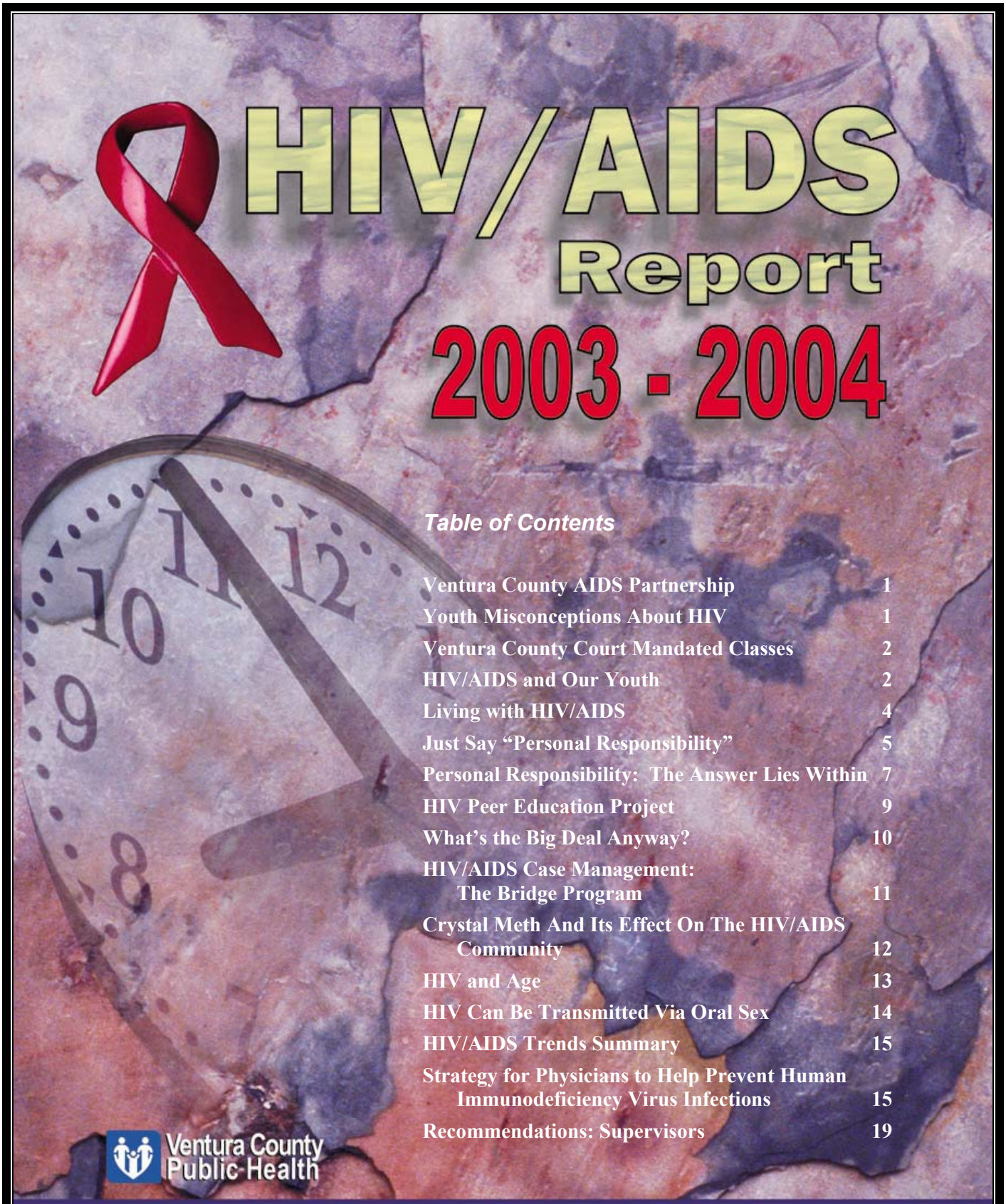

HIV/AIDS Report 2003 - 2004

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Ventura County Public Health

From The HIV/AIDS Advisory Committee to the Ventura County Board of Supervisors

Ventura County
2003 - 2004

Ventura County AIDS Partnership

By Virginia Weber

In the second Harry Potter book, Professor Dumbledore (Head of Hogwarts School) sums up a year's experiences and adventures with the following observation:

"It is our choices, Harry, that show what we truly are, far more than our abilities." (Harry Potter & The Chamber of Secrets, by JK Rowling, 1999).

The HIV/AIDS epidemic - truly a pandemic worldwide - is now entering its third decade. Locally in Ventura County, we are seeing this blood-borne disease migrate into our Latino population as well as ravaging MSMs (men who have sex with men). The political climate in Washington DC is changing and as a result, promotion of condom use is deemed unattractive and is diminishing.

We all have choices to make, and personal responsibility is one that we must make each day. It would be nice to decide once and for all to lose ten pounds or to exercise every day. In reality, such choices have to be made more frequently and amid distractions and temptations. It is imperative that knowledge be shared, that education efforts continue so that people can be armed to make good choices today and tomorrow.

Our Partnership is one of 29 such entities located throughout the continental United States. In one way, we have been wildly successful by engaging local people and stimulating interest and awareness. We have raised money from a host of national and state foundations that has been matched by the National AIDS Fund. The leveraged money has been re-granted to not-for-profit entities in our county to provide critical prevention education and AIDS patient care services to make a real difference in the public health and lives of vulnerable residents.

In another sense, though, our Partnership has been a failure. The community partner model was created so that national resources could leverage local ones to support local response to local needs. We have not been successful in engaging local companies, individuals, and foundations in participating in our efforts. To be a real partnership in promoting prevention and strengthening services for low-income HIV/AIDS patients, we need support from our elected officials, from local philanthropic and business interests.

Each of us has choices to make on how we can best fight HIV/AIDS on the local level. One method is investing in the work of the Ventura County AIDS Partnership. It is a matter of choice. We present a unique way to have a real impact on our local public health, on the lives of people in our communities.

Contact the Ventura County AIDS Partnership at (805) 485-6288, Ext. 232 to learn more about our work and ways in which you can help us to make a beneficial difference locally. Visit the National AIDS Fund's website (www.aidsfund.org) for information on this fabulous resource.

Youth Misconceptions About HIV

By Marggie Valentine, MFT

I have worked since 1972 in various youth church groups, the California Youth Authority, and in college classrooms educating youth about sexually transmitted infections. These kids know a lot more than we think, but much less than they need to know to remain healthy. What we do not know or the information that we choose not to educate our youth with puts them at risk. While the debate grows between what information to publicly fund, children, teenagers and young adults continue the USA trend of encouraging misinformation.

With a high percentage of all new HIV infections happening among people under the age of 25 (Kaiser Foundation Update) what does that say about USA policies and goals for the future? If children are a message that we send to a future we will not see, what is our message? Currently some of the oldest myths on sexual behavior thrive and with the HIV epidemic it is a realty not just a threat that these myths have gone from funny to tragic.

Popular high-risk myths that young people incorrectly believe about why they cannot get HIV include:

1. Because oral and anal sex are not intercourse, I am still a virgin. My Church believes that this is abstinence. Therefore I can't get HIV.

2. Abstaining really means "what it is my family wants it to mean, or the church I go to" or "I fool around some, but no one knows."

3. Modern monogamy includes:
   a. Today I only had sex with one person
   b. That I only have sex with one person at a time
   c. That I have sexual activity with lots of people, intercourse only with one

4. Virginity is about avoiding intercourse. Oral, anal, finger play (sexual activity) are okay, you can't get HIV from them.

5. I'm not gay…the HIV spreaders don't live in my neighborhood…you can tell by looking at them.

The human need for touch, which in some instances leads to exchange of bodily fluids does not have the same goal as the rational mind. Where one of the five body fluids (blood, pre-ejaculate, semen, vaginal fluids, breast milk) is infected with the HIV virus, passed to a receptive area, a risk of infection exists.

Protecting a national asset such as our next generation from HIV infection is not done by one belief system or stereotyping who is at risk. It is achieved by individual, family, and community efforts that combine all of our resources. Our young remain at high risk because they are blatantly uninformed. How many generations do we want to lose before we as adults decide to share all the tools of safety with our kids?

During 2002, 180 youth voluntarily attended information events on HIV in the County. They are telling us by these acts that they need more information. They have the questions. It is time to give them the life-saving answers.

Ventura County Court Mandated Classes

Ventura County Public Health Education Department provides Court Mandated Classes pursuant to the State legislation enacted in 1989, Sections 1001.11 and 1202.6, Title 6 of the penal code, which mandates that individuals convicted of narcotic or prostitution offenses receive basic HIV/AIDS information.

Class participants are ordered by the Courts to attend a one hour class within six months of their probation date or six months from their jail release date. NO FEES are paid directly to the Health Department by class participants. All fees are collected by the Courts.

All classes, English and Spanish speaking, are held on Wednesday evenings from 5:30 PM to 6:30 PM in the Ventura County Public Health Auditorium at 3147 Loma Vista Road, Ventura. The class schedule is announced on telephone line (805) 652-5902. This schedule for the calendar year is prepared every December.

Last year HIV/AIDS testing began being offered to any of the participants who would like to be tested. This is not a requirement of the Court Classes but an additional service being offered by the Ventura County Public Health HIV/AIDS Center. Ten to fifteen percent of the class participate in the testing and then return in 2 weeks for the test results.

HIV/AIDS and Our Youth

By Cheryll C. Reft

Our youth are our future. Whose responsibility is it to educate society, especially our youth, about HIV/AIDS?

In light of our present administration's "abstinence only" policy, this question is posed to us in the HIV/AIDS education/intervention department and though we know what our own answer to this question is, we wanted to get answers from other people, especially the youth. Hence, last month we conducted a focus group with this question posed to the attendees. Responses are listed below.

"I think it is up to our school systems. I mean, they teach sex ed. So why not include education about AIDS into that? We all know what this part or that part is on a female and male body, but honestly, not a lot of people know a whole lot about what HIV really is."

Anonymous, age 19

"You know what? I did not even know about HIV until Magic (Johnson) said that he had it. How sad is that? With so many of our community gone by that time, I did not know about it until Magic …trips me out sometimes."

Anonymous, age 23

"It is up to the government to educate all walks of society, especially the youth. And if they won't do that, then it is up to us to educate ourselves, so that we can teach the youth about how to protect themselves."

Juan Gallardo

If parents can't talk to their kids about sex, how are they ever going to talk about HIV/AIDS? Realistically, I think education might come best in the form of friends educating one another. Juan Gallado and I held a workshop about what HIV is and how it affects the body with the youth here at the center and next thing I know, one of the attendees of that workshop is doing an oral presentation about HIV in his biology class. It is one thing to know the name and the fear of a disease, it is quite another to understand how it operates and how to protect yourself from it.

These responses immediately correlate to several other factors when considering the topic at hand. One of those factors is the notion of perceived risk. What do people think their risks are of contracting HIV? Do they think about their risks at all? Are people misinformed about what is considered a risky behavior? One of the attendees stated that he wasn't quite sure about whether or not he participates in risky behavior. He asked, "What's considered risky? I mean I'm part of the #1 demographic

in terms of who gets it, so is putting on a condom the best thing I can do?" Another attendee, a female, stated that because she's a lesbian, she doesn't really think about getting it; "…I mean, I don't really drink or do drugs, so I don't see how I might be at risk."

Also highlighted was how HIV itself is presently perceived and how understanding of this disease has changed with time. In our focus group, we asked if people, especially the youth, no longer see HIV as a threat. We found three major points that illustrated this idea:

- HIV is no longer seen as a death sentence. With so many people living with the disease, the threat of infection has been diluted.
- Medicine has come a long way. An attitude seems to exist in which people believe the only way their life would be altered by HIV is that they would have to take medications everyday.
- People who feel this way were not around to see their lovers, friends, and family taken away by this disease.

When we talk of responsibility, we must first look at how the current state of mind is set given the topic at hand, and go from there. In the group we found that people do think about HIV and that people do think about their risks. However, where they go from there is hard to say.

"Yeah, I think about it from time to time. When I'm with someone new I ask them if they've been tested but even if they say 'yes', I wonder if they're just saying that."
Anonymous,
age 25

"I do think about it. I play safe but I do get tested every 6 months just to be safe. I think everyone should go get tested every 6 months."
Anonymous,
age 22

"The only time I think about is when I think I might have gotten it from someone."
Anonymous,
age 18

At this point we asked if it is up to the individual to protect himself/herself from HIV, be it by using condoms, be it by getting tested every 6 months, or simply by seriously assessing one's own personal risky behaviors. The answer in unison was a resounding "Yes."

"Yeah, it's up to the individual to protect himself! Even if you don't really know all the facts about HIV, you can still wear condoms, you can still go get tested, you can still ask your partners if they're negative or not. Some people don't do that, and maybe they don't care about themselves enough, but they don't see that they might be infecting someone else. So, for that reason, why would anyone not wear a condom or have their partner wear a condom?"
Anonymous, age 22

"He's right. It is up you, personally, to protect yourself…especially if your behaviors are risky."
Anonymous, age 18

When asked about whether or not they've ever been tested for HIV, only a handful of people replied with a "yes." Curious as to why they'd never been tested for HIV, the remaining attendees cited reasons such as:

1) They just never thought to go get tested
2) They didn't know what it would be like to get an HIV test and
3) They were afraid of other people or parents finding out that they had taken an HIV test.

An hour into the group we again asked the attendees: Given the following choices, which do you feel is responsible for educating and preventing the spread of HIV?

a) The government
b) Parents
c) Educators
d) Community Health Care Centers (i.e., VCRA)

"Man, the government's not gonna do it. Parents won't talk to their kids about it. The schools? Only if you're doing a paper on it. The 'Center' is the only place I see doing anything about this."
Anonymous, age 23

The focus group was a great tool in finding out what people in our community think about in terms of how HIV/AIDS affects their lives. Again, the question is posed: Whose responsibility is it to educate society about HIV/AIDS? Whether we realize it or not, we are all affected by HIV/AIDS.

Hence, it is safe to say that we are all responsible to educate ourselves, our youth, our friends, our families and our lovers. In this day and time, it is our responsibility to educate one another in hopes that this education will continue.

Living with HIV/AIDS

By Sean Michael

Living with HIV/AIDS is a process, a very scary process. Everyone tells you a different story. Some say you will be fine, today's drugs will make you live longer. Yet the unspoken fact is you are going to die.

When you are first diagnosed with HIV you go through a traumatic period of time KNOWING you are going to die. After a year passes if you are lucky and still working, and so far, nothing has really HAPPENED to you, you think that it is not as urgent as you thought and life becomes manageable again.

Then your blood work comes back one day and your doctor tells you that your "T-cells" are lowering and decisions need to be made. Start taking medications or not. It seems simple but it's not. If you START taking the medications you can't STOP taking them. If you do, your body will build resistance and they might not work again.

You decide to take the medications and start hearing words like neucleoside and non-neucleoside, Then you go to the pharmacy to pick up your medications and feel like everyone there KNOWS you have "AIDS" when you get your bag of seven prescriptions every month. The pharmacist and clerk definitely know.

When you get home that night, you read all of the side effects of the medications. They all say "may cause diarrhea, headache, nausea, etc." It REALLY gets scary when they list reactions like psychotic episodes, liver failure and other serious problems.

You start learning a different way of life than you knew before - Your biggest priority in life NOW is not to infect anyone else with the virus – safer sex has a whole new meaning. In fact, life has a whole new meaning, especially the first time you tell someone you just met "I'm HIV positive".

You might become active in committees, coalitions and agencies that deal with HIV/AIDS Education and Prevention. The word "prevention" now means more to you because you know what it is to have the disease. You now think of what you could have done to prevent yourself from getting it. You think of what you must do to prevent giving it to others.

You have to learn how to access services available to you. This is where your case manager becomes your hero and savior. This is also when you start to become dependent on others.

For some people to ask for help is embarrassing and demoralizing. When you quit working and are on disability, the need outweighs your pride. You start going to the Food Pantry at AIDS Project Ventura County (APVC) because you are hungry and can't afford not to go

there. It's not the best food in the world, but its food and you realize the food pantry is a "hand-up" not a "hand-out."

You watch your T-cells start dropping, you start getting sicker – spend some time in the hospital - more drugs, different drugs. Then your doctor comes into the room and drops the bomb on you as smoothly as he can. You don't just have the HIV virus in your body, you have AIDS.

You hear a lot of "we're not sure" and "we are going to run some tests". It has been confirmed you are going to die.

Life has changed once again and taken on yet another new urgent meaning. It gets frightening when people you know with AIDS get sick or worse yet, die. When you get the flu, in the back of your head you wonder, "Is it pneumonia?" With AIDS, words like pneumonia mean something different than they did before. Then it might have been serious. Now you wonder if having pneumonia means you are next to die.

Life goes on. Things change. The only thing that doesn't change is your responsibility to others and the virus you carry.

If you don't get tested how can you be sure you are not infected and worse yet infecting someone else with the virus? You are responsible to know your HIV/AIDS status. You are responsible not to become infected yourself. You are responsible not to give it to others if you have it.

Just Say "Personal Responsibility"

By Daniel Jordan, PhD

The theme of this annual Ventura County HIV/AIDS report is "Personal Responsibility." This may sound simple, but the issue dives fast and deep into complex philosophical waters. People, of course, must take personal responsibility for their own well-being. Mental health professionals especially like to talk about things like "internal locus of control." Taking responsibility, however, implies that one has adequate information. The context in which people live matters. If we live without adequate information, or live in a society that will not give us the information we need to make informed decisions, then it is impossible to demand that people take personal responsibility. Another issue is whether one is responsible only for oneself, but not others. We must also consider whether it is possible to understand personal responsibility, an individual's actions, without also understanding the social context in which the actions occur.

How many of us can say unequivocally that in every aspect of our lives, we have always acted 100% responsibly? Have you, has everyone you know always acted in a perfectly responsible manner? Will the absolutely perfectly responsible person please stand up?

(I'm still waiting.)

A lot of press coverage has gone into the issue of "bug chasing." This is a phenomenon in which some people allegedly seek out sexual partners who have HIV so that they can themselves become infected. I suggest that anyone who ever knowingly had unprotected sex, or engaged in any other sort of high-risk sexual behavior is effectively a "bug chaser." Have you ever done something you knew you shouldn't have done? If so, you're a "bug chaser," whether it is driving too fast, drinking just a bit too much, doing anything that was risky, more importantly risky to others (how about the kids in the backseat at 75 miles an hour?) is no different than this form of risk-taking.

The critical point here is whether someone engaged in high-risk sexual activity "knowingly." You may wonder, "well, how could someone not know they are having unprotected sex or high risk sex?" My answer is, "Very easily." For those of us who have been educated about such things, the pairing of the word "unprotected" with "sex" is meaningful. I suggest, however, that it is not meaningful to everyone in our society. Not everyone is as well informed as we are. For many people, especially young people, disenfranchised people and others, the phrase is meaningless.

Context Matters

If you are not fully informed about the risks of unprotected sex, if you have not been given information in a way that it gets through to you, you left to fly blindly, not aware that you are at risk. By not providing people adequate information, we put them at risk.

If most of us well-informed people have not always acted responsibly, how can we expect others to act any better than we ourselves do? Taken further, how can we expect those with no information to act responsibly? They are not even aware a problem exists. It is very easy to simplify personal responsibility down to a platitude that everyone must take care of themselves, and no one is responsible for anyone else. This has a certain appeal, a certain macho, Western, John Wayne-esque ring to it, especially in our gung-ho every-man-for-himself (and I use the sexist terms here on purpose) society. But, how does that work in a society where many people do not have enough information to "act responsibly" or wisely? Responsible action, based on knowledge, wisdom and caring, implies informed action. A person has to know and appreciate the implications of their own behavior and

understand and appreciate the context in which they live. The steps from data to information, then to knowledge and wisdom cannot be climbed without the data and information in the first place. It is the collective responsibility of those of us who have the information needed to save lives to provide it to people whose lives are at risk.

Even information is not enough. Even if people have adequate information, they still need skills, strategies and help to build the motivation to convert those facts into useful knowledge, and then to act on that knowledge. This is actually a complex process. Simply throwing facts at people, leaving pamphlets on counters, yammering on in a classroom, are inadequate to building knowledge. We must engage with people at a personal level. What does it mean when one "knows," for example, that one can get HIV from sexual intercourse? How does the learner turn that into a useful knowledge base for behavior?

Yet even knowledge itself is not enough. We also have to help people turn knowledge into the wisdom of personal responsibility. This requires that people engage one another with a deep level of empathy. Being able to understand connections, see patterns, comprehend links between actions, outcomes and context requires more than just dumping information into somebody's head.

The final step in the process is reaching wisdom. "Just Say No" is not wisdom. Wisdom requires connecting with people, and understanding that context matters. Wisdom is not something that one gets at birth. It must be learned, conveyed from one generation to the next, and quite frankly, our society does a lousy job of this. We have become so uptight as a society, so convinced of our own individual one right way of doing things, so rigid about what passes for "morals and ethics" that we forget that children's, people's, lives are at stake. This surely is anything but wisdom.

Define Morality

Morality and ethics are necessary, but do not come automatically. In addition, they are not "one size fits all" concepts. People who claim to be acting from a standpoint of morals and ethics often advocate policies that harm people. That leads to the question of "what is moral and ethical?" Is it moral to take a stand or hold a position that "because it is right" actually causes more harm than good? Some people believe that it is immoral to teach sex education. We know from the research, however, that age-appropriate fact-based sex education reduces rates of teen births and sexually transmitted diseases, including HIV. Honest sex education, and access to sexual health services are considered by some to be "immoral." They begin with a preconception about what is moral and ethical, and then apply those pre-determined ideas to the lives of others.

Such attitudes proliferate at a time when our teenagers participate in "oral sex parties" as a "non-sexual" alternative to "having sex." Of course they are engaged in self-delusional behavior because they believe that this is not really sex, does not conflict with what they have been told is immoral, and thus believe it is "safe." We could say of our teens that they are self-deluded. But is it really self-delusion if we do not provide them the facts that oral sex really is sex, and it really can be a means of transmitting sexual infections, including HIV. Whose self-delusion is it not to provide them with information about how to avoid pregnancy and disease if they choose to engage in this behavior?

Transmitting wisdom requires an empirical view of ethics, tied to value-based outcome goals. In this empirical approach to ethics, factual and age appropriate sex education that reduces health risks and saves lives is the moral and ethical thing to do.

Combining wisdom and empirical morality can lead us to realize that each of us has both personal and social responsibilities. No person "is an island." As responsible members of society, we are obliged to provide others, including those coming up behind us, with the best possible information, to help them process and understand the information, then to consider the implications for their own lives and the lives of those around them. We are all responsible to care for ourselves, and to care for others by not making choices that might harm them or us.

The first step in building personal responsibility is ensure that people have factual information they need to protect themselves. The second part of personal responsibility is use that information wisely, to take care of oneself. The third part of personal responsibility is to use the same wisdom to help take care of others.

The HIV/AIDS epidemic is a calamity, one that we collectively create by denying access to information and resources, especially for our young people. To the extent that we deny people information they need to make informed decisions, we are victimizing those people. Derrick Jensen, in "A Language Older than Words" says, "The notion of calamity being in some measure self-inflicted is just one more attempt to deny accountability to perpetrators, one more means to silence victims (p. 321)." So, let's be clear, "perpetrators" are not just "bad people" who prey on innocents, but all of us if we deny adequate information and resources that would help people to be able to act as fully responsible members of society. We must act responsibly as a society to assure that our individual members have what they need to be individually responsible to themselves and others.

We must acknowledge that context matters, that we must enact responsible policy, provide responsible information, if we want people to act responsibly. This need is seen quite well in the issue of syringe replacement programs. The empirical data show that they are effective in reducing the spread of HIV and other diseases. To oppose them based on some pre-defined basis is to overlook real morality which would serve to reduce harm.

Educating Parents about Personal Responsibility

Parents must discuss sexual issues and alcohol/drug use with their kids before they leave elementary school. Youth begin drinking as young as 10-12 years of age.

In our country 70% of people who are diagnosed with HIV are diagnosed with AIDS at the same time. That means they have had HIV for a long time, up to ten years. They have thus probably been spreading the HIV virus for a long time. HIV is an underground epidemic, and years from now, it will attack those we leave in the dark. We need to stress, therefore, personal responsibility to know one's own status, not to infect others, and how to be safe in the many years to come.

Background to this Article

Many poor teens do not receive the sexual health services they need. Lafferty et al. found that of "1,000 adolescents who receive health care through Medicaid managed care plans, fewer than one-third received such sexual health services as STD screenings and contraceptive counseling. Girls who did not speak English were especially unlikely to receive sexual health services, even if they admitted to being sexually active. While earlier studies have shown that only 40 percent of all adolescents are screened for sexual activity during routine office visits, low-income teens are even less likely to be asked about their sexual history or receive sexual health services. This is despite the fact that adolescents are more likely to engage in risky sexual behavior than older patients and that in 1999, chlamydia rates for girls age 15-19 were higher than all other age groups. Interventions to improve sexual health services to enrollees in Medicaid managed care are needed."

From: "Provision of Sexual Health Services to Adolescent Enrollees in Medicaid Managed Care." Contact: William E. Lafferty, MD, University of Washington, billlaf@u.washington.edu for further information on this study.

Personal Responsibility: The Answer Lies Within

By Martin Perrier

The media dailies presents us with examples of the lack of accountability many people display today. We find, all too often it seems, instances of people taking the attitude of "if something goes wrong in my life, it's someone else's fault." Day after day, we hear of lawsuits filed against businesses for something that was fundamentally the fault of an individual. If we don't like the way the government performs or if a law with which we disagree is enacted, we content ourselves with saying, "someone needs to clean up that mess" or "well, that's a politician for you." I fear that, if this attitude continues to be presented as the normal way to deal with life's ups and downs, our sense of personal responsibility – something that is essential to us as civilized beings– will gradually disappear.

If we look carefully at life today, we notice how easily we abdicate responsibility for the basics of our own lives to others. Thanks to progress in technology, life has become convenient for anyone who possesses a checkbook. How many of us have simply written a check for an organization or a cause because we can't be bothered with volunteering our time and talents? Don't get me wrong; money can do amazing things when used wisely, but volunteers are truly the backbone of many non-profit organizations. One of the basic privileges of living in a democracy is the right to vote.

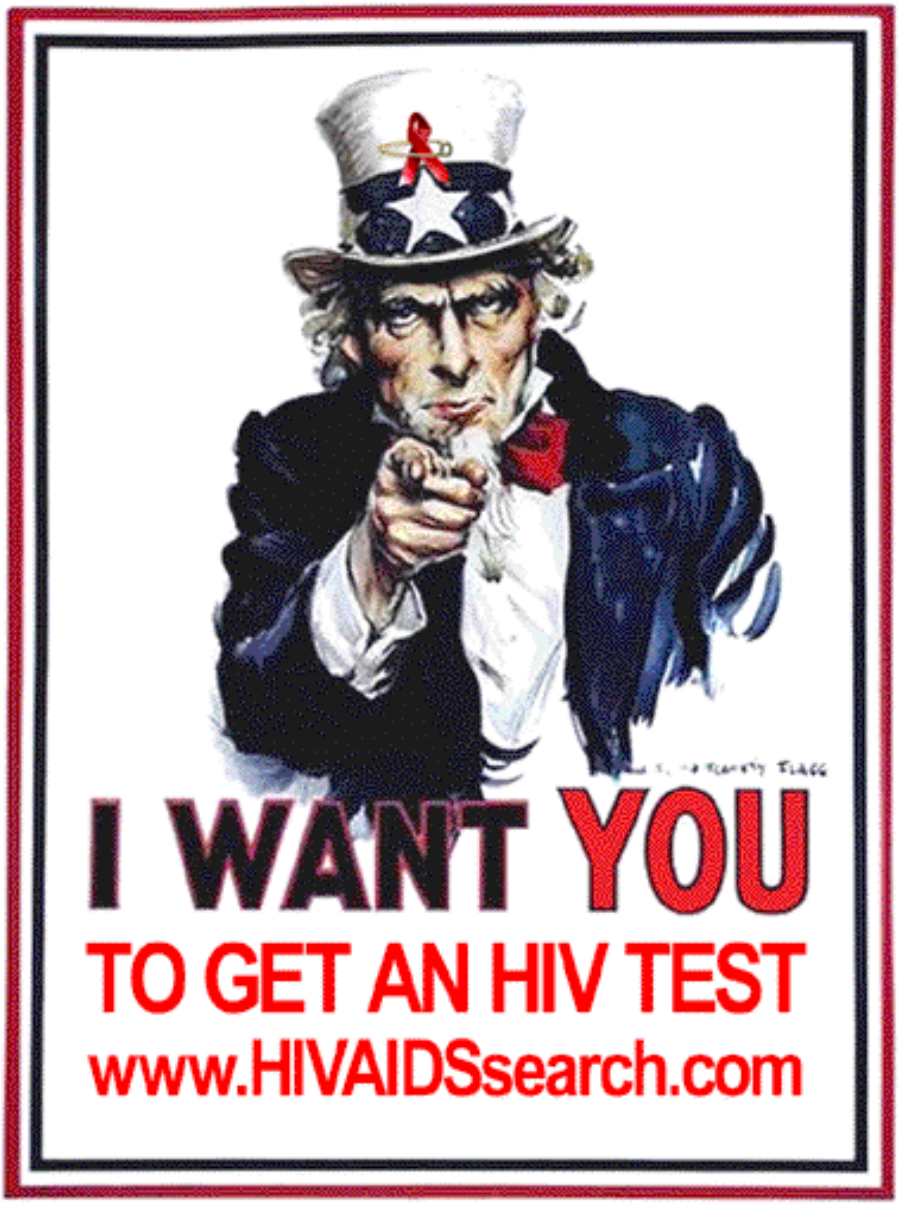
Nevertheless, it seems that with every election, we see a steady decline in voter turnout. Look at basic human needs: food, water, healthcare and education. How many of these do we personally provide for our families in this day and age? I remember my parents telling me about how they helped their parents dig wells to get water for their personal use, for their livestock and for the crops they raised. They also talked about how they harvested their own food, did basic home health care when one of them was sick, as well as teaching their children. In short, they were responsible for the quality of their own life.

I'm not advocating a complete return to what life was like early in the 20th Century. There are certain values, though, that should not change with the passage of time. Among these is the concept of responsibility for our actions.

Even though it seems that I have just painted a rather bleak picture of much of humanity, I am honored to witness personal responsibility in action on an almost daily basis. In the four years I have worked as a Case Manager for men, women and children living with HIV and AIDS in Ventura County, I have encountered many instances of

AIDS Project Ventura County (APVC) clients not only taking responsibility for their own welfare, but also looking out for the welfare of other clients. I have seen clients who should have been home and in bed taking care of themselves come to our weekly Food Pantry because they felt they needed to get out of the house and because they knew of other clients who were worse off and unable to pick up their own food.

This pantry, which is the only one in Ventura County dedicated to those living with HIV and AIDS, is a prime example of people making a positive change in the lives of others. Every person who works in the Pantry, from the Pantry Coordinator on, (including some A.P.V.C. clients) is a volunteer. I have also seen the incredible generosity of many people and organizations in their donations of food, clothes, money and time to AIDS Project Ventura County. All of these folks helped AIDS Project Ventura County provide 18,000 bags of groceries to almost 200 men, women and children infected and affected by HIV and AIDS in 2002.



Two clients of AIDS Project Ventura County made the concept of personal responsibility become real to me early last year. When I first met these men, one was so ill that he needed a cane to help him walk even the shortest distance. He would stay in the car while his partner shopped for them. The only time either of them would engage anyone in conversation would be when they requested housing assistance from the agency. Normally, they would be in and out of the pantry in less than five minutes. As other clients, staff and volunteers reached out to them, they gradually emerged from their shells. Now, they are valued volunteers of the pantry. The man who rarely engaged people in conversation now reaches out to those who come to the pantry and makes them feel welcome. His partner, who was once dependent on a cane to help him get around, now goes to a gym regularly and volunteers at the pantry three days a week, shopping, stocking shelves and preparing boxes for agency clients who need their food delivered. He also assists clients in getting their food out to their cars on Friday mornings while the pantry is open. They have both told me that volunteering at the Pantry has helped them not only with their physical health, but with their mental health, as well.

As the client population of APVC grows, the number of clients who will access the Food Pantry will increase correspondingly. At present, AIDS Project Ventura County has a client population of 155, and over 40% of agency clients access the Food Pantry at least once a month. If present trends continue, AIDS Project Ventura County will be serving 175 clients by the end of 2003. That means that the Pantry will be serving 70 clients at least once a month, so the need for more people to share their time, talents and treasure becomes even more essential. Because rent, utilities, medical and drug bills and other obligations consume most, if not all, of a client's monthly income, most clients are forced to utilize the pantry weekly.

Being put in this position is not easy for someone living with HIV or AIDS. More than one client has told me

that realizing they need the services of the pantry, as well as the other services AIDS Project Ventura County offers is one more reminder that they are losing the independence and dignity for which they had fought their whole lives. At the same time, though, a Ventura County resident infected with or affected by HIV or AIDS shouldn't have to decide whether they are going to eat healthy foods, keep a roof over their heads or keep their lights on each month. It is our task to expand our sphere of responsibility.

I'm going to hazard a guess and say that, at one time or another, each and every one of us has abandoned our sense of responsibility for something that has directly affected us. As Ralph Waldo Emerson wrote, "it is the nature of the beast." If we take a good, hard look at our world today with all its looming crises, we can begin to feel powerless. It would be easy to say, "Let someone else deal with all that." To be overwhelmed, to feel powerless, and to feel like your voice doesn't mean anything is to forsake our membership in the human race.

I've brought up many issues in this article, and I would be remiss if I did not propose a solution. I believe the solution lies in what the ancient Greeks called metanoia – a rebirth or change in attitude. If we take the time to ally ourselves with others who are committed to the concept of personal responsibility, positive change can happen. The negative points of view I have written about can be overcome if we do two things: Begin to believe that recovering our sense of personal responsibility is possible, and secondly, work to put that belief into action on a daily basis.

HIV Peer Education Project

By Judy Seyles

Utilizing a grant from the California Department of Education, the Health Programs Department of Ventura County Superintendent of Schools Office operated an HIV Peer Education Project for five years from 1995/96 through 1999/2000 school years. The purposes of the grant were:

- to develop/produce a student Peer Educator Manual
- to develop/produce a Coordination Manual for use by adult advisors
- to train students to deliver presentations on HIV/AIDS in classroom or community settings
- to train adult advisors in all phases of implementation or expansion of an HIV prevention peer education program

Eventually, the project was expanded to provide training to adult advisors statewide who applied to participate in the project.

Students from nine local high schools, along with their adult advisors, participated in the project. Following the 24 hour student training (two eight hour Saturdays, two Friday evenings of four hours each), the adult advisors were responsible for coordinating opportunities for the peer educators to make presentations at their high schools. Peer educators presented at parent meetings, high school staff meetings, and in a variety of classes (English, social science, math, home economics, health education, ESL, history, etc.).

The Peer Education Project is intended to enhance HIV/AIDS classroom instruction mandated by CA Education Code 51201.5. The rationale for this peer education model was:

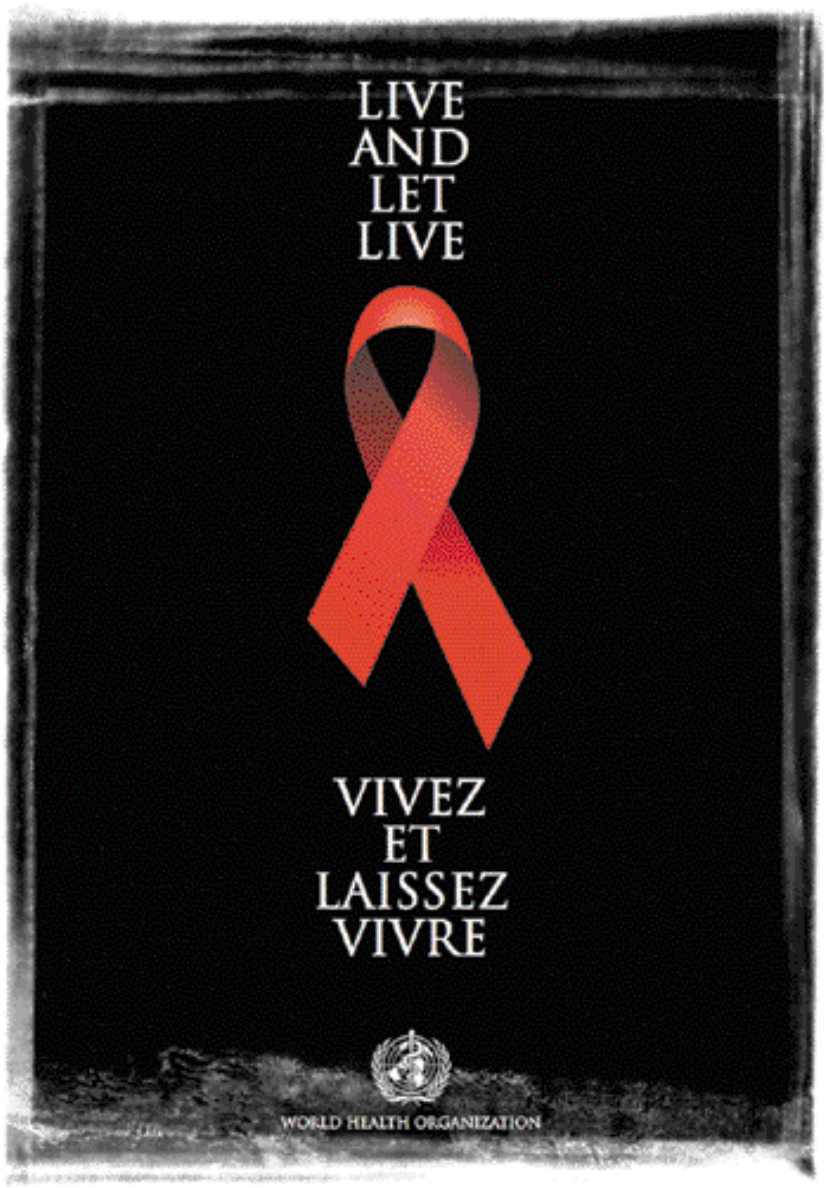
- HIV infection is a critical health issue for adolescents
- Peer educators can reinforce basic factual information and dispel myths
- Peer educators can model healthy peer norms
- Research demonstrates that peer resource programs are effective (Tobler, 1986)
- Research demonstrates that peer resource programs have a great impact on youth directly involved in education or assistance (Bernard, 1990)
- Peer educators experience positive regard (Ozer, et.al., 1997)
- Classroom presentations by peer educators show greater satisfaction and achievement on the part of students (Ozer, et.al., 1997)

Ten presentation outlines were developed with lessons clearly articulated, materials in an easy-to-use format and background information included in order for students to be able to answer questions. The presentations could be stand-alone or combined to fit the grade level, classroom time and skill of the peer educators. Lesson outlines for the following topics are included:

1. HIV 101
2. HIV Antibody Testing
3. Assessing Risk for HIV Infection
4. Myths and Facts
5. HIV/AIDS Statistics
6. Refusal Skills
7. Abstinence: Setting Personal Limits
8. Condom-Sense
9. Substance Use and HIV
10. Positively Speaking

Grant funding was used to print manuals, pay stipends to peer educators who completed training and made 2-3 presentations at their school site, cover costs of meals for the 24 hour training, provide stipends to Positively Speaking speakers who presented at the training, provide stipends to other organizations who provided part of the training, provide stipends to experienced peer educators for presenting lessons at the training, and training facility costs.

Peer Educators were excited about being selected, willing to attend the training, and reported excellent response to their presentations. Experienced peer educators who graduated from high school were able to continue as peer educators, giving vital HIV/AIDS prevention education, in college settings. Adult advisors also demonstrated high energy and support for the peer educators and believed in the logo that students created: *HIV Peer Educators – Youth Empowering Youth.*



What's the Big Deal Anyway?

By Daniel Jordan, PhD & Craig Webb

Those of us who have been around for a while simply don't get it that much of what we take for granted, what we even lived through or experienced, is simply ancient history to our kids. I (Dr. Jordan) was painfully reminded of this recently when a textbook I use in a class mentioned Watergate, and then had a brief footnote at the bottom of the page that described what Watergate was. My first thought was, "Why does Watergate need a descriptive footnote?" Then it hit me. The younger generation (wait a minute, my generation is the younger generation, right?) simply has no idea of what Watergate was. This was a wake up call that we need to do a better job of educating our young folks, and letting them know all the facts.

Similarly, with the new meds, with better health care, with acess to information, lots of our younger people simply have no idea what it means to get HIV. So Some folks, especially younger ones who simply don't know the history of HIV, who have grown up in an era when HIV seems controllable via meds, seem puzzled. They ask "What's the big deal? Get AIDS, take some pills, so what?" In an effort to drive home the point, Craig Webb compiled the following list of terms that everyone should know. If you have the idea that "HIV and AIDS are not a big deal," here are the terms you will have to learn if you decide it is no big deal to contract this disease, and you do not act responsibly to protect yourself and others.

There will be a matching and multiple choice test at the end of the class. You will have one hour to take the exam. Those who fail will have to make some very major lifestyle changes.

Quiz: A Few HIV/AIDS Terms to Memorize if You Become HIV Infected

ACTG – AIDS Clinical Trials Group
ADA – Americans with Disabilities Act
AED – AIDS Educational Development
ADAP – AIDS Drug Assistance Program
AIDS – Acquired Immunodeficiency Syndrome
APA – AIDS Pharmaceutical Assistance
APVC – AIDS Project Ventura County
ARF – Adult Residential Facility

C&T – Counseling and Testing
CARE Act – Comprehensive AIDS Resources Emergency Act
CP – Christopher's Place
CTR – Counseling, Training, Referral
DMH – Department of Mental Health
EC – El Concilio
EFSP – Emergency Food and Shelter Program
EHAP – Emergency Housing Assistance Program
EIP – Early Intervention Program
ELI – Evaluating Local Interventions
ELISA – Enzyme-Linked Immunosorbent Assay
HAART – Highly Active Antiretroviral Therapy
HCD – Department of Housing and Community Development
HIV – Human Immunodeficiency Virus
HIV/EIS – HIV Early Intervention Services/Primary Care
HOPWA – Housing Opportunities for People with AIDS
HPPG – HIV/AIDS Prevention and Planning Group
LMVNA – Livingston Memorial Visiting Nurses Association
NAC – National AIDS Clearinghouse
NDC – National Drug Code
NIH – National Institutes of Health
NLM – National Library of Medicine
NMAC – National Minority AIDS Council
NNRTI – Non-Nucleoside Reverse Transcriptase Inhibitor
NPHRC – National Pediatric and Family HIV Resource Center
OI – Opportunistic Infection
P3, P cubed, P4P – Primary Prevention for Positives
PCR – Polymerase Chain Reation
PCRS – Partner Counseling & Referral Service
PLWA – People Living with AIDS
PLWH – People Living with HIV
PML – Progressive Multifocal Leukoencephalopathy
PT – Physical Therapy
PWA – People with AIDS
PWHIV – People with HIV
RCFCI – Residential Care Facility for the Chronically Ill
RWCA – Ryan White Care Act
SA – Salvation Army
SHIA – Supported Housing Initiative Act
SP – Serra Project
STI – Sexually Transmitted Infection
TCAC – Low Income Housing Tax Credit Program
VCAP – Ventura County AIDS Partnership
VCARC – Ventura County ARC
VCHIVCC – Ventura County HIV Care Consortium
VCMC – Ventura County Medical Center
VCPH – Ventura County Public Health
VCPHAIDS – Ventura County Public Health AIDS Center
VCPHCD – Ventura County Public Health Communicable Disease Program
VCPHE – Ventura County Public Health Education
VCRA – Ventura County Rainbow Alliance

So, are You Ready for the Final Exam?

If you have now memorized the terms above for programs, resources, medications, and other relevant resources, then you are ready to let yourself engage in risky behavior. Once you have memorized these terms, the second list will be available.

If you think all the terms above are too much, here is the final term to learn: TMI – Too Much Information (defined as, it is better not to take the risks)

HIV/AIDS Case Management: The Bridge Program

By Diana Goulet

Aided by a new grant from the California State Office of AIDS, Early Intervention Section, Ventura County Public Health has been able to implement an exciting new program designed to reach out to newly diagnosed HIV positive individuals and assist them in the first weeks and months following their diagnosis. The Bridge Program is a demonstration project coordinated by the Centers for Disease Control in Atlanta.

According to Diana Goulet, Project Director, many clients upon hearing that they have contracted HIV disease are frightened and fearful. They have only limited knowledge about their disease and its treatment and may not know that there are many medications and services available to help them; this confusion may be compounded if the individual is non-English speaking. As a result, the person may not ask for help or begin treatment until much later in their disease. This program aims to support early treatment and assist the new client as he/she learns to cope with their diagnosis. Each new client is also urged to notify partners who may have been exposed, and assisted to identify methods by which they can minimize the possibility that any additional persons are infected.

Teresa Ponce, a Community Health Outreach Worker works full time with Bridge Clients who are referred to her as soon as possible after their HIV test results are obtained. She is frequently present when the medical provider speaks with the client for the first time and is able to talk with them at that time about the many concerns they have. Over the next several months, Teresa continues to meet with her clients wherever is convenient for them. She answers their questions about the disease, explains what

treatments are available, and assists them to make their first appointment with the physician who will manage their HIV disease. Often clients ask that she accompany them to the physician's office which she is glad to do. She is also able to talk with each new client as they begin to consider whether and how to inform their family and friends about their disease.

Teresa grew up in Ventura County and is fluently bilingual and bicultural. She has worked in the HIV/AIDS Early Intervention Services for the Public Health Department for the past 6 years, and was promoted to the Bridge Position in 2002. One client recently remarked that Teresa made all the difference in the world [for her]. She wasn't afraid to go the extra mile. Thanks, Teresa!!

Crystal Meth And Its Effect On The HIV/AIDS Community

By Martin Perrier

The use of "meth" (crystal methamphetamine) has reached epidemic proportions among gay and bisexual men. Health officials are warning that the mantra of HIV prevention - safe sex - has been drowned out by a raucous scene of loud party music, cheap meth and reckless intercourse.

No data for Ventura County exist, but health experts estimate that up to 40% of gay men in San Francisco have tried crystal meth, a powerful form of what's commonly known as speed. Even more alarming, a San Francisco Health Department study last year found that at one high-risk clinic, 25% to 30% of those with new HIV infections reported crystal meth use in the previous six months.

At a meeting about crystal meth in Sacramento last month, the State's top AIDS and HIV prevention officials came up with the smoking gun of all statistics: Gay men in California who use speed are twice as likely to be HIV positive than gays who don't use it.

To be sure, the problem of methamphetamine use is not confined to gay and bisexual men who like to party. Law enforcement officials say meth use has spread to the suburbs, particularly among teens facing boredom, peer pressure and undiagnosed psychological problems. Yet nowhere is the meth concern greater than in the subculture within the gay community of partygoers who attend weekend-long events dominated by alcohol, drugs, sex and ramped-up dance music.

Dr. Jeffrey Klausner, director of sexually transmitted disease prevention and control for the San Francisco Department of Public Health, is convinced of the dangers. "We have all sorts of levels of evidence," he said, "and it's all pointing in the same direction: The crystal meth epidemic is playing an important role in increasing sexual risk behaviors, and that is leading to new HIV and STD infections."

The drug is cheap – $30 for a high of several days – easy to get and powerful. It increases sexual stamina and eases the pain of depression or loneliness. Others find it makes them feel invulnerable – if only for a night.

After cigarettes, alcohol and marijuana, speed is the most commonly used drug in the gay party scene. Known also as "crissy," "'tina," "tweak," and "crank," crystal meth is a powdery substance that can be swallowed, injected, snorted or smoked.

It appeals to men along any paths of life: lawyers to waiters, stockbrokers to health-care workers - all have succumbed to the drug, a stimulant that mimics the body's natural adrenaline. Derived in the early 1900s from amphetamine, it was first prescribed, then made available over the counter, in decongestants and bronchial inhalers.

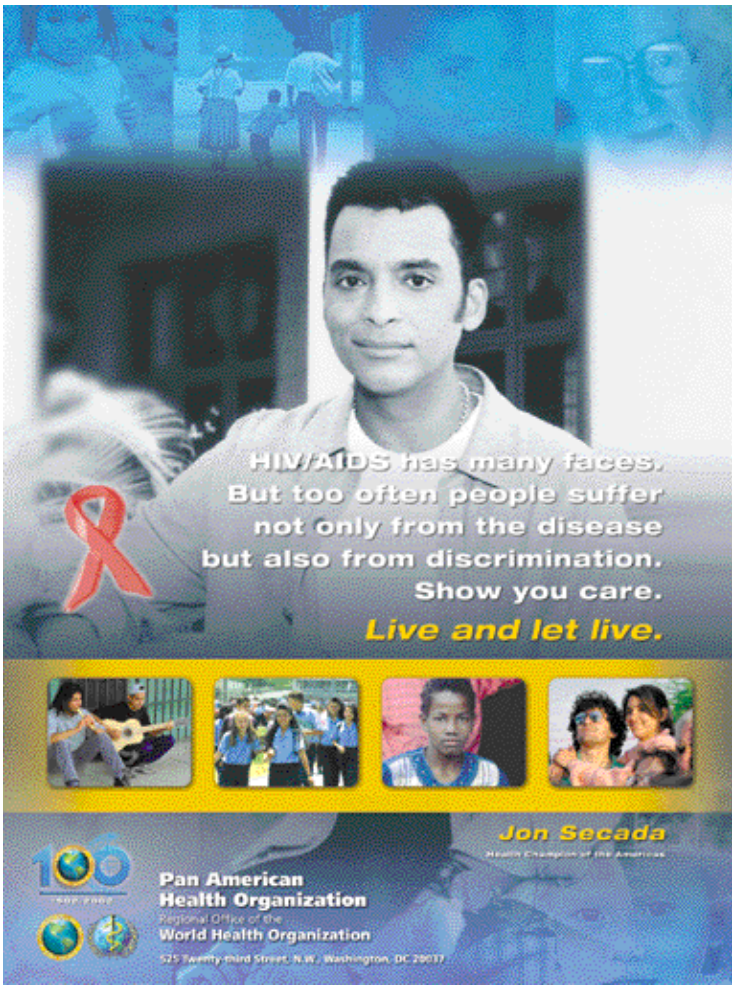
Illicit makers quickly learned how to manufacture the drug cheaply and in mass quantities. The chemical make-up of meth is similar to that of amphetamine, but experts say meth has a stronger effect on the body's central nervous system. Like amphetamine, it brings about heightened activity, reduces hunger, and temporarily promotes a sense of well-being.

The question is not, is crystal methamphetamine being used in the gay community? The question, said Dr. Grant Colfax, director of HIV prevention studies with the San Francisco Department of Public Health, is instead, can the use of speed go much higher? His chilling, current-day viewpoint is this: "We have a dual epidemic - a speed epidemic and an HIV epidemic that are both increasing."

Klausner not only blames crystal meth for new HIV infections, but also for the increase in syphilis and gonorrhea. According to Klausner, 25 percent of gay and bisexual men testing positive for syphilis reported recent speed use. In addition, HIV negative gays who used meth were three times more likely to have rectal gonorrhea than nonusers. In California, a statewide study found that among the gay and bisexual men tested in 2001 and 2002 at publicly funded clinics, 7.1 percent of meth users were HIV positive, compared to 3.7 percent of those who didn't use meth. Researchers found that condom use – considered the most effective barrier against HIV – was lower among gay men who used speed.

Experts have shown that heavy methamphetamine users, those who do two to four grams a week, can suffer serious brain damage. Heavy meth use has been shown to be the equivalent of 40 years of aging, affecting movement and memory.

Although speed creates a sense of euphoria, it is actually knocking out the brain's ability to produce dopamine, which is how the brain naturally creates the



sensation of pleasure. The addict then becomes desperate for his fix because the drug offers a sense of well-being.

"People are using the drug to feel better," said Dr. Nora Volkow, the new director of the National Institute on Drug Abuse, "but they are literally selling their soul to the devil."

While the effects of infrequent use of methamphetamine are unknown, experts say the good news is that studies show that heavy users who quit regained some of the brain's ability to produce dopamine.

"We're continuing to see guys who have been HIV negative for years start using speed," Colfax said, and subsequently contract the AIDS virus.

Crystal meth is anathema to safe sex. It leads to rougher sex and uninhibited, risky sex; condoms failing, or men simply don't use them.

"We're trying to de-link substance use from risk behavior, to get guys to be safer while using substances," Colfax said. "People use it and they're not able to assess their risk behavior. We have a lot of work to do."

Colfax concedes that not all men become addicts, but says even the occasional or weekend user puts himself at serious risk for contracting HIV. He wants the full array of programs - treatment, counseling, prevention - tailor-made to the occasional user. "Members of that audience fall below the drug-dependency radar," Colfax said, "and walk around believing they're risk- free." "Guys start with weekend use and it accelerates," said Board of Supervisors President Tom Ammiano, who is co-sponsoring the crystal meth hearing Wednesday with Supervisor Bevan Dufty. Both Ammiano and Dufty are gay and said they're now hearing of incidents in which men can't function at work because they're still under the influence of meth from their weekend parties.

"There's a tremendous amount of denial around speed use," Ammiano said. "It's pernicious. We're also hearing stories of people failing in rehab after eight, nine tries. It's very brutal." Abstaining from speed doesn't induce the severe withdrawals or vomiting associated with heroin, but those who stop taking meth often face depression, agitation and intense cravings for the drug. What's more, experts say, speed's strong association with sex and partying make it all the harder to kick.

Prosecutor Jim Hammer, who is gay, said the solution is not incarceration but getting more people into treatment programs early on.

One of the dangers of crystal that hasn't been broadcast widely is that mixing it with Viagra can raise heart rate and blood pressure and lead to death. Men on speed commonly use Viagra to counteract the erectile problems caused by meth. "Any amphetamine - cocaine, crystal - mixed with Viagra increases your risk for heart attack," said Fontaine of the New York Gay Men's Health Crisis.

"To the untrained eye, it's invisible," Dufty said. But it's also widespread. "It's a currency that's being traded like dollar bills all around our community. It's impacting people in their 20s, 30s, 40s and 50s. I've heard lesbians talk about crystal use. I recognize people are going to make their own choices. But we have a responsibility to make it an informed choice. As community leaders and friends, we have to speak loudly about the clear and present danger of crystal meth."

HIV and Age

By Lynn Bartosh

HIV/AIDS education and prevention efforts have been concentrated on youth. The Centers for Disease Control, HIV/AIDS Prevention Division has stated, "It has been estimated that at least half of all new HIV infections in the United States are among people under 25 years of age, and the majority of young people are infected sexually." Scientists believe that cases of HIV infection diagnosed

among 13 to 24 year olds are indicative of overall trends in HIV incidence because this age group has more recently initiated high-risk behaviors. An estimated 12 million cases of STIs (Sexually Transmitted infections) other than HIV are diagnosed annually in the United States, and about two-thirds of those are among people under the age of 25. Research has shown that certain factors make people who are infected with an STI more likely to become infected with HIV if exposed sexually.

I think we all would agree that it is vitally important to educate our youth and create prevention messages that will give them the information they need to improve their behavior. However, when we look closely at the statistics across the United States, California and our very own county, the numbers show that the older age groups also are engaged in risky behavior that leads them to have high rates of infection. Keep in mind that we have the most data for AIDS cases (as opposed to HIV) since all states were reporting AIDS. Several states, including California only began reporting HIV cases as of July 1, 2002. So the statistical focus here is on AIDS cases.

In the United States, California and Ventura County the largest percentage of AIDS cases were in the 30 to 39 year old age group. This has been a consistent pattern during the last several years. It generally takes between 7 to 10 years for an HIV positive individual to progress to becoming an AIDS diagnosis. That means that if people do not get tested regularly, they can spend up to 10 years spreading their infection to others, including unsuspecting their mates or newborns of infected mothers, not just casual sex partners, which is the stereotyped mode of transmission. Although the patterns vary widely, the data suggest that 40% of these adults diagnosed with AIDS were probably infected somewhere in their mid to late 20s or early 30s. Interestingly, the next largest percent of cases diagnosed with AIDS comes from individuals over the age of 40: 38% in the United States, 39% in California, and 36% in Ventura County. These percentages are almost double that seen in AIDS diagnosed individuals under the age of 30 with 18% in the US, 15% in California, and 18% in Ventura County.

These numbers are all based on cumulative data. However, in a quick snapshot of people who are living with HIV or AIDS in Ventura County, 22% were under the age of 30, 45% were 30 to 39 years old, followed by 33% over the age of 40. The percentage of HIV/AIDS diagnosis has remained stable over time.

Taken together, these data suggest that Ventura County adults are contracting HIV at higher rates than youth. They most likely contract it during their 20s or early 30s. This has implications for our education efforts, because it means that education needs to have two additional components. Education for youth needs to include a long-range focus that helps them understand that the risk of contracting HIV does not disappear as they get older. We also need an educational effort focused directly on our adult populations who are currently at high risk for contracting HIV.

These data are very important to formulating new and effective HIV/AIDS prevention and education messages. While it is important to educate our youth, we cannot ignore the mid-range to older population whose percentage of cases is actually higher. People are becoming infected during their 30s and 40s and older, not through blood transfusions, but by sexual contact. Many of these individuals have spouses and families who are put at risk. We must be able to discuss these issues as a matter of serious public policy.

HIV Can Be Transmitted Via Oral Sex

Laboratory studies of mouth tissue suggest that 'unprotected' oral sex does have the potential to transmit HIV. The results help to understand how HIV is transmitted and suggest that even oral tissue that is intact--without any tears or sores-- can become infected with HIV under the right circumstances.

Dr. Xuan Liu, of Charles R. Drew University of Medicine and Science in Los Angeles, California and colleagues at the University of California, Los Angeles obtained oral tissue samples from over 50 healthy, HIV-negative patients and exposed the tissue to three different types of HIV. They found that two of the types could infect and reproduce within cells called keratinocytes that line the surface of the mouth, and that these cells can then transfer the infection to adjacent white blood cells. However, the level of infection in the mouth cells was much lower than that seen in white blood cells--approximately one-fourth to one-eighth lower. The findings were published in the March issue of the Journal of Virology.

“HIV is able to get into (keratinocytes), but it reproduces less than it would in blood cells ... because saliva contains an HIV inhibitor,” Liu explained. He said keratinocytes are able to release the virus to blood cells, which proliferate much faster than keratinocytes. Thus, the transfer of the infection from keratinocytes to white blood cells may provide a “foothold” for HIV in the body.

Further research is necessary to determine if the laboratory results mimic what actually happens in a living patient, Liu said.

[Reuters Health, 3/25/03]

HIV/AIDS Trends Summary

By Barbara Spraktes-Wilkins

Ventura County continues along the same trend patterns as before. On a per capita basis, AIDS cases remain lower than in the rest of California, reflecting the good work performed by people involved in this epidemic. Some highlights of the most recent data are:

- Twenty cases were reported in the first six months of 2002
- Nine deaths were recorded, compared to three in the first six months of 2000
- Ninety percent were male, ten percent were female
- As in 2001, more Hispanics than Whites were diagnosed with AIDS
- The greatest number of AIDS cases were among 40-49 year olds, followed by 30-39 year olds, consistent with previous years
- The main route of exposure to HIV was in the categories of "men having sex with men," "men having sex with men and IDU" and "no identifiable risk"
- The diagnosis of AIDS was primarily made through a low CD4 count, followed by other opportunistic infections
- 147 HIV cases were reported July through December 2002

Overall AIDS Statistics 1983 - 2003			
Totals	Ventura	California	United States
Adult Cases	868	174,916	784,032
Adult Deaths	516	75,043	452,111
Pediatric Cases	3	629	8,994
Pediatric Deaths	2	382	5,168
Total Cases	871	125,536	793,026
Total Deaths	518	76,126	457,667

- The age categories are a bit more diverse in 2002. Ventura County has consistently had the majority of the reported cases in the 30-39 & 40-49 age groups in recent years.
- Fifty-two percent of cases were between the ages of 30-39, the rest were over 40 years of age, primarily men having sex with men.

Ventura County AIDS Cases by Age		
Age	2001	2002
<19 years	0 (0%)	0(0%)
20 to 29 years	1 (4%)	5 (12%)
30 to 39 years	16 (43%)	11 (27%)
40 to 49 years	3 (8%)	17 (41%)
>49 years	8 (22%)	8 (20%)

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- Fifty-two percent of cases were between the ages of 30-39, the rest were over 40 years of age, primarily men having sex with men.

Ventura County AIDS Cases Counts		
Totals	2001	2002
Cases Reported	37	41
Deaths Reported	15	13
Males	32 (86%)	36 (86%)
Females	5 (14%)	5 (14%)

- Males continue to have the largest number of newly diagnosed AIDS cases.

Ventura County AIDS Cases by Race		
Race	2001	2002
White	15 (41%)	25 (61%)
Hispanic	18 (49%)	13 (32%)
African-Amer.	4 (11%)	1 (2%)

- The Hispanic population continues to have the largest number of newly diagnosed AIDS cases.

Strategy for Physicians to Help Prevent Human Immunodeficiency Virus Infections

By Robert M. Levin, MD

At the most recent international AIDS conference in Barcelona, Spain, it was projected that in the absence of an expanded prevention effort, 45,000,000 new AIDS infections will occur by the year 2010. Twenty-nine million of these infections could be prevented if existing prevention strategies were expanded. Prevention works. This has been shown both in the United States and in numerous countries such as Senegal, Thailand, and Uganda. Strategies to prevent the spread of HIV infection

for the first two decades of the epidemic focused on keeping HIV negative individuals from contracting the disease. More recent strategies have shifted their attention to keeping HIV positive people from spreading it.

Most of the new programs for combating the spread of HIV in our community rest with community based organizations. However, much can be done to combat the spread of this disease in the physician's office. In medical offices throughout our county patients may be receiving antiretroviral therapy (ART). Some of these patients may engage in high-risk behaviors and, therefore, have the potential of transmitting both drug-susceptible and drug-resistant HIV viruses.

While millions of people behave in ways that put them at risk of acquiring HIV disease, they can only contract it from people who are already infected with HIV. A significant number of people living with HIV infection continue to engage in both high-risk sexual and high-risk drug using activities. Continued risky behaviors have been shown to occur in all groups of HIV infected individuals including injection drug users (IDUs), heterosexual men and women, and men who have sex with men (MSM). While men having sex with men and intravenous drug users have received the bulk of the attention as disseminators of HIV infection, it is important to keep in mind that irresponsible heterosexual men and women are also contributing significantly to the spread of this disease.

Studies show that uninfected men having sex with men who are receiving antiretrovirual therapy may increase their high-risk behaviors if they have subjectively improved feelings of well being or believe that an undetectable amount of virus in their blood tests means it is safe for them to engage in high-risk behaviors.

Once an individual with an HIV infection begins drug therapy, many rapidly develop drug resistant viruses. The transmission of drug resistant strains of HIV has been well documented among all patient groups including men having sex with men, intravenous drug users, heterosexuals, infants, and health care workers. A recent report found that 35% more patients who became positive for HIV in the last year contracted drug resistant HIV than those that became positive in 1995. The virus is evolving in response to our efforts to combat it.

In the last several years highly active antiretroviral therapy (HAART) has been used in many HIV positive patients. The largest study of patients receiving highly active antiretroviral therapy showed that 78% of these patients had drug resistant HIV infections after being on therapy. The transmission of HIV that are resistant to the most highly active anti HIV drugs means not only that the usual anti HIV drugs used when people are first diagnosed may not work, but even the most sophisticated and advanced of HIV drugs will fail to help these patients. This leads not only to a poorer outcome for people being infected with these resistant HIV, but also a constant race to come up with newer and stronger agents to fight resistant HIV infections.

A physician can do a number of things in his or her office to prevent the spread of HIV from his patients to others. Much evidence shows that behavioral counseling works as a prevention strategy. Motivational intervention to reduce risky sexual behaviors was studied for HIV infection among high-risk heterosexual low-income patients. They underwent a seven-session HIV infection risk reduction program during one year. The subjects subsequently reported fewer unprotected sexual acts and had higher levels of condom use. These patients reported they were more likely to use condoms consistently during a twelve month follow-up period.

Motivational intervention therapies can be successful outside of the doctor's office as well. One study analyzed a five-session intervention delivered by community-based paraprofessionals or mental health counselors. Another study analyzed an eight-week course of sex-specific counseling sessions. Both studies found significant benefit in reducing risk behavior for HIV transmission.

Another relevant study compared education alone to counseling. Subjects who received counseling were significantly more likely than those who received only education to use condoms 100% of the time at three months follow-up. The counseling subjects were also 30% less likely at follow-up to have another sexually transmitted disease. This study was performed at a sexually transmitted disease clinic and subjects were selected when they came into the clinic with a documented sexually transmitted disease.

Many barriers to behavioral counseling exist. While physicians believe that health promotion and disease prevention are part of their job, they actually perform very few risk reduction interventions. Obstacles to clinician-delivered interventions include a lack of training about and knowledge of sex and drug related behaviors, a lack of discussion skills, and reluctance to discuss issues of sex and drug use. Physicians often do not perceive that their patients are at risk and even if they do, they tend to believe that their attempts will not be successful anyway. The profession also does not have standardized tools to assess the extent of their patients' risk. Finally constraints on a physician's time and resources impede their playing a more active role in risk prevention.

Physicians often find it uncomfortable to discuss issues such as sex and prevention of infection. They may also believe that their patients are uncomfortable discussing these issues. Additionally, any patient with HIV

infection who is taking antiretroviral agents will require a great deal of physician time discussing issues of adherence, drug toxicity, laboratory tests to monitor the effects of the drug and the progress of the disease, and routine health maintenance. The physician may not feel that there is sufficient time to address the issue of prevention. Some physicians also have an unrealistic expectation that the goal of prevention is the elimination of all high-risk behaviors. This includes the expectation that their patients will be completely abstinent or completely sober rather than the aim of attainable and stepwise risk reduction. They therefore believe that their efforts will be fruitless.

What physicians sometimes forget, but what research continues to show, is that their patients view them as a trusted source of prevention information. A physician's prevention messages can be effective. This has been documented in exercise promotion, smoking cessation, coronary risk reduction, breast self-examination and adherence to medication for the treatment of sexually transmitted diseases. A wide variety of prevention programs have shown success in changing physicians' behavior with their patients.

What can Physicians Do?

Physicians can do a number of things to reduce the spread of HIV among their patients. HIV disease is a chronic illness requiring many clinical encounters and a close patient-doctor relationship. A significant proportion of HIV positive patients go to clinics that specialize in HIV. These programs may be the only place where HIV positive patients will have contact with someone who can inform and educate them about the prevention of HIV transmission. One approach that physicians can use is that of motivational interviewing techniques at each patient encounter to promote HIV risk reduction behavior change. AIDS experts recommend behavioral counseling as a prevention tool in the clinical care setting with the following guidelines:

1. Supportive and non-punitive counseling in a comfortable setting

Surveys indicate that patients do want to discuss such issues as sex and HIV prevention with their physician and that they actually expect these discussions to take place. Creating a comfortable, non-judgmental atmosphere in which the patient can discuss these issues is critical for the clinician and patient to gain insight and to learn the best strategies for HIV prevention for each particular patient.

2. Interactive counseling or motivational interviewing

A technique of motivational interviewing can help the patient discuss behavior and be involved in the decision making process. These strategies include assessing the patient's HIV transmission risk behaviors and asking the patients to rate on ten point scales how important it would be for them to reduce their risk behavior and how confident they are that they could reduce their risk behavior or maintain safer practices. The patient and clinician then together devise prevention strategies to improvement these scores. This interaction occurs at every clinic session and is always tailored to the patients' ongoing transmission risk behaviors. This process encourages patients to describe their behaviors and develop their own solutions. It can open up the door to productive discussions and use the patients own strengths and views as tools to help them arrange safer behavior.

3. Individualized counseling

Given the variability of patients and settings it is difficult to design a single effective intervention to be used in the clinical care setting. Recognizing specific needs for each patient is critical in terms of formulating a plan for prevention. Although some patients may not be engaging in any high risk behaviors, this can change over time and it must be assessed at each visit.

4. Scripting of conversations

Initiating and incorporating discussions of sexual and drug use behavior is often difficult for clinicians. Some clinicians find it helpful to have a scripted conversation to initiate discussion. This can help both by serving as a reminder to the clinician and by providing a way for the clinician to feel more comfortable introducing these issues.

5. Goal directed counseling

It is important that patients have a concrete sense of what they can do at the individual level to prevent the spread of HIV disease. Together with physicians, patients can come up with goals that would specifically apply to their own risk of transmitting HIV. For example, a patient may agree to use condoms consistently or agree to always inform partners that he or she is HIV positive.

6. Repeated sessions

Studies have shown that although prevention messages may be part of initial encounters, they are much less

frequently incorporated into subsequent visits. However, prevention messages need to be repeatedly delivered to be effective. In addition, patients' behaviors change over time as their disease courses and social situations vary – which further emphasizes the important of tailoring prevention messages to a particular point in time.

For example, a patient may be asked, "now that we have finished discussing your medications, I would like to ask you some questions about your sex and drug use behaviors. What behaviors are you involved in now? Would you feel comfortable discussing them? Can you think of anything that you might like to change about these behaviors and what interest might you have for changing them? How might you be able to reduce the riskiness of your sex and drug use behaviors?" Of course, the way that the patient answers these questions will lead the physician to an impromptu discussion of these issues.

Motivational intervention research with HIV positive people is still fairly new. Studies of the technique have been conducted on various issues (risky sexual behavior, smoking cessation and substance abuse) and have found positive results. Applying the technique to the issue of HIV transmission, Douglass Fisher and Rosemary Ryan found positive outcomes. "Six month follow-up data with 38 participants showed a 31% reduction in the proportion of participants reporting unprotected anal sex with a partner of negative or unknown serostatus." (http://www.motivational interview.org/clinical/HIV risk.html).

Motivational interventions appear sufficiently useful in the area of pediatric substance abuse that they have been included in the American Academy of Pediatrics' guidelines for treatment of adolescent substance abuse. "Physicians can enhance the motivational process in their patients by expressing their concerns and encouraging an evaluation or formal assessment. Successful recovery usually begins when the patient stops denying that substance abuse is the cause of the life consequences experienced. Active participation by the pediatrician can assist in breaking down the denial and facilitate entry into the recovery process." (Jacobs, et al., "Indications for Management and Referral of Patients Involved in Substance Abuse" Pediatrics. 2000; 106.)

Beginning to use motivational interventions appears to start with the simple act of expressing concern and encouraging evaluation.

Conclusions

Ultimately, every individual is responsible for protecting themselves against getting HIV infection. Equally, everyone with HIV is responsible not to pass their disease to others. Acknowledging this is part of the reason for the shift over the last two decades from focusing on how HIV negative individuals can protect themselves, to focusing on the HIV positive individual and the importance of their taking responsibility for preventing the spread of their disease. Likewise, it is important that physicians take some of the responsibility for this counseling of their HIV positive patients. They can play an important role in decreasing the spread of this terrible disease.

For more information about motivational interviewing with HIV positive patients, see: http://www.motivational interview.org/clinical/HIV risk.html

Strategies for Clinicians

Behavioral counseling interventions are effective, with the following guidelines:

- Supportive and non-punitive counseling in a comfortable setting
- Interactive counseling and motivational interviewing
- Individualized counseling
- Scripting of conversations
- Goal-directed counseling with reasonable, attainable goals
- Repeated sessions and incorporation into every clinical encounter

Medical interventions

- Antiretroviral therapy
- Reduction to and maintenance of undetectable virus load
- Drug resistance monitoring
- Promotion of adherence to therapy
- Postexposure prophylaxis
- Screening, diagnosis, and treatment of sexually transmitted diseases

Public health interventions

- Promotion and distribution of condoms and clean needles
- Use of HIV infection prevention posters, fact sheets, and brochures
- Partner counseling and notification
- Referral services: Substance abuse and psychiatric treatment

(This article is liberally based on the publication; "Human Immunodeficiency Virus Infection Prevention: Strategies for Clinicians", Clin. Infec. Dis. 2003; 36:1171-6)

Recommendations: 2003 Report to the Board of Supervisors

A subcommittee of the HIV/AIDS Advisory Committee members met in February and reviewed the recommendations from the last two annual reports. A list of suggested recommendation topics was passed out and discussed with the following conclusions:

1. Primary prevention education and outreach inclusive of all at-risk populations, including those who are HIV positive are needed.
2. Be supportive of community efforts to support people with HIV/AIDS.
3. Provide moral support for the continued education of law enforcement and emergency services agencies/personnel.
4. Encourage continued inter/intra agency collaboration for those with dual diagnosis.
5. Encourage schools to adopt Abstinence Plus Program that promotes abstinence and comprehensive STI (Sexually Transmitted Infections) prevention information.
6. Continued support of the Syringe Replacement Program (SRP).
7. As opportunities arise, promote recognition of the need for affordable housing for those with HIV/AIDS - including the need for Skilled Nursing Facilities (SNF).

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