

lies receiving food assistance. I cited WIC because federal regulations mandate that nutrition education be considered a benefit of the program and be made available to all WIC recipients at least twice in each six-month certification period (US Dept. of Agriculture, Food & Nutrition Service, 7 CFR Part 246.11).

Certainly EFNEP is a fine program and does provide, as Ms. Schuster states, "long-term, intensive education that WIC cannot. . ." but, to a limited number of families.

I have some figures on the extent of EFNEP in Pennsylvania, provided to me by Lisa Sullivan, the state EFNEP Coordinator, and on Food Stamp Participation in Pennsylvania, provided by Carol Case, Supervisor, Bureau of Food Stamps, for FY '86-'87.

Food Stamp Recipients (PA, FY '86-'87): 401,216 households (990,342 individuals)

EFNEP Recipients (PA, FY '86-'87): 6,777 homemakers/households (representing 21,945 individuals)

EFNEP is available to persons whose income is 125% or less of the poverty level. In Pennsylvania, EFNEP is available in 45 of the 67 counties. In FY '86-'87 (PA), 69% of EFNEP recipients were on Public Assistance, 81% received Food Stamps, and 50% were on WIC.

Barbara C. Sterne, MS, RD

Nutrition Consultant, Northwestern District Office, Department of Health, Commonwealth of Pennsylvania, Downtown Mall, 900 Water Street, Meadville, PA 16335.

© 1988 American Journal of Public Health

HIV Seropositivity in IV Drug Users in Ohio

Intravenous (IV) drug users are at high risk for human immunodeficiency virus (HIV) infection.¹ To determine the statewide seroprevalence of HIV among this population, the Ohio Department of Health (ODH), in cooperation with the state Bureau of Drug Abuse, undertook a study of methadone clinic participants. Nine of the eleven licensed Methadone Treatment Programs (MTP) (Cleveland [3], Columbus, Cincinnati, Dayton, Akron, Toledo, and Youngstown) in the seven largest metropolitan areas in Ohio participated in the survey. Individual enrollment in the survey was voluntary. Questionnaire data obtained included: demographic information, sexual history, and drug use history including drug

use while traveling both within and outside of Ohio. Each sample was tested for HIV antibody using an enzyme-linked immunosorbent assay (EIA) at one of Ohio's five contract laboratories for HIV antibody testing using the Litton or Abbott test. Positives were confirmed by Western blot (except for one specimen which was repeatedly EIA positive for which inadequate serum was available).

Of clients attending the nine MTPs between April and November 1986, blood samples were obtained from 509 with IV drug use histories. Of these 509 individuals, seven (1.4 per cent) were seropositive for HIV. The sexual orientation of the group was primarily heterosexual, with eight males (1.6 per cent) giving a history of homosexual. Blacks and Hispanics were noted to have a greater prevalence of HIV seropositivity (OR 3.1, 95% CI = 0.5, 55.1, and OR 17.7, 95% CI = 2.4, 133.0, respectively), as were males who gave a history of gay or bisexual lifestyles (OR 14.1, 95% CI = 1.3, 153.0).

Of the seven HIV positive cases, three gave histories of having shared a needle in New York City since 1981, compared to 32 of 502 seronegative males. Controlling for sexual orientation, those who shared needles in New York City were at greater risk of HIV infection (OR 10.7, 95% CI = 2.1, 55.0)

This survey represents the first reported statewide data on the prevalence of HIV infection among IV drug users in methadone treatment programs. Being Black or Hispanic in Ohio and having shared needles in New York City appear to be associated with HIV positivity. It is likely that the survey underestimates the prevalence of HIV infection among all IV drug users in Ohio as users outside methadone programs may inject and possibly share needles more frequently than those in methadone programs. Motivations to reduce or eliminate use of IV drugs, particularly the fear of contracting acquired immunodeficiency syndrome (AIDS), may differ substantially from drug users not enrolled in a treatment program. Nevertheless, the majority (85 per cent) of the study participants had a history of having injected a drug within the 12 months prior to the study, suggesting that infection prevalence between IV drug users in and out of methadone treatment may not be dramatically different.

Educational efforts to prevent HIV transmission in the Ohio drug-using population with apparently low HIV

seroprevalence offers a reasonable opportunity to limit the spread of AIDS.

REFERENCES

1. Curran JW: The epidemiology and prevention of the acquired immunodeficiency syndrome. *Ann Intern Med* 1985; 103:657-662.

Paul J. Seligman, MD

Robert J. Campbell, MS

Gordon P. Keeler, MAS

Thomas J. Halpin, MD, MPH

From the AIDS Activity Unit, Ohio Department of Health, Columbus, Ohio. Dr. Seligman is currently with the Division of Surveillance, Hazard Evaluations and Field Studies, National Institute for Occupational Safety and Health, Cincinnati, Ohio.

© 1988 American Journal of Public Health

Changing Patterns of Drug Abuse in a Seaport: New Orleans, 1975-85

A prior investigation of drug use patterns in 1975 and 1980 of all patients admitted to the New Orleans Veterans Administration Medical Center (NOVAH) Drug Dependence Treatment Program (DDTP) indicated that heroin was the most frequently cited drug of choice in both years, although a downward trend was evident in 1980 and "Ts & Blues" were increasing. A trend toward lower preferences for marijuana and "downers" (tranquilizers and hypnotics) as drugs of first choice was observed in 1980 as compared to 1975, while stimulant use, Preludin and cocaine, was showing increases in 1980.

Descriptions of drug abuse patterns were obtained from all patients admitted to the NOVAH-DDTP in 1980 (307 patients) and in 1985 (215 patients). By 1985, the profile of first choice drugs of abuse had shifted from heroin and "Ts & Blues" in 1980 to cocaine, heroin, and marijuana. The 1980 second choices were primarily Preludin and "Ts & Blues," while in 1985 the order was cocaine, heroin, and marijuana. All ages and education levels showed such a switch in choice. Cocaine has now been elevated to the status of the most frequently preferred first drug (50.5 per cent) and second drug (23.1 per cent).

It is interesting to note that the 1975-80 study indicated that cocaine use was restricted primarily to White, single individuals, while the 1985 study shows that race is not associated with drug choice. Thus we see the increase in cocaine use moving across the demographic boundaries of race, marital status, age, and education levels.

In another ongoing series of drug incidence surveys conducted by our

group at a private university in New Orleans, the greatest difference in drug use between 1972 and 1986 was a 16-fold increase in those students who used cocaine more than 10 times. Comparing these data with the drug incidence data on the college campus and High School Senior Survey conducted by the University of Michigan, it appears that cocaine will be the drug of choice for the next several years.* All drug detoxification and rehabilitation programs should now be in the process of revising the treatment approaches to incorporate new specific treatment modalities for this widely abused drug.

B. D. Schwartz
L. Murray
B. Alexander
F. R. Kauders
D. M. Gallant

Tulane University School of Medicine, and Veterans Administration Medical Center, New Orleans, LA

Guidelines for HIV Antibody Counseling, Testing

The recent letter by Stankaitis and Bigos¹ highlights incongruities between good policy statements and the ability to practically implement policy in terms of funding needs. To parallel their concerns, recent guidelines from the Centers for Disease Control² state that "after counseling and testing are effectively implemented in settings of high and moderate prevalence, consideration should be given to establishing programs in settings of lower prevalence." Here is an example of poor policy, influenced perhaps by perceived funding constraints.

While on the surface it appears politically defensible to channel resources to those areas where the AIDS (acquired immunodeficiency syndrome) problem is greatest, I submit that, in fact, it is not rational. Indeed, such policy lacks foresight and appears to have been borne out of a continuing North American trend of channeling resources primarily into regions demonstrating a sizable AIDS head count.

*Niven R: Personal communication: 1974-1984 National Institute of Drug Abuse Report: Monitoring the future study, 1984.

Such policy directions, of course, are desirable for directing medical care resource needs, but are neglectful of primary prevention resource needs. Under the recommended policy scenario, while low prevalence regions are awaiting their programs, windows of opportunity that could be seized upon for primary prevention early in their experience of the epidemic, will continue to be lost. It is important therefore that resources for prevention not be confused with the resource needs for health care. Their respective bases for justification are quite different—diametrically opposed, in fact.

I urge therefore that the rationale behind the policy to target high HIV (human immunodeficiency virus) prevalence areas at the expense of low prevalence areas for primary prevention requires urgent reconsideration. I base this on the likelihood that in high prevalence regions, people already are highly motivated to modify their risk behaviors. High prevalence regions might rather be targeted with resources for skills development among that small proportion of individuals who, regardless of knowledge of their antibody status, appear incapable of eliminating risk behaviors. This number among homosexual men in Chicago was recently reported as being about 20 per cent between 1984 and 1986.³

It remains unforgivable to continue to neglect low prevalence regions; if neglect persists, they too likely will approach in the next few years the HIV prevalence levels of those regions currently perceived as the moderate-to-high prevalence regions.

Policy can be good or poor. In the AIDS era, however, good policy, supported by adequate resources, is essential for effective prevention.

REFERENCES

1. Stankaitis JA, Bigos JP: Screening for HIV exposure. (letters) *Am J Public Health* 1987; 77:1354.
2. Centers for Disease Control: Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS. *MMWR* August 14, 1987; 36(31):509-15.
3. Joseph JG, Montgomery S, Kessler RC, et al: Two-year longitudinal study of behavioral risk reduction in a cohort of homosexual men. Paper (T.10.6) presented at the III International Conference on AIDS, June 1-5, 1987, Washington, DC.

Colin L. Soskolne, PhD

Department of Health Services Administration and Community Medicine, 13-103 Clinical Sciences Building, University of Alberta, Edmonton, Alberta, Canada T6G 2G3

© 1988 American Journal of Public Health

Response from CDC Director Mason

Thank you for the opportunity to respond to Dr. Colin Soskolne's Letter-to-the-Editor entitled "Guidelines for HIV Antibody Counseling and Testing." Dr. Soskolne raises an excellent point about the need to emphasize AIDS prevention programs in low-prevalence areas *before* the human immunodeficiency virus (HIV) becomes widely distributed. At the same time, prevention services also need to be provided in areas where HIV has become established in order to limit further spread. The Centers for Disease Control (CDC) AIDS prevention cooperative agreements, which have been awarded to States since 1986, have attempted to address this dual need by providing support to:

1. *Augment existing programs* in areas with substantial numbers of cases of AIDS and operational, comprehensive AIDS community health education programs (e.g., San Francisco, New York, Los Angeles, etc.).

2. *Build capacity* in low-prevalence States which had not yet begun implementation of AIDS prevention programs.

Our goal is to prevent HIV transmission among people whose behavior increases their risk of infection, whether in high- or low-incidence areas. As with all communicable disease, maintenance of "disease-free" or low-level incidence status depends upon the effectiveness of local programs and the effectiveness of programs in neighboring areas of higher incidence.

I hope this clarifies the direction which CDC is taking in allocating AIDS prevention resources.

James O. Mason, MD, DrPH
Assistant Surgeon General, Director, Centers for Disease Control, US Public Health Service, Department of Health & Human Services, Atlanta, GA 30333