CONNECTICUT RESPONDS TO AIDS

A Report of
The Department of Health Services
AIDS Prevention Programs

APRIL 1988

A I D S

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STATE OF CONNECTICUT

DEPARTMENT OF HEALTH SERVICES

OFFICE OF COMMISSIONER

April 29, 1988

Dear Reader:

I am pleased to present to you this report from the Department of Health Services describing its AIDS-related activities. The report presents the scope of the AIDS problem in our State and the programs the Department is carrying out to prevent further spread of the virus. Among the key points of the report are the following:

-As of December 31, 1987, there had been 602 cases of AIDS in Connecticut. By April 29, 1988, that figure had risen to 719.

-More than sixty percent of the new cases of AIDS in Connecticut are related, either directly or indirectly, to intravenous drug use.

-By the end of 1991, there will have been 2,900 cases of AIDS in Connecticut.

-Between twenty and fifty people are infected with the virus for every case of AIDS. Therefore, we believe that there are between 12,000 and 36,000 people in the State who are already infected.

-In the absence of a cure or a vaccine to prevent AIDS, education is our only weapon in fighting its spread.

The prevention program in the Department of Health Services has grown in a very short time to a 4.4 million dollar program. It includes surveillance, testing and counseling, education and prevention, and laboratory services. This report describes the activities in each area.

It is my hope that this report will explain to you the dimensions of the AIDS problem in Connecticut and our efforts to fight the disease.

Sincerely,

Frederick G. Adams, D.D.S., M.P.H.
Commissioner

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CONNECTICUT RESPONDS TO AIDS:

A Report of the Department of Health Services AIDS Prevention Programs

Purpose of Report

Acquired Immune Deficiency Syndrome (AIDS) has become one of the most significant worldwide public health problems of the century. All countries need to share the challenges posed by this newly recognized fatal disease that will soon become one of the top causes of mortality in many parts of the world. In our State, more than 700 residents have been diagnosed with AIDS, and that number is projected to total 2,900 by the end of 1991. In October 1985, Governor William A. O'Neill designated the Department of Health Services the lead State agency in Connecticut's AIDS prevention initiative. This report describes the scope of the AIDS epidemic in Connecticut and the programs developed by the Department to control and prevent it.

Defining The Problem

AIDS is caused by the Human Immunodeficiency Virus (HIV). HIV attacks and depletes an individual's immune system, reducing the ability to ward off certain cancers and infections. Progressive destruction of the immune system by HIV predisposes the person to a wide variety of infections and diseases. However, AIDS is only diagnosed according to the U.S. Centers for Disease Control (CDC) criteria, when specific types of "opportunistic" infections and diseases occur which indicate severe immune system deficiency. The two most common of the diseases are *Pneumocystis carinii* pneumonia and a previously rare form of cancer called Kaposi's sarcoma. **Once AIDS is diagnosed, the prognosis is poor; 50% of patients die in the first year and more than 80% die within three years.**

AIDS has been classified as a reportable disease in Connecticut since 1983, and cases must be reported by physicians to the Department of Health Services and the local health department.

Many people who have the HIV infection may become ill and even die without ever being counted as an AIDS case because they don't meet the official CDC definition of AIDS. For every person with AIDS, it is estimated that two to five people have AIDS-Related Complex (ARC). ARC patients can have symptoms such as chronic fatigue, swollen glands, sustained diarrhea, fevers and weight loss. Other people with HIV infection may not develop any symptoms of illness for years. They, like everyone with the virus, are still capable of transmitting the disease.

Because AIDS is a recently recognized disease which often does not develop until years after a person is infected with HIV, it is not yet known whether everyone with the virus will eventually get AIDS. **It is important to remember that the official number of reported AIDS cases is only the tip of the iceberg in the AIDS epidemic** *(See Figure 1)*. It is believed that 12,000 to 36,000 Connecticut residents may currently be infected with HIV and are at risk for developing AIDS.

Transmission and Prevention

HIV is transmitted in 3 ways:

1. Through intimate sexual contact, including anal and vaginal intercourse;
2. Through blood to blood contact with infected blood (most often through intravenous (IV) drug use); and
3. From an infected mother to her unborn child.

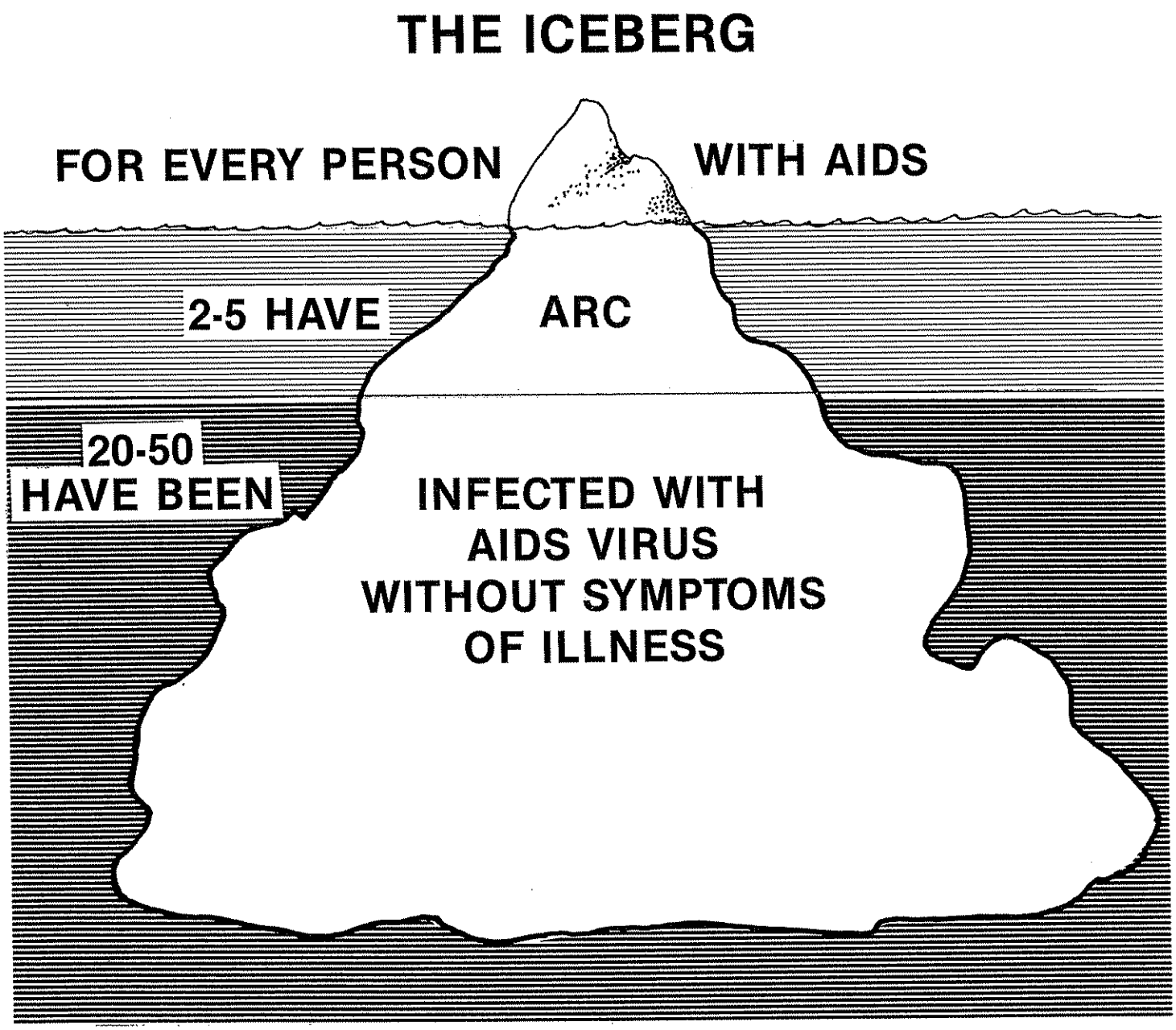
No evidence has been found that HIV is spread by casual contact. People are not getting AIDS from mosquitoes, toilet seats or sharing dishes. Family members living with HIV-infected people, the group with the most "casual contact" with HIV, are not being infected with HIV unless they have had unprotected sexual relations or blood contact through sharing needles or other means.

Since HIV transmission is limited to one of the three means described above, the potential to prevent the spread of AIDS is great. Possible strategies to prevent HIV transmission include vaccination, treatment of HIV infected individuals to eliminate the virus, screening of blood and blood donors for possible HIV infection, and public education to increase understanding of how HIV is spread to encourage people to reduce or eliminate behavior which may transmit HIV.

Efforts at vaccine development and treatment of HIV infected persons are still in their infancy and will not contribute to the prevention of HIV transmission in the near future. By contrast, the risk from blood products has been virtually eliminated. Since 1985 all donated blood and blood products in the United States and Connecticut have been tested for HIV before they have been used for transfusion. Additionally, people who indicate a history of high-risk behavior are discouraged from donating blood. In spite of the success of this mode of prevention, most cases of AIDS have been and will continue to be transmitted via largely voluntary human behavior. At present, public education to modify this behavior is the only means to curtail the AIDS epidemic.

More than 700 Connecticut residents have been diagnosed with AIDS and 12,000 to 36,000 residents may currently be infected with HIV.

Figure 1.

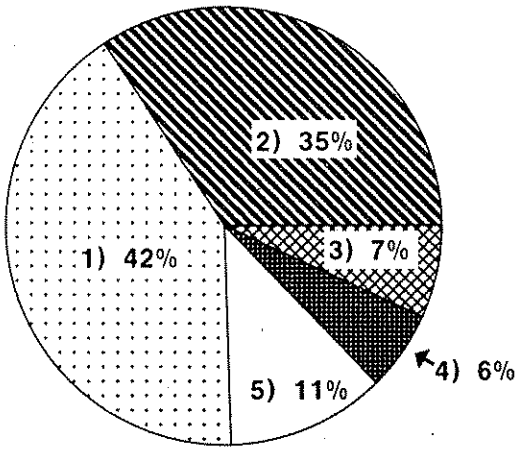


A Profile of Connecticut AIDS Cases

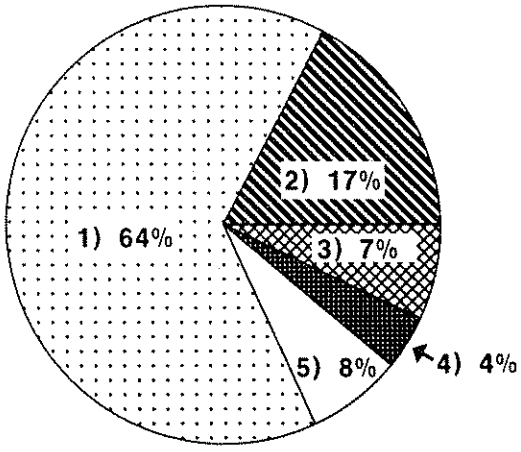
The profile of AIDS in Connecticut is different from the overall national profile *(see Figure 2)*. **Connecticut has twice the national percentage of cases of AIDS in women, children and IV drug users.** More than half of all cases in Connecticut (52%) have been either Black or Hispanic, whereas minorities account for 39% of the cases nationally. Connecticut currently ranks 9th among states in the number of AIDS cases per million people (193). As of December 31, 1987, 601 cases of AIDS, including 17 cases in children less than thirteen years old, had been reported in Connecticut *(see Figure 3)*. The death toll as of that date was 367. The number of all reported cases has doubled in the last 15 months. The "doubling time" for AIDS in IV drug users is currently 12 months, which has resulted in this group constituting the single largest transmission category for recently diagnosed AIDS cases. The majority of all cases have been males (84%) between the ages of 20 and 39 (67%).

Figure 2: Total AIDS Cases Reported in Connecticut and the U.S. by Transmission Category

Connecticut = 601
(cases reported as of 12/31/87)



United States = 49,743
(cases reported as of 12/28/87)



Transmission Category	No. Cases Conn.	No. Cases U.S.A.
1) Homosexual/bisexual male	251	31,825
2) IV drug user	208	8,411
3) Homosexual/bisexual male & IVDU	41	3,689
4) Heterosexual cases	35	1,964
5) Other Categories:		
a) Hemophilia/coagulation disorder	10	524
b) Transfusion, blood components	16	1,221
c) Parent with/at risk for AIDS	16	566
d) Undetermined	24	1,543
Total	601	49,743

Transmission Categories

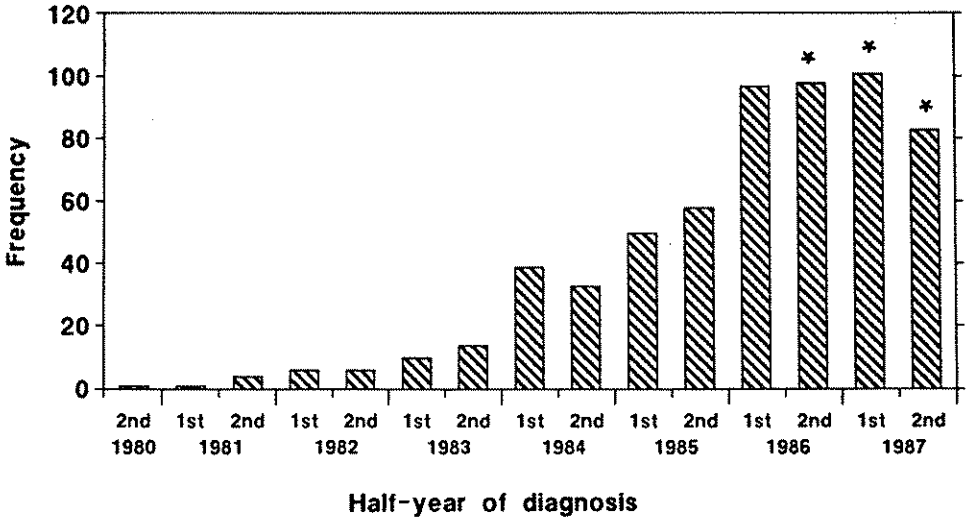
Bisexual or homosexual males account for 42% of the AIDS cases in Connecticut. Thirty-five percent of adult AIDS cases have had a history of IV drug use and another 7% of cases have been homosexual/bisexual males who were also IV drug users.

A total of 48% of all Connecticut cases of AIDS have been either directly or indirectly linked to IV drug use.

Among female AIDS cases, 60% have a history of IV drug use and 25% report having had sex with an IV drug using partner. Ninety-four percent of the children with AIDS in Connecticut had a parent who was an IV drug user. Intravenous drug use and subsequent transmission and infection of fetuses has been the primary mode of transmission among minority AIDS cases. It has accounted for 79% of all AIDS cases in Hispanics and 70% of cases in Blacks *(see Figure 4)*.

Approximately 6% of the AIDS cases have resulted from heterosexuals having sex with infected partners. The use of latex condoms can greatly reduce the possibility of contracting AIDS or any sexually transmitted disease. A disturbing indication of the lack of condom use and the potential threat of AIDS among heterosexuals is revealed in the dramatic rise of other sexually transmitted diseases in this group in Connecticut. The number of gonorrhea cases reported in Connecticut increased by 25% in 1987, while the number of syphilis cases jumped a record 109% between 1986 and 1987. Although the number of cases of sexually transmitted diseases is decreasing in the homosexual population, it is increasing among heterosexuals. Heterosexuals accounted for 92% of the syphilis cases in 1987. IV drug using prostitutes and their patrons and subsequent sexual partners composed at least 20% of the 1987 syphilis cases. **The trend in all sexually transmitted diseases in Connecticut, including AIDS, appears to indicate that "safer sex" educational efforts have been more effective in promoting behavioral changes in the homosexual than in the heterosexual population.**

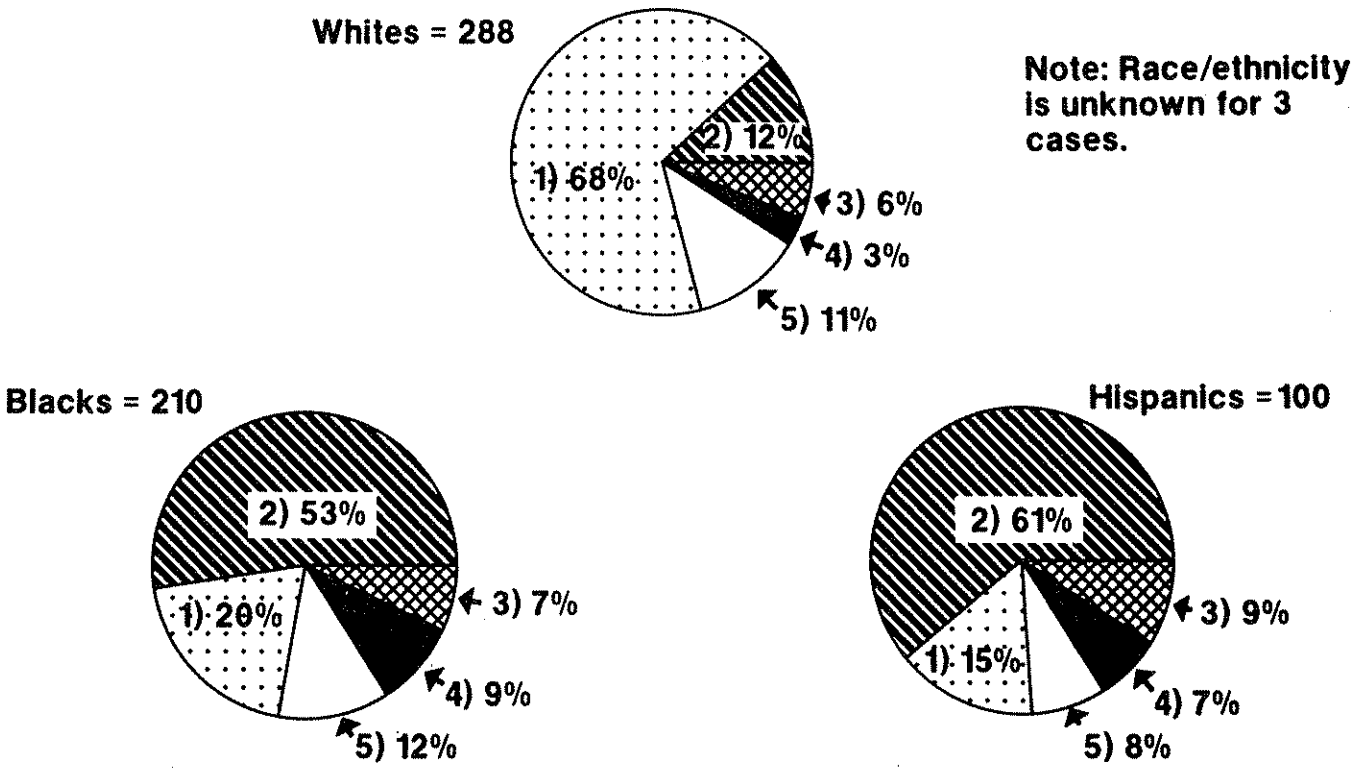
Figure 3: Connecticut AIDS Cases by Half-Year of Diagnosis



*This graph is based on cases reported by 12/31/87. Cases diagnosed in the last year and a half underestimate actual cases because of reporting lag and the 1987 revision of the CDC case definition for AIDS. It is expected that when cases diagnosed during this period are received, numbers will increase.

Figure 4: AIDS Cases in Connecticut by Transmission Category and Race/Ethnicity

(Cumulative Cases Reported by 12/31/87 = 601)



AIDS Cases in Connecticut by Transmission Category and Race/Ethnicity

(Cumulative Cases Reported by 12/31/87 = 601)

Transmission Category	No. Cases Whites	No. Cases Blacks	No. Cases Hispanics
1) Homosexual/bisexual male	195	41	15
2) IV drug user	34	111	61
3) Homosexual/bisexual male & IVDU	17	15	9
4) Heterosexual cases	10	18	7
5) Other Categories:			
a) Hemophilia/coagulation disorder	9	0	0
b) Transfusion, blood components	13	3	0
c) Parent with/at risk for AIDS	2	12	2
d) Undetermined	8	10	6
Total	288	210	100

AIDS in Minorities

Minorities suffer disproportionately from AIDS in Connecticut. Although only 7% of our population is Black and 4% Hispanic, 35% of our AIDS cases are Black and 17% are Hispanic. **These minority groups have accounted for 71% of all AIDS cases in Connecticut's seven major cities, with an incidence rate 3 to 9 times greater than Whites living in the same areas.** It is estimated that 10% of Black and Hispanic males and 2% of minority women between the ages of 20 and 49 living in these urban areas may already be infected with HIV.

The increased rate of HIV infection in minorities has also been demonstrated in seroprevalence studies where samples of blood have been drawn and tested for HIV. Data collected in new military recruits by the Department of Defense show that Black male recruits are 10 times and Hispanic recruits 6 times more likely to be infected with HIV than White recruits from Connecticut. Data from a seroprevalence study of entrants to methadone treatment programs in Connecticut have shown seroprevalence rates 5 times higher among Black and Hispanic clients than among Whites enrolling in the programs for intravenous drug use treatment.

Variations By Age

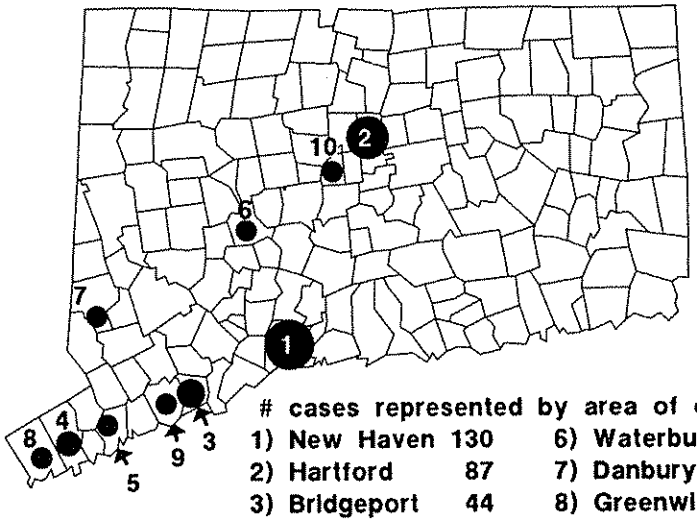
Rates of new AIDS cases are increasing most dramatically for the 20 to 49 year old group. This is not surprising since this group is the most sexually active and the most likely to use IV drugs. Although there have been no cases in the 10 to 19 year old group, many of the AIDS cases in the 20 to 24 year old category were probably infected with HIV as teenagers. Teenagers have also had particularly high rates of other sexually transmitted diseases.

Connecticut has had a significant problem with AIDS in children. Although our State has contributed about 1.2% of all AIDS cases in the United States, it has accounted for 2 to 3% of the cases reported in children under age 13. By December 31, 1987, 17 cases of AIDS in children were reported. **It is estimated that over the next several years, 100 to 300 children per year will be born to Connecticut women who are infected with HIV.** About 40% of these children will continue to show evidence of infection with HIV after the first year of life and an estimated 25% of this group will develop AIDS by 3 years of age. The other 60% of children born with the HIV infection are assumed to have passively acquired maternal antibodies to HIV which disappear 6 to 15 months after birth. Seroprevalence studies which the Department has initiated on all newborns will provide additional insight into the true incidence of HIV infected babies and allow us to target special interventions for women in areas with high rates of infection.

Distribution Of Cases By Town

All counties and 95 of the 169 towns in Connecticut have reported AIDS cases. The majority of cases have been concentrated in seven major cities as displayed in *Figure 5.* New Haven County has the largest percentage of recent cases; Fairfield and Hartford Counties have the second and third largest. Since 1983 there has been a slight shift in relative HIV incidence away from Fairfield County, the county closest to New York City.

Figure 5: Connecticut AIDS Cases for Towns with 10 or more Reported Cases as of 12/31/87



 # cases represented by area of circles

1) New Haven	130	6) Waterbury	22
2) Hartford	87	7) Danbury	15
3) Bridgeport	44	8) Greenwich	12
4) Stamford	40	9) Fairfield	11
5) Norwalk	26	10) New Britain	10

Note: 95 of 169 towns have reported at least one case.

Connecticut Department of Health Services AIDS Section

The Department of Health Services (DHS) is responsible for public health promotion and disease prevention programs, provision of certain health services and regulation of health care providers. The Preventable Diseases Division of DHS, in which the AIDS Section is located, is charged with reducing the occurrence of diseases caused by infectious and environmental agents.

The Preventable Diseases Division initiated AIDS surveillance activities in 1981. In 1983, DHS received federal funding for a fulltime AIDS surveillance position. For the next two years, efforts focused on surveillance to determine the incidence of, and risk factors for, AIDS in Connecticut. However, as the number of AIDS cases multiplied, questions about transmission were answered, a causative agent (HIV) was identified, and a test for screening blood was developed, demands increased for the AIDS Section to provide additional services. The Section was asked to offer education and leadership around AIDS policy and guideline development. At the same time, it became apparent that public education would be crucial to any attempts to slow the spread of AIDS. In 1985, DHS, the designated lead State agency, was authorized to hire staff to educate the population and prevent the spread of AIDS.

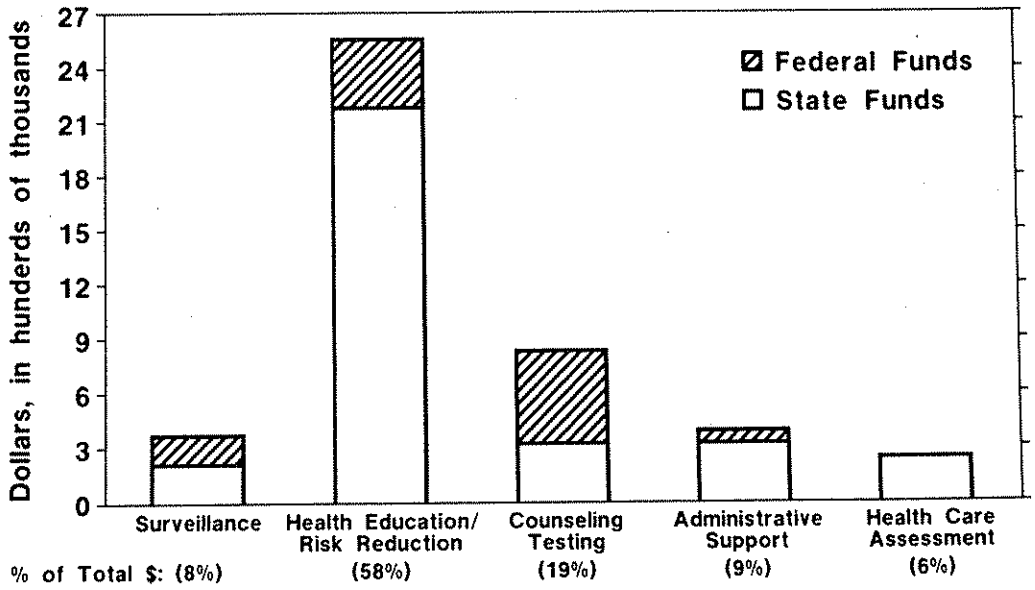
AIDS Funding

Federal and State appropriations allowed the AIDS Section to expand from a $40,000 program in 1985 to a $4.4 million program in State Fiscal Year 1988. Approximately 30% of the Preventable Diseases Division's 1988 budget of 14 million dollars is allocated to AIDS spending.

As indicated in *Figure 6*, 58% of the AIDS expenditures this year are directed towards **Health Education and Risk Reduction** activities. Funding of **HIV Testing and Counseling** sites throughout Connecticut accounts for 19% of the Section's budget. The remainder of expenditures are directed at the other two program components; **Surveillance** (8%) and **An Assessment of Future Health Care Needs** (6%), as well as personnel and other administrative support costs (9%).

Figure 6
Department of Health Services
Spending Plan for AIDS by Program

SFY 1988 Total Budget: $4,451,719



Currently, 49% ($2,172,786) of the total AIDS Section budget is passed along to local health departments, AIDS volunteer organizations and other private agencies to support education, counseling and testing programs in the community. In addition to providing technical assistance for local AIDS program development, DHS offers consultation and leadership on AIDS issues to the other State and private organizations offering prevention and treatment services.

It must be emphasized that DHS expenditures for AIDS represent only a fraction of the total State, local and private resources being consumed in Connecticut's response to this costly disease.

AIDS Program Components

1. SURVEILLANCE

The Surveillance Program monitors the spread of AIDS in Connecticut in two major ways: 1) by gathering information about new cases of AIDS, and 2) by conducting special seroprevalence studies to determine the percentage of people in target populations that are infected with HIV as indicated by a positive HIV antibody test.

A study demonstrated that approximately 90% of AIDS cases are reported to the Surveillance Program although, as noted in *Figure 3*, there is often a delay between the date of diagnosis and the date of case reporting. The Surveillance staff also gather necessary information about cases by contacting the infection control practitioners in the 36 general hospitals and 12 additional inpatient facilities in Connecticut on a regular basis. These activities allow the Department to track where and how the disease is occurring as well as the characteristics of those affected by it.

Staff also conduct No Identified Risk (NIR) investigations to complete the data base in the small number of cases (about 4%) that are reported without any risk factor for HIV. The additional information gathered in NIR investigations usually uncovers known risk factors which were not identified when the cases were reported. All records of AIDS patients are strictly confidential and protected by Connecticut General Statute Section 19a-25.

Due to a long incubation period, present AIDS cases reflect the outcome of HIV infections which occurred 2 to 8 years ago. Therefore, it is possible that high levels of HIV transmission could go undetected for at least several years if only diagnosed AIDS cases were monitored. For that reason, DHS has begun seroprevalence surveys to measure the extent of HIV infection in the following specific populations:

1) All babies born in Connecticut, which will reveal the prevalence of infection in child bearing women;
2) Former and current tuberculosis patients, since they are at higher risk for concurrent infection with HIV;
3) Patients attending clinics for sexually transmitted diseases;
4) Women of child bearing years seen at selected health clinics;
5) Intravenous drug users in Substance Abuse Treatment Programs; and
6) Connecticut residents applying for marriage licenses (one-time sample).

The majority of these surveys will be longterm and "blinded," which means the HIV antibody test will be performed on blood that is collected for other purposes (e.g. syphilis test, PKU on newborns, etc.) The person whose blood is being tested is unaware that it is being tested for HIV, and DHS does not retain information on the identity of the person. Basic demographic information such as age, sex, ethnicity and geographic location of the tested person is maintained in order to allow DHS to monitor trends in infection levels and target populations for special prevention and education interventions. Limited nonblinded studies (i.e. voluntary, confidential testing) will be performed only with patient consent.

Due to a long incubation period, present AIDS cases reflect the outcome of HIV infections which occurred 2 to 8 years ago.

The longterm (2 to 5 years) federally funded surveys will be conducted in the greater New Haven metropolitan area. **New Haven and 29 other cities in the country have been selected as sentinel cities in a national, federally funded effort to determine the prevalence and trends of HIV infection in various segments of the country.** Information from these surveys will also be used to evaluate the impact of prevention efforts on transmission and to project health and social resources needed for the future.

2. HEALTH EDUCATION AND RISK REDUCTION

The AIDS Health Education and Risk Reduction (HE/RR) Program has two major components. The Public Information component is designed to increase the

AIDS Case History No. 1

When she was 6 months old, Stephanie Ernest*, the daughter of a prominent real estate developer and his wife, died of *Pneumocystis carinii* pneumonia and AIDS. She was a beautiful baby, bright and lively until the illness began. First there was a brief hospitalization for diarrhea, then a longer hospitalization at a large medical center when the diarrhea recurred and didn't respond to conventional treatments. Finally at the age of 5 months she was hospitalized for severe respiratory distress which required mechanical ventilator support to allow her to breathe. Her parents were at her bedside when she died one month later.

Her parents said this couldn't be AIDS, and extensive interviews of both parents uncovered no risk factors. The parents were in excellent health.

Two years later Stephanie's mother was diagnosed with disseminated tuberculosis. Soon after she also developed *Pneumocystis carinii* pneumonia and died. Until her death she said it was impossible for her to have AIDS. Again, an investigation revealed no risk factors.

Within six months of his wife's death, Bob Ernest, Stephanie's father, was diagnosed with cytomegalovirus (CMV) infection and AIDS. Before dying he was finally able to tell doctors that there was in fact a risk factor which even his wife was not aware of. Occasionally, on weekends, he shot heroin with his sister's husband and they shared needles.

A 7 year old daughter is the only survivor of this family.

*Real names have been changed.

general public's awareness of how AIDS is transmitted and how it can be prevented. The message is directed throughout the State via the mass media, written and audiovisual materials, peer group presentations and educational outreach. The second component of the program focuses on targeted groups with the highest chance of coming into contact with HIV. Outreach programs and educational materials provide high-risk individuals with tailored education and referrral to counseling and testing sites where they can receive personal counseling about how to eliminate their risk for contracting and/or transmitting HIV.

The role of DHS staff has been evolving from one of direct provider of HE/RR services to one that sparks development at the local level and provides leadership, direction and coordination of local activities statewide. New program and evaluation capabilities have been developed at the local level with the funding and resources provided by DHS. The AIDS Section of DHS has two Regional Coordinators who serve as the liaisons between DHS and the network of 37 local agencies receiving State funds to carry out education, outreach and counseling and testing programs in Connecticut. Statewide programs, such as a comprehensive public information campaign, will, however, continue to be provided directly by the AIDS Section or contractors to DHS.

Public Education

The AIDS Section has contracted with Mintz and Hoke Inc., a public relations firm in Avon, Connecticut to design and implement an AIDS public education campaign including advertising support for a statewide AIDS hotline. The target audiences will include:

1. The general public, to reduce unwarranted fear of HIV infection and to generate support for AIDS prevention initiatives;
2. People who engage in behaviors that put them at risk for becoming infected with HIV; and
3. People who may soon be engaging in risky behaviors (e.g. teenagers) in order to reduce the number who adopt these behaviors.

DHS will encourage private industry to contribute funds for the campaign, including money to purchase television and radio time, print advertisements and other written materials. The Public Information Campaign will be highly visible by the autumn of 1988.

Pursuant to legislation passed in 1987, DHS is also reimbursing any town in Connecticut which mails the *Surgeon General's Report on Acquired Immune Deficiency Syndrome* to its residents. Several hundred thousands of other pamphlets which provide a general audience with basic facts about AIDS have been developed and distributed by DHS. Also, by responding to approximately 300 media inquiries during 1987, the AIDS Section staff disseminated information about the disease to Connecticut residents through newspapers and television news and interview programs.

Professional Education

Health care professionals whose activities involve contact with patients' blood or other body fluids have expressed concern regarding the risk of acquiring HIV infection during the course of their work. **Well controlled studies of health care workers have demonstrated that the risk of occupational infection is extremely small.** DHS has developed and distributed *"Infection Control Guidelines"* which reiterate the Centers for Disease Control (CDC) universal blood and body fluid precautions. The Guidelines also present a protocol for the management of potential exposures to HIV infected fluids in health care workers. During 1987, staff presented seminars for health care workers, issued circular letters and provided numerous individual consultations aimed at describing precautions which health care workers should follow to prevent infection with HIV.

Training has also been provided to other professionals who may come in contact with the blood or body fluids of HIV infected individuals, such as morticians, police, firemen, paramedics, correctional officers, day care and school personnel and human services employees in State and community agencies. Additionally, a protocol entitled, *"Precautions for Funeral Directors and Morticians"* was developed. It summarizes universal blood and body fluid precautions and appropriate burial methods for clients infected with blood borne viruses. It also recommends disinfection methods capable of killing these viruses on environmental surfaces and equipment. Finally, it describes special requirements for reporting persons deceased with a communicable disease to the appropriate public health authorities.

The AIDS Section has developed a questionnaire to assess the knowledge and attitudes of the audience before and after training sessions. The data from these questionnaires is analyzed to determine the effectiveness of lecture presentations and to help shape future training strategies. Future plans include the development of continuous educational programs for health care providers which would include instructions on AIDS counseling techniques.

State and Community Agency Staff

All providers who serve clients who may be HIV infected, whether in state institutions, community agencies or cared for in their own living settings, require training regarding the physical and psychosocial care of clients with HIV infection as well as guidance on how to ensure protection of the patients' rights and confidentiality. In February 1987, DHS and the Department of Administrative Services published *"AIDS Guidelines for State Personnel"* which confirm the right of HIV infected persons to work and ensure protection of their privacy and the confidentiality of their medical information. They also contain general recommendations for State health care workers on the handling of blood and body fluids which are consistent with the CDC's Guidelines.

The AIDS Section has provided training to the staff of 14 other State agencies during the past 2 years. In order to reach additional workers on a regular basis, DHS will contract for professional services to establish a system of train-the-trainer programs. A contact person at each agency will be trained to enable that person to then instruct coworkers. The curriculum will be developed in consultation with other State agencies.

Schools

In conjunction with the Department of Education (DOE), DHS developed a guideline booklet entitled *"Prevention of Disease Transmission in Schools: AIDS,"* which has had a distribution of more than 8,000 copies. The State Board of Education adopted the policy recommended in these guidelines. That policy states that HIV infection, in and of itself, is not a reason to exclude a student from the regular classroom setting. It creates a due process mechanism to ensure that HIV infected children have the right to the least restrictive education. **Issued in May 1986, this was one of the first guidelines developed in the nation for admission of HIV infected children into schools.** The joint effort of DHS and DOE also resulted in a model Secondary School (grades 7-12) Curriculum and Resources Packet on AIDS which consists of learning objectives, lesson plans, and a list of recommended videos and pamphlets. It can be integrated with the health, family life and substance abuse curricula now being used in Connecticut schools. An elementary school curriculum is also near completion.

Local Agencies

The AIDS Section funds 14 full time educator positions at Local Health Departments and clinics throughout Connecticut. Funding is also provided for local telephone AIDS Information Lines which operate an average of 20 hours per week at each site. The Information Lines respond to inquiries generated by the public education outreach efforts and refer individuals needing risk reduction counseling to trained counselors. The educators distribute AIDS pamphlets and posters and conduct AIDS educational seminars and presentations for both high risk populations and social and community groups such as health care organizations and youth groups. **Data from the AIDS Surveillance Program on the rates of infection by transmission category allows the educators to focus HE/RR activities on one or more of the target groups most at risk in their community.**

Homosexual/Bisexual Community

DHS funding augments the extensive HE/RR work being directed at the gay community by the Connecticut voluntary AIDS Service Projects and the Hartford Gay and Lesbian Health Collective. These organizations provide prevention services to homosexual and bisexual men, place risk reduction messages in the gay press, distribute pamphlets aimed specifically at gay men in gay bars and other social gathering locations, and promote the counseling and testing sites which offer anonymous, low or no cost HIV testing.

DHS is currently performing a series of surveys to evaluate the continuing educational needs of this group. In addition, funding is being sought to support voluntary efforts to reach minority gay and bisexual men.

Minority Education

Because of the disproportionate number of minority individuals who are at risk for contracting HIV or are already infected, DHS has targeted significant resources to educational and outreach programs reaching Black and Hispanic individuals and communities in Connecticut. The AIDS Section's minority education efforts have been led by the Section's Hispanic and Black Community Educational Specialists. In an attempt to broaden the Specialists' outreach activities, DHS has initiated a prevention project called Project SOLO, an acronym for Saving Our Lives Ourselves, which aims to bring culturally appropriate educational materials and approaches directly into the streets of Hartford, New Haven, and Bridgeport in order to promote knowledge about the means of HIV transmission and reduce risk taking behaviors.

Project SOLO will be reaching out to health professionals who serve minority communities, to high risk youth and to sexually active minority adults, especially those who may be the sexual partners of IV drug users. Teams of peer health educators will work with individuals in neighborhoods as well as in more organized group and communitywide settings. Public awareness campaigns featuring nationally recognized Black and Hispanic entertainers will complement the development and distribution of specially designed literature and intensive community outreach in high risk areas.

Another Department funded project involves the Community Council of Hartford, the Institute for Community Research, the Hispanic Health Council, the Hartford Health Department, and the Urban League of Greater Hartford. The collaborative is conducting a 300 household survey in the Asylum Hill neighborhood of Hartford designed to assess the baseline prevalence of AIDS knowledge, attitudes and behaviors in that culturally diverse area; contribute to the development of more culturally appropriate AIDS educational materials; and to assess the acceptability of the counseling and testing sites available to persons at risk.

Additional Department programs aimed at improving knowledge and reducing the spread of AIDS in minority communities include a contract with the Hispanic Health Council to explore prevention in the Latino community and an initiative with the New Haven Health Department to develop media materials designed to reach women at risk. DHS is also seeking substantial new federal funding for minority education and outreach from the Centers for Disease Control (CDC).

Outreach to Drug Users

Educational and outreach activities directed at IV drug users have emphasized that the risk of HIV transmission is not limited to sharing contaminated needles. Infected drug users who have unprotected sexual relations with their sexual partners are the major cause of heterosexual AIDS and AIDS in children in Connecticut.

In an effort to reach IV drug users who are not enrolled in substance abuse treatment programs, DHS has provided funds to the Connecticut Alcohol and Drug Abuse Commission (CADAC) which is contracting with local agencies to hire 16 street outreach workers to service the 7 major cities in Connecticut. The AIDS Risk Reduction Outreach Workers (ARROWS) frequent *"shooting galleries"* and other informal gathering spots for IV drug users and distribute bottles of bleach (which can effectively kill the HIV virus on contaminated needles) and free condoms to encourage *"safer sex"* practices. Information about AIDS and the potential for its sexual transmission, the availability of substance abuse treatment programs and the location of confidential HIV testing sites are relayed by the workers in the street to complement the more traditional HE/RR activities.

Infected drug users who have unprotected sexual relations with their sexual partners are the major cause of heterosexual AIDS and AIDS in children in Connecticut.

3. COUNSELING AND TESTING

A major thrust of AIDS prevention efforts has been to make high quality counseling and HIV antibody testing readily available to all whose behavior has potential risk for HIV infection. Anonymous or strictly confidential, free or low cost expert counseling and testing capability has been developed in a number of settings, including community-based health clinics, substance abuse treatment programs, prisons and one hospital. Additional funding has been sought to make similar services available on-site in sexually transmitted disease clinics and urban family planning clinics.

Community-based Clinics

During 1986 and 1987, DHS funded the development of 14 local HIV counseling and testing sites (CTS) in the following cities: Bridgeport, Danbury, Greenwich, Hartford (2 sites), Middletown, New Britain, New Haven, New London, Norwalk, Norwich, Stamford, Waterbury and Torrington *(see Appendix)*.

AIDS Case History No. 2

Sandra Watson* worked hard to escape a life of poverty. She excelled in college and decided to enhance her opportunities for a fulfilling and more prosperous life by enrolling in graduate school. In 1984, as a second year graduate student, Sandra noticed that she tired easily and felt "run down." She consulted the Student Health Service which initially attributed her problem to "exam stress." However, Sandra's symptoms persisted and worsened even after final exams were over.

Within several months, Sandra developed *Pneumocystis carinii* pneumonia, an opportunistic disease commonly associated with AIDS. Tests confirmed that she had AIDS. Sandra, her family and her physician were shocked and devastated. An investigation of potential risk factors for AIDS in Sandra's life revealed that two former boyfriends were at increased risk for AIDS. One of Sandra's boyfriends in college was bisexual and another of her former lovers was from a country in central Africa where heterosexually transmitted AIDS rates are higher than in the United States. Both men had been healthy during their involvement with Sandra. Neither of the two men experienced any symptoms of AIDS at the time Sandra's diagnosis was confirmed.

Sandra's condition worsened at the hospital. She died two weeks after her AIDS diagnosis was confirmed.

*Real name has been changed.

Appointments can be made by telephone or referral to see specially trained HIV counselors. The counselors assess the client's knowledge about AIDS and the specific behaviors that have made HIV exposure a possibility. Specific personal counseling about how to reduce the risk of future exposure is also provided. For those who would like to have the HIV antibody test, an indicator of infection with HIV, the counselors explain the implications of the test results. HIV antibody positive persons are counseled about their potential for developing AIDS and how to avoid transmitting HIV to others. They are also asked to voluntarily refer sex or needle sharing partners for individual or couples counseling. Referrals to medical and psychological services are made as indicated. HIV antibody tests from these sites are performed free of charge at the State Laboratory.

All State funded HIV community counseling and testing sites must adhere to DHS's requirement that patient counseling records and test results be either anonymous or strictly confidential. Since March 1986, more than 5,000 people have been counseled and tested at these sites. Approximately 90% of the individuals that received pre-test counseling also requested HIV-antibody testing. Funding has been received to extend these services to all Sexually Transmitted Diseases (STD) clinics in the State and to selected urban family planning clinics. By the end of 1988, counseling capability at these sites is expected to be more than 10,000 persons per year.

Substance Abuse Treatment Programs

As a group, IV drug users are not well organized, often poorly educated, and tend to have less interaction with the health care delivery system than other groups who participate in high-risk behaviors. With an estimated 51,000 IV drug abusers in Connecticut, the problem of HIV infection is considerable. Because substance abuse treatment programs are among the few places where IV drug abusers interface with the health care delivery system, they are important potential sites of HIV counseling and testing.

In 1986, under a Cooperative Agreement with the Centers for Disease Control, the DHS and the Connecticut Alcohol and Drug Abuse Commission (CADAC) funded the provision of HIV counseling and testing services at substance abuse treatment programs funded by CADAC for IV drug abusers. **Since January 1, 1987, HIV counseling and optional, confidential testing have been available in 10 drug treatment programs in 6 Connecticut cities.** Counseling is not limited to pre- and post-test counseling sessions, but is available on a continual basis to clients, their sexual partners and family members. Clients must make appointments to receive test results.

In 1987, 962 persons received pre-test counseling at the funded sites. Of those, 46% were new admissions to

methadone maintenance, 28% were clients already in methadone maintenance, 23% were in other drug treatment modalities, and 3% were sexual partners or family members of clients. Overall, 75% received the HIV antibody test. Of those tested, 62% have requested test results and have received post-test counseling. One third of the 2,065 counseling sessions in 1987 were for other than pre- and post-test counseling, which reflects the need for ongoing counseling services.

In April, 1988, a CADAC counselor hired with federal funds supplied by DHS will begin to provide pre-test HIV counseling to all entrants to the Fairfield Hills Hospital (FHH) alcohol and drug detoxification and residential programs and their families. The counselor will also provide post-test HIV counseling to all persons in the detoxification program on whom HIV antibody testing is performed, and pre- and post-test counseling to others hospitalized in FHH residential rehabilitation programs. State funding has been awarded to expand the counseling/testing program to the remaining outpatient drug treatment modalities statewide. Additional funding has been sought to develop HIV counseling and testing programs in 3 other residential programs based at state hospitals.

Connecticut's HIV counseling and testing program in drug treatment programs is the only such statewide program in the United States.

Drug treatment programs have become important sites of HIV counseling and testing in our State. In this setting, an integrated approach to prevention of both drug use and HIV transmission is possible.

Corrections Facilities

In 1987, DHS and the Department of Corrections were awarded federal funding to develop an HIV counseling and testing program for inmates in State correction facilities. Many inmates are believed to be at particular risk for HIV infection as a result of past IV drug use. Two counselor positions have been established and funding is being sought for additional counseling positions as well as for an educator for inmates and staff. These positions will work out of the Central Department of Corrections (DOC) office in Hartford and be responsible for providing HIV counseling and testing (as indicated) in priority order to:

1) all known HIV antibody positive inmates;

2) the pre-incarceration steady sexual partners of HIV antibody positive inmates who have maintained an on-going relationship;

3) all inmates eligible for "trailer visit" privileges with spouses and/or sexual partners;

4) all inmates to be allowed out of prison on furlough;

5) all inmates prior to discharge; and

6) corrections staff with specific exposure concerns.

Hospitals

DHS has contracted with Yale/New Haven Hospital to explore the feasibility and utility of offering initial and follow-up counseling to HIV antibody positive persons referred to AIDS specialty clinics. Based on the initial success of this program, additional funding has been sought to expand expert HIV counseling services to the more than 600 HIV antibody positive persons who enter the YNHH system annually.

Outreach to Sex and Needle Sharing Partners

In addition to developing the capability to provide HIV counseling to persons at risk in a variety of settings, the AIDS Section will be initiating activities to help assure that the sex and needle-sharing partners of persons with HIV infection have the opportunity to be made aware of their risk and receive appropriate risk reduction counseling and education. **This outreach program, known as CARE (Companion Awareness and Risk Education), will focus on voluntary identification of partners at risk and on referring them to an HIV counseling and testing site.** As with partner referral programs for syphilis and gonorrhea, all personal identifying information will be kept to a minimum and held in strict confidence.

The CARE staff will be working with HIV counselors, physicians, street outreach workers and other health professionals who serve HIV infected persons to augment existing partner outreach efforts. CARE staff will also assist HIV infected persons in referring their needle-sharing and sexual partners.

Initially, the CARE program will consist of a coordinator and an outreach worker. If funding permits, the program may be expanded to include additional personnel.

LABORATORY SERVICES

The State Laboratory in the Department of Health Services began performing blood tests for HIV antibodies in April 1986. The Laboratory does not offer diagnostic testing services. Only blood specimens submitted as a result of State-funded HIV counseling and testing activities and pre-approved HIV seroprevalence surveys are accepted. Confidentiality is ensured since a code, rather than a client's name, is used for all specimens submitted for HIV testing. **The demand for HIV testing increased by 286% in 1987 alone, from an average of 245 tests per month in the first quarter of 1987 to an average of 700 tests per month during the last quarter.**

Strict guidelines govern the HIV antibody testing procedures used by the Virology Section of the Laboratory. If the ELISA (Enzyme Linked Immunoabsorbant Assay) initial blood test for HIV antibodies is positive, the blood specimen is retested twice by the ELISA method. If at least one of these two tests is also positive, an indirect immunofluorescence (IFA) confirmatory test is performed. Specimens indeterminate by IFA are then tested by the more specific Western Blot (WB) method. The Laboratory adheres to the criteria for a reactive WB as established by the Association of State and Territorial Public Health Laboratory Directors.

In addition to the routine HIV testing, the Virology Section investigates and evaluates advances in technology which might improve the accuracy of diagnosing HIV infections.

The Laboratory Standards Section of the State Lab has established conditions of certification for all laboratories which perform HIV testing on Connecticut residents *(See Appendix)*. Licensed laboratories must seek approval from the Lab Standards Section to provide the testing and must adhere to the following conditions of certification. They must:

1) use a Food and Drug Administration (FDA) approved kit for ELISA testing;

2) use a supplementary confirmatory test before reporting a positive HIV finding;

3) provide for a discussion of the implications of testing with the patient and encourage written informed consent from the patient;

4) have arrangements with at least two physicians who are available for patient counseling purposes; and

5) use an HIV Antibody Test Information Form for each specimen submitted for testing.

Adherence to these standards provides for high quality testing and attempts to ensure that the rights and welfare of patients requesting tests for HIV are addressed.

4. ASSESSMENT OF HEALTH SERVICES

Hospitals and home health care agencies have been the primary sources of health care for AIDS patients in Connecticut. **The Connecticut Hospital Association projects total inpatient costs for AIDS patients in the State will be $81.9 million in 1991.** That figure is 11 times higher than Connecticut's total inpatient costs in 1986. Current information indicates that Medicaid paid 51% of the cost of inpatient care for AIDS patients in the State last year, while commercial insurance covered 38% of all AIDS inpatient costs.

As the number of AIDS cases caused by IV drug use continues to increase, the financial burden of caring for people with AIDS or HIV infection will fall increasingly upon the state and federal governments since many in this risk group are not covered by private health insurance.

DHS has contracted with Yale University to perform an assessment of the impact of AIDS in Connecticut on the health care system. By merging DHS data files on persons with AIDS with the Department of Income Maintenance Medicaid claim forms on HIV-related diagnostic codes (maintaining strict confidentiality), the study will provide critically needed information on the cost and types of health care services provided AIDS patients. Thus far, the study has revealed that during 1987, inpatient care accounted for approximately 80% of the total health care charges generated by AIDS patients on Medicaid in Connecticut. The assessment will also determine what changes are needed in the health care system to ensure that an appropriate spectrum of care options are available to persons who are ill from infection with HIV. When the study is completed in the summer of 1988, DHS and other state and private organizations will be convened to discuss the report's recommendations and coordinate future program planning.

Policy Development and Task Forces

The Connecticut response to AIDS consists of tracking the epidemic, group or individual education about the disease and its prevention, caring for persons affected and more. Organizations, like people, have significant issues to confront when responding to AIDS. Rational and effective policy on AIDS requires accurate scientific and medical knowledge and should take into account the public health, legal and ethical implications of considered actions.

Since October, 1985, when DHS was designated the lead State agency on AIDS issues, the Department has served in a leadership role in the development of effective guidelines and policies to protect the public health and promote the prevention of AIDS. Therefore, the staff of the Department of Health Services have been actively engaged as facilitators and consultants in policy development groups throughout Connecticut and nationally as outlined below:

1) ***Governor's Human Services Cabinet***

The Governor's Cabinet for Human Services consists of a variety of State agencies which provide social services to the residents of Connecticut. These include the Departments of Children and Youth Services, Corrections, Education, Health Services, Human Resources, Income Maintenance, Mental Health, Mental Retardation, the Connecticut Alcohol

AIDS Case History No. 3

Jerry Anderson*, a 34 year old successful attorney with a prominent Connecticut law firm, was very happy in the monogamous relationship he had shared with his lover Steve since 1982. In January 1985, they purchased a 1750 colonial home which they planned to restore. That March, Jerry noticed that he had swollen glands and a purplish skin lesion on his back, which he initially assumed was just a bruise from the remodeling work. When the bruise failed to heal and he lost 20 pounds in 6 weeks, he began to worry and decided to see his physician. A blood test ordered by the doctor revealed that Jerry was infected with HIV. The doctor diagnosed Jerry as having Kaposi's sarcoma and AIDS. Jerry and Steve sought counseling from a gay men's counseling service. Although Steve discovered that his blood also carried HIV antibodies, he remained symptom-free.

Four months later, Jerry was hospitalized with *Pneumocystis carinii* pneumonia and continued to suffer frequent bouts of illness as his disease progressed. Steve spent much of his time caring for Jerry when he was home from the hospital. Jerry's family was also very supportive. In December, Jerry resigned his position at the law firm and committed himself to helping others better understand AIDS and the people it affects. Working with a local AIDS counseling program, Jerry spoke to a wide range of audiences explaining how AIDS had affected him and his loved ones and outlining the types of services people with AIDS need. Since Jerry's death in 1986, Steve has attempted to continue Jerry's work of educating others about AIDS. As of April 1988, Steve remained free from any serious symptoms from his HIV infection.

*Real names have been changed.

and Drug Abuse Commission, the Commission on Long Term Care and the Office of Policy and Management. The AIDS working group of this Cabinet has collected information from each of these agencies on current AIDS related programs and resources and those that will be needed in the future. The group will continue its planning work on an ongoing basis.

2) ***The Task Force to Review Research and Recommend State Policy on AIDS***

This group was formed under Public Act 87-527 in June of 1987, convened in the autumn of 1987 and submitted a report to the Legislature on January 15, 1988. The group has fulfilled four basic charges. It has:

a) reviewed existing studies and guidelines from state, federal and private agencies on HIV infection;

b) assessed the magnitude, trends and nature of the AIDS epidemic in Connecticut;

c) developed a State policy to encourage confidential testing of those at possible risk; and

d) made recommendations on the means to protect the civil rights of persons infected with HIV.

3) ***The Commissioner's Task Force on AIDS***

Pursuant to Public Act 87-389, a Task Force was created as a permanent advisory body to the Commissioner of Health Services. The group will advise DHS on the planning of programs for persons with AIDS and their families. It consists of persons with a variety of relevant backgrounds, including public health professionals, HIV counselors, representatives of minority communities, AIDS service organizations, legislators, and HIV infected individuals. The group meets on a quarterly basis to review and recommend policy.

4) ***Interagency Task Forces in the State of Connecticut***

DHS has participated in task forces of other state agencies to develop and implement agency-wide policy on AIDS and HIV issues. The agencies involved to date include the Departments of Administrative Services, Corrections, Mental Health, Mental Retardation, the Rocky Hill Veterans Home and Hospital and the Connecticut Alcohol and Drug Abuse Commission.

5) ***Local and Regional Task Forces***

DHS AIDS Section staff participate as consultants on a number of task forces created to develop and coordinate local efforts to prevent AIDS. Policy and planning expertise is available through these groups to the private and public sectors in their areas.

6) ***The State General Assembly***

In cooperation with DHS's Office of Government Relations, the DHS AIDS Section staff regularly advise the Legislature on health policy matters related to HIV and AIDS. This consists of submission of proposed legislation, testimony on legislation under consideration and educational programs for State legislators and policymakers.

Controlling the AIDS Epidemic

The epidemic of the Human Immunodeficiency Virus is a serious and extremely complicated problem. To be successful, our response requires carefully gathered and up-to-date scientific and medical information; vigorous and rational efforts to control the disease through health education about risk reduction; accessible counseling and antibody testing; and creation of policies, guidelines and laws geared to effectively promote the public health while protecting our citizens from discrimination and loss of privacy. These components should not be mutually exclusive. They can work together to promote AIDS prevention.

Policies and laws should foster the success of prevention/control efforts. These efforts, to be effective, require the permanent change of basic human behaviors. To do this, the voluntary cooperation of persons at risk is necessary.

The Department of Health Services has worked in coalition with other State and federal agencies, municipal health departments, health and mental health care providers, AIDS service organizations and community-based social service organizations to accomplish this. The task of stopping the first epidemic in history through behavior change is daunting, but the citizens of the State of Connecticut are making significant steps toward achieving this goal, as evidenced in this report.

AIDS PERSONNEL IN THE CONNECTICUT DEPARTMENT OF HEALTH SERVICES

Office of the Commissioner 566-2038

Frederick G. Adams, D.D.S., M.P.H.,
Commissioner of Health Services

Dennis F. Kerrigan,
Deputy Commissioner of Health Services

Wanda Rickerby,
Director of Center for Health Communication

Marie Roberto, M.S., R.N., C.N.S.,
Director of Policy Development and Community Relations

Bureau of Health Promotion 566-5475

Peter D. Galbraith, D.M.D., M.P.H., Bureau Chief

Kelly McGarrity, Coordinator of Bureau Administration and Evaluation

Preventable Diseases Division 566-2048

Beth Weinstein, M.P.H., Director (Acting Chief — AIDS Section)

James Hadler, M.D., M.P.H., Chief of Epidemiology Section

Matthew Cartter, M.D., Coordinator of Epidemiology Program

AIDS Section 566-1157

Beth Weinstein, M.P.H., Acting Chief

Richard Melchreit, M.D., Medical Associate

Patricia Checko, M.P.H., AIDS Epidemiology Coordinator

Renee Coleman, M.P.H., Regional Coordinator

Frank DeFrancesco, M.A., Counselor Coordinator

Pamela Fitzgerald, M.P.H., Regional Coordinator

Brenda Groce, M.S., Statewide Contracts Coordinator

Gwendolyn Lewis, M.Ed., Black Community Educator

Catherine King, Outreach Coordinator for Sex and Needle Sharing Partners

Ann McLendon, M.Ed., Education Coordinator

Tricia McCooey, M.S.W., AIDS Policy Analyst

Julia Miller, Ph.D., Surveillance Epidemiologist

Hector Seda, Hispanic Community Educator

Susan Taff, M.P.H., Acting Grants Coordinator

Terri Wright, M.P.H., Grants Coordinator

Bureau of Laboratory Services 566-5102

Jesse Tucker, Ph.D., Bureau Chief

Earl Thompson, M.S., Chief of Laboratory Standards

Don Mayo, Sc.D., Chief of Virology

LOCAL HIV COUNSELING AND TESTING SITES FUNDED BY THE DEPARTMENT OF HEALTH SERVICES*

Local Health Departments

Bridgeport Health Dept.
752 East Main Street
Bridgeport, CT 06608
576-7469 *No Charge*

Danbury Health Dept. out of
Danbury Hospital
24 Locust Street
Danbury, CT 06810
797-7900 *No Charge*

Greenwich Health Dept.
101 Field Point
Greenwich, CT 06830
622-6488 *No Charge*

Hartford Health Dept.
80 Coventry Street
Hartford, CT 06112
722-6742 *No Charge*

Middletown Health Dept. out of
Middlesex Memorial Hospital
28 Crescent Street
Middletown, CT 06457
344-9998 *No Charge*

New Britain Health Dept.
27 West Main Street
New Britain, CT 06051
224-2420 *No Charge*

New Haven Health Dept.
1 State Street
New Haven, CT 06511
787-6453
$5.00 Charge Can Be Waived

New London Health Dept.
120 Broad Street
New London, CT 06320
447-2437 *No Charge*

Norwalk Health Dept.
137-139 East Avenue
Norwalk, CT 06851
854-7979
$5.00 Charge Can Be Waived

Norwich Health Dept. out of
William Backus Hospital/STD Clinic
326 Washington Street
Norwich, CT 06360
823-6343 *No Charge*

Stamford Health Dept.
P.O. Box 10152
888 Washington Street
Stamford, CT 06902
977-4399 *No Charge*

Torrington Area Health District
19 Taylor Street
Torrington, CT 06790
489-0436 *No Charge*

Waterbury Health Dept. out of
Public Health Nursing
232 North Elm Street
Waterbury, CT 06702
574-6883 *No Charge*

Clinic Hartford Gay & Lesbian Health Collective, Inc. — Community Health Services
520 Albany Avenue, Hartford, CT 06145 • 236-4431 *(No Charge)*

*HIV antibody testing is also available, for a fee, to any individual through private health care providers.

SUBSTANCE ABUSE TREATMENT PROGRAMS WITH HIV COUNSELING AND TESTING CAPABILITY FUNDED BY THE DEPARTMENT OF HEALTH SERVICES

Liberation Program, Inc.
125 Main Street
Stamford, CT 06901
325-4191, 356-1980

Hartford Dispensary
522 Albany Street
Hartford, CT 06106
525-9376

Regional Network of Programs
171 Golden Hill Street
Bridgeport, CT 06604
333-4105

Connecticut Counseling Centers
31 West Avenue
Norwalk, CT 06854
838-6508

Connecticut Counseling Centers, Inc.
951 Chase Parkway
Waterbury, CT 06708
755-8874

APT Foundation Central Medical Unit
301 Orchard Street
New Haven, CT 06604
787-3090

LIST OF LABORATORIES CURRENTLY APPROVED BY THE DEPARTMENT OF HEALTH SERVICES TO PERFORM HIV TESTING ON CONNECTICUT RESIDENTS

Laboratories in Connecticut

Bridgeport Hospital Laboratory
267 Grant Street
Bridgeport, CT 06602
384-3599

John Dempsey Hospital Laboratory
UCONN Health Center
Farmington, CT 06032
674-2865

Hartford Hospital Laboratory
80 Seymour Street
Hartford, CT 06115
524-2207

Middlesex Memorial Hospital
28 Crescent Street
Middletown, CT 06457
347-9471

Hospital of St. Raphael
1450 Chapel Street
New Haven, CT 06511
789-3085

Newington Children's Hospital Lab
181 East Cedar Street
Newington, CT 06111
667-5200

Norwalk Hospital Laboratory
Stevens Street
Norwalk, CT 06856
852-2652

St. Mary's Hospital Laboratory
56 Franklin Street
Waterbury, CT 06702
574-6053

St. Joseph Medical Center
128 Strawberry Hill Avenue
P.O. Box 1222
Stamford, CT 06904
352-2000

American Red Cross
Blood Program Lab.
Connecticut Region
209 Farmington Avenue
Farmington, CT 06032
678-2770

Connecticut Department of
Health Services Laboratory
(State Clinics Only)
10 Clinton Street
Hartford, CT 06106
566-4776

St. Francis Hospital Laboratory
114 Woodland Street
Hartford, CT 06105
548-4484

Burt Medical Laboratory
126 Sherman Avenue
New Haven, CT 06511
865-2147

Yale-New Haven Hospital Laboratory
789 Howard Avenue
New Haven, CT 06519
785-2443

Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320
442-0711

United Laboratory Services, Inc.
One Bulkeley Place
New London, CT 06320
444-6777

Waterbury Hospital Laboratory
64 Robbins Street
Waterbury, CT 06702
573-2169

W.W. Backus Hospital Laboratory
326 Washington Street
Norwich, CT 06360
889-8331

Out-Of-State Laboratories

Bioran Medical Laboratory
415 Massachusetts Avenue
Cambridge, MA 02139
(617) 547-8900

Roche Biomedical Laboratories, Inc.
5 Johnson Drive, Raritan, NJ 08869
Performs Screening — **(800) 621-5250, Ext. 2242**
North Carolina Facility — Performs Western Blot **(800) 334-5161**

New England Pathology Services, Inc.
330 West Cummings Park
Woburn, MA 01801
(617) 938-9438

MetPath, Inc.
One Malcolm Avenue
Teterboro, NJ 07608
(201) 393-5600