Broad-based HIV testing availability to sexually transmitted disease clients may select for individuals minimally or perhaps only capriciously interested in HIV testing. In the absence of comprehensive, effective pre- and posttest counseling, lack of self-motivated interest in testing may be associated with low adherence to counseling messages. Sexually transmitted disease clients have much lower posttest counseling return rates than persons specifically seeking HIV testing.[2] Perhaps clients not specifically seeking HIV testing may be less likely to adhere to counseling messages such as behavioral risk reduction messages. In other areas of behavioral change—smoking cessation, for instance—client motivation is a key predictor of successful behavioral change.

Only comprehensive pre- and posttest counseling should be offered, even if this means testing fewer people. The implications of HIV testing are far too serious and easily misinterpreted for abbreviated counseling. Clients should be screened for prior interest in HIV testing before engaging formal pretest counseling. The Pima County Health Department in metropolitan Tucson, Ariz, initially had relatively low posttest return rates when it broadly offered HIV testing to sexually transmitted disease clients. However, after it began informally screening these clients (testing only those with some stated prior interest in testing), posttest return rates increased from 38% to 62%. Although it is appealing to offer HIV testing to all persons seeking clinical services (such as sexually transmitted disease treatment), consideration must be given to maintaining the quality of counseling and assessing the readiness of clients to receive both testing and counseling toward risk reduction. □

Douglas Hirano, MPH
Frank R. Slaughter
Lawrence Sands, DO, MPH
George A. Gellert, MD, MPH, MPA

The authors are with the Division of Disease Prevention, Arizona Department of Health Services, Phoenix.

Requests for reprints should be sent to Douglas Hirano, MPH, Arizona Department of Health Services, 1740 W Adams, Phoenix, AZ 85007.

References

1. Otten MW, Zaidi AA, Wroten JE, Witte JJ, Peterman TA. Changes in sexually transmitted disease rates after HIV testing and posttest counseling, Miami, 1988 to 1989. *Am J Public Health.* 1993;83:529–533.
2. *CTS Summary Record Database, US Total, October–December 1992.* Atlanta, Ga: Centers for Disease Control and Prevention; 1992.

State Health Departments' Role in AIDS Policy: A Clarification

In an editorial[1] in the June 1994 issue of the Journal, Kristine Gebbie referred to our article[2] on acquired immunodeficiency syndrome (AIDS) policy-making in the same issue. We have no desire to enter into a substantive debate with Ms Gebbie, but we do wish to respond to some specific questions she raised.

Regarding the response rate to our survey, for every state, at least one type of informant among the state health departments, hospital associations, and legislative committees took part.

As to the possibly limited view of those legislative health committee chairs who do not have exclusive jurisdiction over AIDS policy, in the questionnaire we tried to elicit a comprehensive picture by asking the chairs to "indicate whether your committee, or another committee in your house of the legislature has held a hearing on a bill on each subject and whether it is now law."

On the specific question of legislative action to authorize quarantining persons who are infected with the human immunodeficiency virus, 20 of 68 respondents (29%) in 16 states said that some committee had held hearings on that subject. □

Leonard Robins, PhD
Charles Backstrom, PhD

Request for reprints should be sent to Charles Backstrom, PhD, Department of Political Science, University of Minnesota, 1414 Social Science Bldg, 267 19th Ave S, Minneapolis, MN 55414.

References

1. Gebbie KM. Formulating public health policy: the case of AIDS. *Am J Public Health.* 1994;84:888–889.
2. Robins L, Backstrom C. The role of state health departments in formulating policy: a survey on the case of AIDS. *Am J Public Health.* 1994;84:905–909.

Promoting the Potential of Community-Oriented Primary Care

Regarding the fine articles on the history of community health centers in South Africa and Jack Geiger's editorial on the legacy of Sidney Kark,[1–4] I fear the implication that there has been a related social/health movement behind the growth of community health centers in the United States is overstepping.

It is impressive that Geiger spent much energy in the early 1970s promoting the Pholela approach based on his experience in South Africa. However, by the late 1970s few community health centers in the United States remained directed toward achieving community involvement.

The US effort depended upon the "war on poverty" legislation and lost its grounding in the fading civil rights movement. In 1974, the federal criteria for evaluating centers became productivity standards and the poverty levels of communities served. Support for a comprehensive model withered.

Community-oriented primary care has been reinjected into the US arena in the past 10 years by public health advocates, but the full potential of the social model has not been promoted. Thus, I wrote a health department grant in 1987 based upon coordinating community-based primary care and public health approaches, yet I had not heard of Kark's work.

Yach and Tollman point out that "South Africans in the 1940s were influenced not only by the results of their own empirical studies but also by earlier work from the 19th century, such as that of Friedreich Engels and Rudolf Virchow . . . ," which showed that mortality was related to social conditions.[3] When Kark's advocacy of social equality—the right to both food and health—came into conflict with the South African state, he was labeled a communist and he emigrated.

The very fact that South African health planners then (Susser also risked his own future, for one) and now (Yach and Tollman) faced and fought such conflicts with the Nationalists reflects a level of maturity in their efforts that has been unparalleled here.

Most North Americans involved in community health centers have taught prevention in the context of a patient-oriented prevention model, not a community-oriented social model. Patients remain individuals from a particular community, rather than individuals *and* community members.

There have been inadequate efforts to use indigenous community health workers, census taking, surveying, and follow-up in homes and neighborhoods;

there has been little interaction with the communities as communities. Centers lack the resources to implement an epidemiologically based model. This situation results from a failure of medical and nursing schools to provide a public health and social/environmental orientation in their teaching as well as from government resistance and weak funding.

The American Public Health Association should widely distribute materials on the social-epidemiologic model. □

Marc Sapir, MD, MPH

The author is with the Center for Elders' Independence, Oakland, Calif.

Requests for reprints should be sent to Marc Sapir, MD, MPH, 1326 Spruce St, Berkeley, CA 94709.

References

1. Phillips HT. The 1945 Gluckman Report and the establishment of South Africa's health centers. *Am J Public Health.* 1993;83:1037–1039.
2. Susser M. A South African Odyssey in community health: a memoir of the impact of the teachings of Sidney Kark. *Am J Public Health.* 1993;83:1039–1042.
3. Yach D, Tollman SM. Public health initiatives in South Africa in the 1940s and 1950s; lessons for a post-apartheid era. *Am J Public Health.* 1993;83:1043–1050.
4. Geiger HJ. Community-oriented primary care: the legacy of Sidney Kark. *Am J Public Health.* 1993;83:946–947.

The Validity of Self-Reported Height and Weight Is Questioned

I was very interested in the letter to the editor that Zhang et al. wrote regarding the validity of self-reported height and weight in perimenopausal women.[1] As a graduate student at Northeastern University, I am working with an interdisciplinary team at Edith Nourse Rogers Memorial Veterans Hospital to develop a clinical indicator to identify patients at risk for disease due to undernutrition. Weight is an important clinical indicator and using self-reported weight has the obvious benefit of saving staff time. Therefore, I was particularly interested in the accuracy of the variable self-reported weight.

Our team has a problem with the letter because the mean self-reported and measured weights were not reported. Neither was a statistical test reported to examine the possible differences in the mean scores of the two weights. Although the authors demonstrated that the self-reported and measured weights were highly correlated, there was no evidence that the two weights were similar. Without knowing the similarities, one cannot make a judgment as to the accuracy of self-reported weights. Our team suggests that the authors report the value and statistical significance of a paired *t* test in order to determine the accuracy of the self-reported weights. □

Sandra L. Sgro, RN, BSN

The author is with Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Mass.

Requests for reprints should be sent to Sandra L. Sgro, RN, BSN, 40 Apple Rd, Beverly, MA 01915.

Reference

1. Zhang J, Feldblum P, Fortney J. The validity of self-reported height and weight in perimenopausal women. *Am J Public Health.* 1993;83:1052–1053. Letter.

Zhang Responds

We thank Ms Sgro for her letter. We reexamined our data and found that mean self-reported height was virtually identical to the measured height (error = 0.1%) (Table 1). The average self-reported weight, however, was consistently lower than the measured weight by 2 to 3 lb across the categories. We further grouped the women on the basis of their measured weight (Table 2). With increasing weight, the discrepancies between self-reported

TABLE 1—Means and Standard Deviations of Self-Reported and Measured Weight and Height, by Women's Characteristics

		Height, in			Weight, lb		
	n	Self-Reported, Mean ± SD	Measured, Mean ± SD	*P*[a]	Self-Reported, Mean ± SD	Measured, Mean ± SD	*P*[a]
Age, y							
40–44	151	65 ± 2	65 ± 2	.11	139 ± 25	142 ± 26	<.01
45–49	115	65 ± 2	65 ± 2	.48	137 ± 24	140 ± 25	<.01
50–54	86	64 ± 2	64 ± 2	.21	142 ± 32	145 ± 33	<.01
Education							
High school graduate or less	33	64 ± 3	64 ± 3	.09	155 ± 40	157 ± 40	<.01
Some college or college degree	177	65 ± 2	65 ± 2	.18	138 ± 26	141 ± 27	<.01
Graduate work or degree	142	65 ± 3	65 ± 2	.26	137 ± 22	140 ± 24	<.01
Occupation							
Managerial or professional	178	65 ± 3	65 ± 2	.30	139 ± 25	142 ± 27	<.01
Technical sales or administration	106	65 ± 2	64 ± 2	.10	139 ± 29	142 ± 30	<.01
Other	68	65 ± 2	65 ± 2	.35	139 ± 27	141 ± 26	<.01
Menopausal status							
Premenopausal	171	65 ± 2	65 ± 2	<.01	137 ± 22	140 ± 23	<.01
Intramenopausal	93	65 ± 3	65 ± 2	.70	143 ± 30	146 ± 32	<.01
Postmenopausal	88	64 ± 2	64 ± 2	.90	140 ± 31	142 ± 32	<.01
Overall	352	65 ± 2	65 ± 2	.04	139 ± 26	142 ± 28	<.01

[a]Paired *t* test.