

A Message from the President of the Association for the Study of Connecticut History

This issue contains four articles that are revised versions of papers delivered at a conference on Epidemics in Connecticut, 1600 to the Present, held on October 15, 1994 at the University of Connecticut Health Center. The conference was sponsored by the Association for the Study of Connecticut History and the University of Connecticut Health Center and received special funding from the Connecticut Humanities Council. The conference directors were Ralph Arcari, Robert Asher, and Sandra Lade Wheeler.

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With this issue, *Connecticut History* inaugurates regular publication of exhibition reviews, covering exhibitions in Connecticut and surrounding states. *Connecticut History* will also be expanding its coverage to include articles and features on the history of material culture in Connecticut.

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HIV Infection in Connecticut, 1980-1990

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I

In the *Morbidity and Mortality Weekly Report* published on June 5, 1981 a brief note was made of five cases of unexplained immunodeficiency in otherwise healthy young gay men. It was the first published report on AIDS in the world.¹ In Connecticut, two cases were reported to the state health department, the Department of Health Services (DHS), in 1981.² Meanwhile, the number of new cases increased exponentially in the "epicenters" of New York City, Los Angeles, and San Francisco.³ Connecticut soon followed. Emphasis was placed by the Connecticut DHS on characterizing the new disease. Current staff were assigned to epidemiologic investigations as new cases were identified and reported to the DHS by physicians and infection control practitioners. Extensive interviews of all new cases were conducted because the degree and the modes of communicability were not known. Like most brand-new diseases, this new entity was voluntarily reportable. At that time it was not known by the moniker "AIDS."⁴ Like the rest of the country, Connecticut's early cases were predominately young gay men. But even at this early stage cases due to the infusion of blood products were beginning to arise. Cases resided most commonly in those counties closest to New York City (Fairfield and New Haven).⁵ People described the epidemic as moving up the corridor formed by the interstate highways I-95 and I-91.

At the time, this new disease was seen as just one of several emergent epidemic public health problems requiring surveillance and control. Among the others: Lyme Disease, Legionella, and Toxic Shock Syndrome. At first, the so-called "general public" was not aware of the new disease and did not express high levels of anxiety. However, the first "affected community," the gay community, was quite soon aware of the seriousness of the situation and started mobilizing.

AIDS was made reportable to the state health department in 1983, as permitted by the Public Health Code.^{6,7} By now it had a name, though its cause was not known; or, to put it more accurately, its cause had not been isolated. Early epidemio-

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logic information suggested that the cause of AIDS was blood borne and sexually transmitted, just like the hepatitis B virus. Clusters of AIDS cases among sexual partners, clusters among injecting drug users who shared injection equipment, and cases among the recipients of blood transfusions donated by persons diagnosed with AIDS all pointed to a blood borne infectious disease. The identity of the cause of AIDS was confirmed by 1984, when an RNA virus called HTLV-III (later renamed HIV) was discovered by Dr. Luc Montagnier in France and Dr. Robert Gallo and his associates in the United States.^{8,9}

In August 1983 Connecticut's Department of Health Services hired its first full-time staff person devoted to the AIDS epidemic. This required the first allocation of funds solely devoted to AIDS. The total annual AIDS-specific funding in the Department at the time was \$40,000. William (Bill) Sabella, M.P.H. was hired as an epidemiologist to implement active AIDS surveillance.¹⁰ Up to this point in the epidemic, surveillance had been passive; epidemiologists counted cases reported by physicians, but they did not seek out the physicians to determine how many new cases they were diagnosing. Sabella's job was to regularly contact physicians and the infection control practitioners at hospitals to solicit reports of new cases. People were becoming more aware of the new disease. Sabella was quickly swamped with requests for speaking engagements from a huge host of people: health care workers, police, educators, firefighters, and politicians. The DHS also prepared blood-borne disease guidelines written for health care workers, laboratorians, and funeral directors.¹¹

Just as the new AIDS epidemiologist was being hired by DHS, the first community in Connecticut hit hard by AIDS established the first AIDS-specific service and educational organization in the state. A dozen persons from New Haven founded APNH (AIDS Project New Haven). APNH was modeled after organizations in the gay community providing leadership on AIDS prevention and care, such as New York City's Gay Men's Health Crisis, AIDS Project Los Angeles, and the San Francisco AIDS Foundation. Such organizations depended heavily on volunteers as they developed innovative education programs. Soon thereafter, other AIDS Projects (such as AIDS Project Hartford and the Northwest Connecticut AIDS Project) were founded elsewhere in Connecticut.

At first, APNH did not receive grants or technical assistance. Like the other early community organizations devoted to AIDS, it was "homemade." At first the Project raised all its funds through informal means, such as individual donations, carwashes, bake sales, and the like. The first year income was approximately \$600. In the late spring of 1985 a major fundraiser at the Schubert Theater in New Haven raised \$19,000 and permitted the hiring of a half-time "Executive Director."¹²

Around this time, Connecticut's first big AIDS-related media circus erupted. It was in response to reports that a prostitute in New Haven was actively working the streets and that she had AIDS. There was no HIV Confidentiality Law in 1983, so her identity and HIV/AIDS status had no legal privacy protection. The media learned about the prostitute and widely publicized her name and diagnosis. In response to the publicity, calls came from the public to lock her up. Pressure mounted on the

state Commissioner of Health Services, Dr. Douglas Lloyd, to quarantine her as a danger to the public health. He did not order the quarantine. A year later she died.¹³

This was the first case in Connecticut, and one of the first in the nation, of what later became a familiar debate, pitting the rights of the individual with HIV against demands for restrictive, even draconian, measures (such as mandatory testing, quarantine, or tattooing of HIV "carriers") to fight the epidemic. Medical historians inform us that similar actions against prostitutes were initiated during the anti-syphilis public health campaigns of the early years of the century.^{14:15} Public health officials across the country followed Dr. Lloyd's example and did not bend to public pressure to quarantine prostitutes. This was the first of many situations where persons have accused public health officials of bowing to political pressure from the gay community or civil libertarians, at the expense of what the accusers perceive as sound public health policy.

The state health department still gets occasional calls about such problems, but none has generated the same interest, publicity, or action as this first case. It has been suggested that for the first time this case raised the specter of the spread of HIV to the wives and girlfriends of the johns. It is curious how the prostitute was the focus here while the johns escaped scrutiny in the policy debates, especially as HIV transmission is more likely from males (the johns) to females (the sex workers) than vice versa. The situation revealed another phenomenon. First cases in the AIDS epidemic often generated vastly more publicity, interest, fear, and controversy than similar cases even a short time later. Why is this? Perhaps unfamiliarity is more likely to arouse more fear than a repeated event. I defer a fuller analysis to the social psychologists.

In response to the New Haven sex worker episode, the state quarantine law was rewritten in 1984. This change was initiated by state representative Richard Tullisano, chair of the legislature's judiciary committee and a civil libertarian. Due process provisions were bolstered. It was expected that it would be used rarely. Since 1984, it has never been invoked in a case involving HIV.¹⁶

This media storm around this case foreshadowed the hurricane that would hit in 1985 when the world learned that movie star Rock Hudson had AIDS.

II

The announcement that Rock Hudson had AIDS is thought by many to be the event which made the general population, outside of the gay community, understand the seriousness of the AIDS epidemic.¹⁷ Rock Hudson was the first very famous person to go public with an HIV diagnosis. The world watched him sicken and die. Some behavioral studies have shown that knowing someone who has died of AIDS has powerful effects: it raises AIDS awareness, fear, and the motivation to do something about AIDS.^{18:19} Other developments in these years also greatly influenced the national attitude and the national response. After the cause of AIDS was identified in 1983-1984, intensive research was applied to development of a cheap and reliable HIV test by Dr. Robert Gallo and other leading scientists in this field. The HIV antibody test was approved by the FDA in March 1985.²⁰ In the summer of that

year the first international AIDS conference was held in Atlanta, the home city of the federal Centers for Disease Control (CDC). Since then these annual conferences have been milestones marking how far we are along the road to preventing HIV infection and controlling the epidemic. Finally, in 1986 Dr. C. Everett Koop published the landmark Surgeon General's Report on Acquired Immune Deficiency Syndrome²¹ in which he powerfully argued for a rational, measured, and effective response to the epidemic. On the basis of his stature and credibility as a conservative and as an eminent physician, his report had great impact. It should be noted that President Ronald Reagan, celebrated as the "Great Communicator," had yet to give a speech on AIDS. Dr. Koop filled this void to a greater degree than anyone had anticipated.

Meanwhile, the Connecticut Department of Health Services hired a new state epidemiologist, Dr. James Hadler. Among his numerous duties, Dr. Hadler oversaw the AIDS problem. He was particularly well prepared for this responsibility, since he was a physician with a masters degree in public health and postgraduate training in infectious diseases. Hadler had worked on hepatitis B control with the United States Public Health Service. Dr. Hadler had the vision to broaden greatly the state health department's AIDS activities to include prevention programs and public health research in addition to its traditional role in surveillance. First, an AIDS Program had to be established. It was created by executive order of the Governor in September 1985. From a one-man show the program expanded to eleven by the summer of 1986. Surveillance, prevention programs, policy development, and contract monitoring were all program responsibilities. Resources started to match mandates, and the staff even got a personal computer, a newfangled thing in those days.

With the advent of a quick, inexpensive, and reliable test for HIV antibodies in 1985, federal money started to flow into the states, including Connecticut. Cooperative agreements for HIV testing from the CDC began in some of the larger and most heavily affected states, such as California, in 1985. CDC had been designated the lead federal agency for HIV prevention and started a series of cooperative agreements (contracts) with states and some of the larger cities in the US. Connecticut applied for a cooperative agreement with the CDC and was awarded funding to start HIV counseling and testing sites in 1986. Part time pre- and post-test counseling programs were established in ten local health departments, one community-based health collective in the gay and lesbian communities, and two small counseling programs in state agencies, the Connecticut Alcohol and Drug Abuse Commission and the Department of Correction. Connecticut was one of the first states in the country to offer HIV counseling and testing on-site in drug treatment programs. Tiny amounts were allocated to three AIDS projects for educational materials. APNH got the most, all of \$7,000.²²

Active surveillance of AIDS cases continued and was expanded to include serosurveillance (surveillance for HIV infections) to determine the prevalence of HIV infection in various populations of interest, such as injecting drug users in treatment programs. This was to get a better handle on more recent patterns of the epidemic's progression than could be gleaned from AIDS case reports. AIDS cases reflect HIV

infections that occurred years earlier because it takes years for HIV to cause the severe immunodeficiency that is the hallmark of AIDS.

HIV testing presented great opportunities: persons at risk could learn their serostatus and avail themselves of medical care if infected and receive counseling on risk reduction. HIV testing also represented risks: testing without the patient's knowledge or consent; and invidious discrimination such as the loss of job, housing, and insurance. To prevent these problems, laboratories performing the testing were required by an emergency regulation to document whether informed consent was obtained.²³ This requirement (regulation) was later codified into state law when the HIV confidentiality law was passed.²⁴

Outside the state health department, formal policy development and planning for AIDS prevention and AIDS care started in 1986 after Dr. Alvin Novick, a professor of biology at Yale University and a founder of AIDS Project New Haven, met with Mayor Ben DiLieto of New Haven to discuss the disturbing implications of the epidemic for the city. After that conversation, Mayor DiLieto established the New Haven Mayor's Task Force on AIDS. Dr. Novick and the city's health director, Mr. Ed DeLouise, were named co-chairs and were authorized to report directly to the mayor. The New Haven Foundation gave the Task Force a grant in 1987, funding the hiring of a staff person (Ms. Sher Horosko) who was creative, capable, and energetic. The New Haven Mayor's Task Force was a catalyst for policy in the region, and by extension, the state. This group created proposals and completed the organizing needed to start a program of outreach to injecting drug users, including passing out bleach to clean needles (in 1987). The New Haven Mayor's Task Force also completed early comprehensive community-based needs assessments. In time they addressed the issue of access to clean needles.²⁵ Other local and regional task forces began soon thereafter, either due to perceived need or in response to contractual expectations of DHS.

The next hot policy issue was school attendance by HIV infected children. This debate demonstrated that many people who were willing to balance risks and costs of AIDS prevention policies when adults were involved had a zero-tolerance attitude when children were involved. Several children with AIDS were excluded from regular classrooms in the New Haven schools. Dr. John Dow, the superintendent, lobbied successfully for the creation of a state task force on aids in the schools. Established in 1984, the task force was of the first in the United States to deal with the issue. Dr. Hadler and Elaine Brainerd, a nurse and health services coordinator at the Department of Education, co-chaired the Task Force. Public health officials, educators, and parents participated. The recommendations were published in 1985 and served as a source document for CDC's national guidelines for schools and daycare, also published that year. Despite the guidelines, the HIV-infected children were kept out of the regular classrooms in the New Haven schools and were being educated in a church basement in 1988.^{26,27}

The scene of the AIDS school policy debate then shifted from the urban south to an affluent small subrural town in the north of the state. A child with hemophilia attending the East Granby schools was diagnosed with AIDS. In accordance with the

recommendations of the state task force, the school was notified in confidence of the child's condition. Somehow, other parents got wind of the situation. Massive publicity began almost immediately. The level of anxiety was extremely high and the timing was bad, as the story broke over the Columbus Day weekend, making it difficult for officials to develop an immediate and coordinated response. Mr. Rick Matheny, the regional health director, had one of the worst weekends of his life. Anxious and angry parents confronted him at his child's soccer game. Right after the holiday, over seven hundred persons crowded into the local high school for a public meeting of the board of education to consider whether to allow the child back into school. Dr. Hadler testified to the board and educated the town extensively on the transmission of HIV in the school setting. The meeting received such extensive local and national media attention that Dr. Hadler's slides were hard to see in the klieg lights of the bank of TV cameras. In its essence, the debate boiled down to whether or not any risk was acceptable, whether zero risk tolerance is rational, and whether it is being discriminatorily applied to AIDS. Most parents seemed satisfied after getting their questions answered at the first meeting, but a small but vocal group of parents remained skeptical. A second meeting was held. A reputed AIDS expert, a doctor of education, was flown in from Nebraska by this group of parents to address the board of education. He debated Dr. Hadler in a public meeting in front of the school board, emphasizing the lack of absolute guarantees against transmission due to casual contact. However, he damaged his credibility when he passed out anti-gay literature. At the end of the second night the board decided to keep the child in school.²⁸

III

In June 1987, at the third International AIDS Conference, held in Washington, D.C., President Ronald Reagan attended an AIDS fundraiser, and for the first time spoke in public about AIDS. In October of that year the Quilt was first displayed in Washington, D.C., at the March on Washington for Gay and Lesbian Rights.²⁹ Since then, the Quilt, officially the Names Project, has become a focal point, a ritual of remembrance that moves nearly everyone, much like the Vietnam Memorial.

After re-election in the fall of 1986, Governor William O'Neill was re-inaugurated in January 1987. As is traditional, all Commissioners resign and are reappointed at the Governor's pleasure. Governor O'Neill did not renew Dr. Lloyd's appointment, ending his 14 year tenure as DHS Commissioner. Dr. Frederick Adams, a dentist, African-American, and former dean of the UCONN School of Allied Health, was installed as DHS commissioner in March 1987.

Dr. Adams immediately undertook a top-down review of the Department and of the AIDS Program. Communities most affected by AIDS were hopeful for an activist commissioner. By now the disproportionate impact on African Americans and Latinos in Connecticut was clear; 35% of AIDS cases reported in Connecticut through 1987 were African American and 16% were Latino, but African Americans only represented 12% and Latinos 4% of the state's population. During the review, Dr. Adams noted that people of color were underrepresented in staffing AIDS organi-

zations and that organizations serving racial and ethnic minorities received little AIDS prevention funding. He wanted fast action, and chose a contractor from out of state, Expand Associates. Dr. Adams knew this firm and was confident of their ability to do the work of outreach and education in the African-American and Latino communities. At this time the legislature voted a large state funding appropriation for HIV prevention, \$2.5 million per year.

All of this set the stage for l'affaire Expand. The firm received a large contract, \$450,000 per year. As mentioned before, APNH got no more than a \$7,000 state grant in 1986 (one year earlier). A statewide publicity campaign costing \$750,000 was kicked off about the same time. The Expand and publicity contracts alone ate up half of the newly appropriated \$2.5 million. There were other reasons for the controversy too. Expand was an out-of-state contractor with no AIDS and little Connecticut experience. It was selected in a noncompetitive, no-bid contracting process. Expand was a minority-owned and operated firm, but it clearly was not a grassroots organization. The press asked many probing questions about the award of Expand's contract, and scrutinized the project carefully. The past performance and fiscal stability of the contractor were repeatedly questioned. A very long and very critical analysis of the Expand contract and its lack of success was published in *Northeast*, the *Hartford Courant's* weekly newsmagazine.³⁰ Finally, after a year, the community outreach program was taken over by the Department. The Department's AIDS Section hired in-house minority staff and developed a network of in-state contractors with access to the minority communities. By 1989, Expand was no longer in the AIDS prevention business with DHS.

After a massive expansion in funding for the AIDS Program, it was apparent that an experienced and talented administrator had to lead it. Beth Weinstein, a high-level administrator in the Department, took over. The nearly twenty members of the new AIDS Section reported to her. The administrative challenges of the "outbreak" of cash were formidable but they also represented opportunities for much needed public health studies. CDC started a series of serosurveillance surveys in clinics frequented by persons at risk (such as STD clinics) in twenty "sentinel cities" across the country. New Haven was one of the twenty. Setup began in October 1987 and the project started soon thereafter. A series of knowledge, attitude, and behavior (KABB) surveys begun with federal funding at around the same time.³¹

Across the United States HIV confidentiality was recognized as a major problem. Sometimes persons were tested without their knowledge or consent. On occasion information was inappropriately shared with employers, family, and landlords, leading to discrimination in housing, employment, access to medical care, and loss or insurance. There were calls for mandatory testing of various groups of people, i.e., drug users, prisoners, prostitutes, marriage license applicants, and health care providers.³² In Connecticut, personal experiences of AIDS discrimination coupled with public calls for mandatory HIV testing created an atmosphere of distrust that both DHS and AIDS activists felt was an impediment to HIV testing and treatment. At first, many persons at risk said they did not want to be tested because there was nothing that could be done if they were found infected. With the Food and Drug

Administration's approval in 1988 of Azidothymidine (AZT)—now named Zidovudine (ZDV)—as a safe and effective antiviral therapy, many persons at risk for HIV now wanted testing. Still, confidentiality and discrimination problems were formidable obstacles to widespread voluntary testing of the persons most in need of it. The CDC encouraged states to pass confidentiality laws; a federal statute was proposed, but never passed.

Many states had already passed HIV confidentiality laws when the Connecticut legislature formed a task force on HIV confidentiality and discrimination in 1987 and charged the group to make recommendations for the 1988 legislative session. Dr. Adams chaired and DHS staffed the task force. Task force members included community representatives, experts on AIDS, legal experts, state agency representatives, and legislators. The group made recommendations on confidentiality, informed consent, and discrimination. A new law was recommended on informed consent and confidentiality. Current law was deemed sufficient to cover discrimination. The task force's finding that current law protecting the handicapped interdicted discrimination against persons with HIV was publicized by the state civil rights agency, the Commission on Human Rights and Opportunities.³³ After much wrangling and horse trading in the Legislature, an HIV confidentiality law was passed, taking effect on October 1, 1989.³⁴ Connecticut was the 35th state to pass a law protecting the confidentiality of HIV-related information. The German statesman Otto von Bismarck was right when he said that the writing of legislation was like making sausages: the making of the law on informed consent and confidentiality was ugly, and sometimes bloody, but once written it satisfied a gnawing hunger.

Since 1985, when DHS was designated lead state agency on AIDS, it seemed that this designation fostered buck passing. Having an AIDS-specific program within DHS also fostered buck passing. It seemed that any time an AIDS issue arose, the problem was sent to the AIDS program, whether appropriate to its surveillance and prevention mission or not, even when the problem should have been addressed through another state agency or another program within DHS. At one time the Department mail system even routed correspondence about hearing aids to the AIDS program!

This Governor's interagency task force was to organize and motivate all state social service sector agencies to become involved in AIDS issues. Policies covered a wide range of topics: confidentiality, testing, and discrimination. The interagency task force was a good successor to the legislative task force, but it did not solve many of the problems caused by inadequate resources (despite the recent large appropriations) in the face of an epidemic growing rapidly in size and complexity. It did start some important collaborations between DHS and other state agencies, and strengthen others, including the Department of Correction.³⁵

Late in the 1988, the Department of Correction was sued by the Connecticut Civil Liberties Union for inadequate AIDS care and prevention services for inmates. The lawsuit was settled by consent decree. The consent decree specifies service provision levels in detail, such as the number of HIV counselors that must be on staff. It requires an AIDS educational session for all new inmates. Condoms are still

not allowed into the facilities due to the fear they may be used to hide contraband, a matter of ongoing controversy. Nine years later the consent decree is still in effect.³⁶

In the last year of the decade, HIV surveillance and prevention programs started to come of age. Now community-based organizations as well as governmental agencies had enough time to plan, assess needs, evaluate the quality of programs, and develop collaborations. Before then most AIDS prevention energy was expended getting programs started from scratch and addressing the crisis of the day. Immediate action was more important than deliberate planning and evaluation. The increase in frontline staff permitted administrators time to plan strategically. Building on the accomplishments of the first eight years of the epidemic, some creative projects were launched at this time. The first mobile testing unit in the state, called the Hartford HIVan, started this year. It was the beginning of outreach HIV counseling and testing in Connecticut, and one of the earliest such projects in the country. An even more radical concept was gaining adherents, especially in New Haven. It was needle exchange.

Passing out bleach to injecting drug users (IDU) for use in disinfecting drug paraphernalia had been a controversial policy in 1987 when it began in New Haven and other Connecticut cities in response to the increasing proportion of Connecticut's AIDS cases who were IDUs. In 1986, the injecting drug users were 26% of AIDS cases reported since 1981. By 1988, an illegal needle access project for actively injecting drug users began in New Haven. A group called the AIDS Brigade, run by Jon Parker, started passing out clean syringes and needles on the street. Meanwhile, discussions of the possible impact of a legal needle exchange program began in New Haven, led by (among others) Sher Horosko of the Mayor's Task Force, Dr. Alvin Novick, Elaine O'Keefe of the New Haven Health Department, and State Representative Bill Dyson. Discussions continued despite the abject failure of the needle exchange program in New York City. The New Haveners were not fazed by the New York experience because the design of the program was so thoughtless—the exchange site was located in the City Health Department offices, next door to Police Headquarters. After initial study, the New Haven Mayor's Task Force undertook an extensive grassroots campaign to garner support for the proposal.^{37:38} This was necessary because there was much opposition, a lot coming from communities disproportionately affected by AIDS cases among injection drug users. Grave concerns were expressed that the needle exchange would decrease the emphasis on drug treatment, would take resources from drug prevention and treatment, would lead to increased injection drug use among the young, and would put non-drug users at risk for needlesticks from discarded needles. This debate continued and spilled into the 1990s, the second decade of AIDS in Connecticut. In the ensuing years a law was passed authorizing and funding a pilot needle exchange program in New Haven. While the Legislature debated this law, the DHS had no official position on it. Once the needle exchange plan was approved by the Legislature, the New Haven Health Department and Dr. Ed Kaplan and his associates at Yale University collaborated on the protocol and evaluation method which generated data demonstrating the success of the program, making it a model emulated across the state and the nation.³⁹

IV

At the beginning of the 1980s AIDS was unknown. At the close of the first decade of AIDS an estimated 12,000 to 15,000 persons in Connecticut were HIV infected, 1,600 AIDS cases had been diagnosed, and 1,100 had died. In those ten years the face of AIDS had changed, but not completely. Gay white men were still a major transmission category, but they were no longer predominant. Persons of color, women, and injection drug users were now heavily represented. In 1990, 55% of AIDS cases were in injection drug users, 20% of cases were female, and Blacks and Latinos together were 55% of cases reported that year.

The number of diagnosed AIDS cases kept growing each year. Connecticut's response, indicated by funding levels, had three broad phases. At first, few or no AIDS-specific resources were allocated, as the apparent size of the problem was small and poorly characterized. Later a building program started as the number of cases grew and a test was available to determine who was infected with the virus and in need of medical care to slow progression to AIDS. Then, with the massive publicity attending celebrated cases and with the unmistakable signs of a major public health emergency, the floodgates of funding opened. This led to problems of administration, but it created great opportunities to better investigate and prevent the epidemic.

So many things have happened since 1989 that the end of the first decade in the AIDS era seems a long time ago, conventionally historical, even though we are far from the final chapter in the AIDS story. Many recent events have had impacts on Connecticut's response to the HIV epidemic, impacts as great as anything that occurred during the first decade of the epidemic. Some of the most important events in the 1990s have been Magic Johnson's announcement that he has HIV infection, the Dr. Acer/Kimberly Bergalis case, the repeal of the Connecticut needle prescription law, the Ryan White CARE Act (services for the HIV infected), and Community Planning (a process whereby government agencies, community-based organizations and consumers form partnership to plan and evaluate our response to the HIV epidemic).

Each of these "new" major happenings had precedents in the first decade in the AIDS era. Magic Johnson parallels Rock Hudson. The infected health care worker controversy parallels the fears of contagion from children attending school. The prescription requirement repeal has antecedents in the bleach provision and needle exchange initiatives. The case management services of the CARE Act carry forward care services begun by purely volunteer organizations. And Community Planning follows the example of the early organizational meetings of the AIDS projects and the ongoing work of local planning groups like the New Haven Mayor's Task Force.

Reviewing my memoir, a history written by a participant-observer, leads naturally to questions like, "If we could do it over again, what would we do differently? Could I or my co-workers have done it differently?" I believe that upon returning to the conditions of the 1980s, any fine resolutions we made to "do things right this time" would be overwhelmed by immediate problems and driven by the primitive state of public opinion early in a serious epidemic. Therefore, I believe we would

behave as we did. In the 1980s we were always trying to balance the need to motivate people to learn about AIDS against the danger of creating a panicked stampede toward inadvisable overreaction. We had to accomplish this delicate operation while shouldering the daunting task of developing effective programs to foster major behavior changes in persons at risk. Despite the controversies, everyone agreed that AIDS had to be fought, even when our efforts seemed futile. To know why, all we had to do was watch the Quilt grow.

NOTES

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