Letters to the Editor

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"Getting Real" about HIV and Homeless Youth

I would like to echo the sentiments voiced by Dr Karen Hein in her editorial " 'Getting Real' about HIV in Adolescents,"[1] particularly a "sex-positive" approach to public health that includes explicit, age-specific, prevention messages and access to risk reduction materials. However, I would also like to offer caution about the seeming conclusion that this formula of messages and access will be sufficient. My concern is based upon ethnographic research related to acquired immunodeficiency syndrome (AIDS) risk behavior conducted among homeless and runaway youth in New York City over the last 4 years. Although this population is certainly unique in some respects, there is perhaps something be learned from these youth that has relevance to AIDS prevention in general.

Numbering in the thousands, these youth evidence the cumulative harm of life on the streets, the loss of their childhood, overwhelming feelings of self-doubt and self-blame, and chronic dependence upon the exchange of sex for food, shelter, and money. Many turn to the ephemeral comfort of crack cocaine or the numbing effects of alcohol and opiates. Lost in a downward spiral of self-destruction, many become dependent on the street economy and are increasingly vulnerable to the lack of power they have within this system of exchange. Little wonder that this population already has human immunodeficiency virus (HIV) seroprevalence rates as high as 20%.

The notion that prevention can be accomplished by information, HIV testing and counseling, delay of the onset of sexual activity, or condom distribution alone is, in my view, terribly and tragically shortsighted. Such a conclusion is based upon the mistaken assumptions that the problem is entirely or even primarily a cognitive one and that behavioral change can be achieved simply by altering knowledge and psychological response. The plain fact is that the vast majority of the people in the world who will become exposed to HIV infection in the coming decade will do so not because of inadequate knowledge, mistaken beliefs, or failures of intention, but rather because of the larger social and economic inequalities that have disparities in power and wealth as their core. Certainly, the development of appropriate prevention messages and easy access to prevention materials are important public health goals. But we also need to "get real" about the circumstances that propel youth into high-risk situations: poverty, homelessness, sexual abuse, homophobia, and limited employment opportunities. Until we are prepared to redress these systemic conditions, we are unlikely to stem the course of this disease, particularly its rapid spread among this most vulnerable group of youth. □

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Reference

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Crack Users' Cracked Lips: An Additional HIV Risk Factor

Although the use of crack cocaine has been indicated as a risk factor in the transmission of the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) through sexual activity (particularly the trading of sex for drugs[1,2]), there is less information on the process of smoking itself as a possible risk factor. For the past year and a half, we have volunteered on a weekly basis as HIV/AIDS educators and street outreach workers for a community organization in North Philadelphia, Pa, a low-income area whose residents are primarily African American and Latino and that is a major center of drug sales and use. We give weekly presentations on AIDS prevention at a drug detoxification center and do street outreach in major drug trafficking areas and in "shooting galleries."

In our group presentations and our visits to shooting galleries where crack is used, crack users have frequently told us that there may be increased risk of HIV transmission through the way crack is smoked. There has been a shift away from the use of commercially made crack pipes because they are too expensive. Cur-

rently, a popular means of smoking crack in this area is through the use of metal "straight shooters" or tubes; pieces of metal car antennas are also used. The metal tubes transmit the heat from the flame used to vaporize crack; thus, burned or blistered lips are especially frequent among those who utilize them. Glass pipettes, which are also popular, often chip or splinter and cut the user's lips. In addition, a form of brass wool is often used as a filter for crack stems; the steel wool filter gets hot and pieces may be inhaled through the pipe and may burn the lips. Because crack stems are frequently shared, our informants stressed that people may be exposed to blood on the instruments regularly through blistered, burned, or cut lips from the use of hot metal tubes or chipped glass stems. These openings may provide exposure to HIV-infected blood on the implements or increased risk of exposure to HIV-infected semen or vaginal fluid through the frequent oral sex in crack houses.

If these findings are substantiated in other cities, AIDS prevention efforts among crack users must stress that crack smoking implements should not be shared and that the risk of HIV transmission may be increased during oral sex for those who smoke crack in ways that are particularly likely to cut or blister the lips. □

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The Methodology of Fatal Occupational Injury Surveillance

Two papers exploring methods of conducting fatal occupational injury surveillance were published in the Journal in 1991: Stout and Bell[1] combined data from 10 state studies in a meta-analysis to draw conclusions about the individual usefulness of four data sources for identifying occupational injury deaths; Russell and I[2] used data from these same four data sources (death certificates, workers' compensation records, medical examiner/coroner records, Occupational Safety and Health Administration (OSHA) records) within one state to examine the representativeness of deaths identified through the injury-at-work item on the death certificate.

Although the article by Stout and Bell provides a useful synopsis of studies that address ascertainment of occupational deaths, the reader should consider the methodological limitations of Stout and Bell's meta-analysis when deciding whether death certificates are the best tool for surveillance in a specific state, country, or other population of interest. There are three methodologic concerns that should be considered in Stout and Bell's article. First, results were not weighted. Therefore, results from a state with 86 deaths incorrectly contributed as much weight as results from a state with 872 deaths. Second, their averaging of results that were estimated by different methods does not conform to statistical methods of meta-analysis.[3] For each of the 10 studies, the total number of deaths was calculated with different combinations of data sources. Thus, the totals are not comparable. For example, if sources A and B in state X were used to estimate a total, this total would be different than if sources A, B, and C were used. Estimates of the sensitivity of source A would differ (A/A + B and A/A + B + C) according to which total was used. The percentages of total deaths captured by each data source are therefore not comparable, and the averages of these percentages would not provide meaningful information. Third, it is not appropriate to average the capture rates of sources in different states because these sources are not all independent. For example, medical examiners and coroners are legally responsible for investigating fatalities and completing the injury-at-work item on the death certificate in virtually all states.[4,5] Finally, because each state's data sources are unique in some respects, these 10 studies may provide more useful information when considered individually.

Before deciding upon the best data source for a surveillance system, researchers must define the purpose for the system. For national-level surveillance, death certificates may be the least expensive and most easily accessed records providing an estimate of the magnitude of occurrence of occupational death. However, results of previous studies have shown medical examiner/coroner records to be extremely valuable for fatal occupational injury surveillance.[2,4–6] Moreover, since 1986, the Centers for Disease Control and Prevention has had a program aimed at improving the quality and accessibility of medical examiner/coroner records.[4] The capture rate for the New Jersey Medical Examiner was reported by Stout and Bell to be 32%. However, in a letter to the editor the authors of the original New Jersey study noted that the true capture rate was 56%.[7] This correction should also be noted when evaluating the information presented in Stout and Bell's paper.

For state-based surveillance, linking existing data systems to study both fatal and nonfatal injuries and to achieve maximum case ascertainment may be feasible. Linked data provides information, not obtained through the use of a single source, that can be used to identify emerging injury problems, identify high-risk groups of workers, target prevention strategies that are responsive to the needs and resources of states, and evaluate the effectiveness of prevention strategies over time. The US Bureau of Labor Statistics is currently funding states to link the four data systems described in both of these papers.[8]

In conclusion, the rationale for constructing a surveillance system should be inherent to the decision reached on the "best" data source for that system. What works for one state or one researcher may not be appropriate for another. As public health professionals, we need to remember that our ultimate goal is to use surveillance data to drive prevention efforts; this should be considered first when we are developing a surveillance system. □

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