

COMMUNICATION #3-12

To: All Members of ACHA Task Force on AIDS

From: Rich Keeling

Date: November 30, 1987

Method: First Class Mail or Federal Express

This Communication brings with it the final draft of our revised *General Statement on Institutional Response to AIDS*. I very much appreciate all the assistance I got from many of you in preparing this revision. 16 of you returned the previous draft with comments, most of which have been incorporated in the revision.

I ask that you now re-read the final draft with a close eye, looking to see that the many small changes made are OK with you. Several major re-arrangements of material have made the document read even easier, I think, and I will be interested to have your reactions. I have included a little new material; you will find several references to education and support services for people with established HIV infection directed at limiting the consequences of infection once it is established. There is particular reference to the need for clinicians in our health services to pay attention to new developments in the evaluation and therapy of HIV infection so that they can provide (or refer for) the best available intervention. This recommendation will become increasingly important as antiviral and immunomodulating therapies for pre-symptomatic HIV infection evolve. Although this may sound technical for our *Statement*, it is important that the information be there; as time goes on, the obligation for institutions of higher education will be not just to prevent new infections but to help students and employees deal effectively with infection once it exists. See what you think of the new material.

So: your job: please go through the revised General Statement carefully. Scribble any comments, editorial changes, or suggestions on your copy (in red, if possible), and send it back to me. When? Yesterday, of course; but, please, try to get it back to me no later than December 14. I have changed the publication date to January 1, 1988 but would not want it to go much beyond that.

Also included in this Communication package:

1. A copy of the AIDS Action Council "News in Brief" for October, for your information.
2. A copy of "Guidelines for handling health data or individuals tested or treated for the HIV virus," from the

Journal of the American Medical Record Association. Bob Wirag and Wayne Ericson both sent me one of these, and I thought the rest of you would like to read it as well.

3. A copy of an article from Science, "A frustrating glimpse of the true AIDS epidemic." This article discusses the intention of the PHS and CDC to conduct a nationwide seroprevalence study to try to determine exactly how common seropositivity is. They propose to some of this testing on college campuses, and we have a meeting scheduled in Washington on December 11 with Dr. Helene Gayle of the CDC to discuss how ACHA can cooperate and assist in the process. Obviously a big part of our interest will be in guaranteeing that appropriate procedures are in place for separating identifiers from test results, etc. Dr. Gayle asked to meet with several directors, and I have agreement from Bill Christmas (Vermont), Mimi Collins (Penn), Maggi Bridwell (Maryland), and Bob Wirag (Texas) to meet with her. CDC has also spoken with Don Char (Hawaii) directly, and I had a chance to discuss this all with him during my recent visit there. I'll report about this meeting during the CDC meeting on December 12 and the Task Force meeting on December 13, as well as in a subsequent Communication.

4. A copy of the revision of our NIMH psychosocial issues supplement draft. This revision incorporates changes initiated by the NIMH officers. You will recall that our work was due in March, got there on time, and then we heard nothing for a long time. Finally Gail Bassin reports that they contacted her (at Johnson, Bassin, And Shaw) with their changes. I have not had time to read it closely yet, so all of you and I are starting together.

Your job: look through the revisions, comment, and react. For those of you who will be in DC on December 11-12-13, we will discuss this at our Task Force meeting on the 13th.

CDC Cooperative Agreement Review Panel Meeting: Those of you involved in the meeting in Washington December 12 have heard directly from Doug Conaway about arrangements. If there are any questions or uncertainties, don't hesitate to call Doug at 301-963-1100 to settle them before the meeting.

Special Note: Steve Blom at ACHA has arranged for us to have some kind of Friday evening social event with the people from the ACHA/NAFSA Task Force on International Students, who will also be in town at the same time. Details coming from Doug.

Our Task Force Meeting: Those of us who are on the REview Panel and can stay overnight in DC on December 12 will meet for a few hours on December 13 at the DuPont Plaza Hotel (where all the other meetings are). Big issues for this meeting will be:

1. Feedback about the General Statement, revised brochures
2. Discussion of the CDC Seroprevalence study
3. Drafts of brochures on Women's Issues (Chris Lyman) and Sexual DEcision-Making (Annie Lomax).
4. Review of the NIMH final draft.
5. Most important: catching up with each other.

Satellighting Show: after our experience with the College Satellite Network show, you may wonder why I would even consider another one...but whenever people do AIDS education for college students on a national scale, I think we should be represented/involved. Hence, yes, another satellite show. This one, February 17 1988 from fort Worth, a company called Satellighting (yes, for real). I have given 8 or 10 of your names to their Exec Producer, a woman named Suzanne Prytherch, so if she calls and says I told her to, she's legit. If some of you are interested, we'll convene in Fort Worth!

Now for the news: I'm returning from Hawaii, where I did a speaking/consulting visit for Don Char at the University of Hawaii and then attended and spoke at the Pacific Coast College Health Meeting. I missed seeing Cathy there, but she was in DC for the FIPSE grant meetings...and Paul, Lee, Rich, and Joy, all of whom couldn't go for other reasons...but I'll see Cathy, Lee, and Rich at the CDC meeting in DC. I've just finished scheduling (rescheduling, actually) an appearance at Penn in February, so will see Chris then (as well as in DC next month), and am waiting for Annie to invite me back to Delaware (hint, hint).

Weather report: Hawaii was wonderful...I'm still waiting for a formal apology from Paul Walters for all the rain when I was at Stanford...but I'm told that I'll be flying back into rain and cold in Charlottesville.

Thanksgiving has come and gone without my getting a Communication out to you in time to wish you a blessed and peaceful one, but know that I was thinking of all of you as I remembered my gifts this year. Thank you for all you are, all you do, and all the wisdom you've given me.

Keep in touch, please; I've attached a return sheet, since that seems to work well.

COMMUNICATION #3-12
ACHA TASK FORCE ON AIDS
RETURN SHEET

Return to: Rich Keeling
Box 378
University of Virginia Medical Center
Charlottesville, Va 22908

Your Name _____

1. Please enclose your copy of the revised *General Statement*
draft, red-marked. Any additional comments? _____

2. Comments on the revision of the NIMH material?

3. Any items you would like the Task Force members present
in DC on December 13 to discuss?

4. Any comments regarding the CDC seroprevalence study?

COMMUNICATION #3-11

To: All members of ACHA Task Force on AIDS

From: Rich Keeling *RC*

Date: October 29, 1987

Method: First Class Mail

By now, you all should have received Communication #3-10, which is a Working Communication, so to speak, in that it tells you a lot of stuff and asks you to respond on a number of important points, especially regarding the revision of the *General Statement on Institutional Response to AIDS*. This one is a less intense one by a long shot -- I'm sending it mostly to transmit a bunch of information that wasn't ready to go in the other packet.

This is just a series of materials that you might find useful in your individual work:

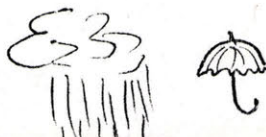
1. An editorial by the Surgeon General from last week's issue of JAMA, which deals with ethics and responsibility in the provision of medical care.
2. An AMA interim report from the same issue of JAMA, which details the strategies the AMA proposes using to control the epidemic. Most of it you will agree with; some of it you will not.
3. Two sample model letters designed for use in college settings by people in the New York City Public Health Department; they can be adapted for use in colleges in lots of other places, as well. Feel free.
4. Copies of a wonderful complimentary letter we got about our pamphlets.

Anyway, this communication needn't cause you any heartburn -- not "more work," as Lee's mailman says. It's just FYI.

I'm flying along on the way to Stanford at the moment, by the way, looking forward to the wonderful, unequalled weather that Paul has promised me. The weather report therefore refers to the interior of a Piedmont Boeing 727, which is dry and cool at the moment...

!! ★

URGENT NEWS UPDATE: I AM NOW RETURNING FROM STANFORD. IT WAS CLOUDY AND RAINY ALL DAY YESTERDAY AND IT WAS RAINING WHEN I LEFT THIS MORNING. PAUL WALTERS BLAMES ALL OF THIS ON ME -- SAYS I BROUGHT IT WITH ME -- BUT MAYBE, JUST MAYBE, WE'VE BEEN SERIOUSLY MISLED FOR ALL THESE MONTHS...IT DOES RAIN IN PALO ALTO.



Keep in touch!
RC

Physician Leadership in Preventing AIDS

This week's *JAMA* includes "Prevention and Control of Acquired Immunodeficiency Syndrome [AIDS]: An Interim Report,"¹ a report from the American Medical Association's (AMA) Board of Trustees. This report is part of the continuing joint efforts of the AMA, the Public Health Service, other health professional organizations, and the community at large to prevent and contain the spread of human immunodeficiency virus (HIV). The AMA is to be commended for its foresight and progressive approach.

See also p 2097.

Acquired immunodeficiency syndrome is not like any disease or syndrome we have faced before. By its nature, AIDS raises unnecessary fear and unwarranted complacency at the same time. Its complexity causes misunderstandings. However, in the area of prevention, the prevention message of the Surgeon General's report on AIDS² is as valid now as when it was issued almost a year ago. The report of the AMA Board of Trustees reinforces and expands on these concerns in a balanced and responsible manner.

While the containment of HIV is everyone's responsibility, society has given us as physicians the scientific mandate to provide leadership in this situation. As the Surgeon General of the Public Health Service, I ask that you join with me in assuming this leadership for the benefit of all of us.

There are a variety of ways in which you can help. Since there is neither a vaccine to prevent nor a cure for AIDS, and since sexual activity is by far the most frequent mode of transmission, I wish to focus on prevention of sexual transmission of AIDS. My moral and religious background has made it difficult for me, as it may be for you, to discuss sexual issues in public. The frankness of my report on AIDS in October 1986 shocked many. I had no choice as a health officer when the alternative is almost-certain death.

The emphasis in the media on condoms for protection against HIV infection has diluted an important message: for those who are abstinent or those who have a mutually faithful monogamous sexual relationship, AIDS presents no problem. But for sexually active individuals who are neither abstinent nor have a mutually faithful monogamous relationship, we have little to offer except condoms. I am asking you to make yourselves as knowledgeable about condoms as possible.

Condoms are not 100% effective, but if correctly used they can dramatically reduce one's risk of exposure. Only latex condoms should be used, since natural membrane products may not prevent viral transmission. The Food and Drug Administration is moving aggressively to ensure that the condom industry's standard of no more than 4/1000 condoms failing the leakage test is met. Based on reports presented at the Third International Conference on AIDS, I also recommend that condoms be supplemented by lubricating with a jelly or cream containing at least 65 mg of nonoxynol 9.

The greatest problem with condoms is that many people do not know how to use them. Condoms should be placed on the penis after it becomes erect and before it comes in contact with the body of the sexual partner. The condom should be

rolled onto the penis, leaving a small space at the end, but allowing no air pockets beyond that point. The penis should be withdrawn from the partner before the erection is lost. A new condom should be used with each sexual act.

As a physician you should tell your patients this:

1. Acquired immunodeficiency syndrome cannot be transmitted by casual nonsexual contact. Dispel the myths about AIDS. Questions from your patients may signal deep-seated, unreasonable fears.

2. Never inject unsterilized materials into your body or use previously used injection equipment. Acquired immunodeficiency syndrome is spread by tiny amounts of blood that may be in syringes, needles, or drugs.

3. Abstain from sex with individuals other than seronegative partners. They should not have had intercourse with others for six months prior to or any time after testing negative for HIV. Partners must have abstained from having sex with other people as well.

4. A woman who tests positive for HIV antibodies should be advised that AIDS may be passed to any child she conceives.

5. If in doubt, seek a blood test performed by a physician or other health provider after discussing the meaning of such a test with him or her. Follow his or her advice after you receive the test results. Patients should be informed that physicians are required to keep results in confidence, sharing the information only with other professionals who need to know. The physician should discuss the advisability of notifying a spouse or other sexual contacts.

6. Do not practice anal intercourse; the rectal mucosa bleeds easily and provides an entry for HIV. Condoms provide some protection, but anal intercourse is simply too dangerous a practice. Since the AIDS epidemic began, the majority of AIDS cases in the United States probably became infected by anal intercourse.

7. Abstain from sex with people you do not know, with certainty, to be uninfected. Beware of people who belong to organizations that offer "sexual safety" because they issue a health card. Such cards are always out of date and such people usually have a reason for being tested.

8. If you have any doubts about your sexual partner, require the use of a condom. You should have doubts about anyone who has had sex with anyone other than yourself.

I think that most physicians will agree that AIDS is the most pressing public health problem in America. If the public will heed and practice the advice above, I believe that the AIDS epidemic can be contained. If not, AIDS will be with us for a long time to come. You as physicians are the best-equipped people in the country to help in the struggle. Some of you find it unpleasant to recommend condoms to young people. So do I. Acquired immunodeficiency syndrome is an unpleasant disease and recommending condoms to those who need protection is preferable to treating AIDS.

The people of America need your help and guidance. Use these rules to help them, for they are your patients, and, in a way, our patients.

C. Everett Koop, MD, ScD
The Surgeon General of the
Public Health Service
Rockville, Md

1. Prevention and control of acquired immunodeficiency syndrome: An interim report, BOARD OF TRUSTEES REPORT. *JAMA* 1987;258:2097-2103.

2. Koop CE: Surgeon General's report on acquired immune deficiency syndrome. *JAMA* 1986;256:2783-2789.

Prevention and Control of Acquired Immunodeficiency Syndrome

An Interim Report

RESPONDING sensitively, intelligently, and effectively to the growing acquired immunodeficiency syndrome (AIDS) crisis is one of the crucial public health problems facing the nation. Prevention and control of the disease must be an essential part of that response because there is, at present, no known cure for AIDS.

For editorial comment see p 2111.

Recommendations in this report have as their foundation an overriding concern for a judicious balance between the well-being of human immunodeficiency virus (HIV)-positive patients and the protection of the public health. These recommendations are based on the best information and data available at present. The American Medical Association (AMA) will continuously monitor and analyze developments in AIDS and update AMA policy and recommendations as dictated by advances in knowledge.

Education continues to be the major weapon against the spread of HIV infection. Physicians should assume the leadership role in educating themselves, their patients, and the public. Individuals in society also must assume

responsibility for being well informed and for actions that affect their own health and the health of others. In developing this report, the Board emphasizes the need for concerted and cooperative efforts by all members of society in the fight against AIDS. The recommendations outlined later herein are designed to help successfully confront this challenge to society's well-being.

BACKGROUND The Current Climate

It is estimated that 5 to 10 million people are infected with HIV worldwide, and AIDS has been reported in more than 100 countries. In the United States, HIV-infected individuals may number 1.5 million, approximately 35 000 of whom have been reported to suffer from AIDS and more than 20 000 of whom are dead.

The Public Health Service has projected that by 1991 there may be 323 000 reported patients with AIDS and that as many as 200 000 of them may be dead by that time. In addition, conversion rates of seropositive people to AIDS status now seem to be higher than early preliminary estimates. Originally, fewer than 20% were thought to convert. It now seems that, without treatment advances, a much higher percentage will develop the disease.

Seventeen percent of the patients with AIDS have been intravenous (IV) drug abusers, 66% have been homosexual/bisexual men, and 8% have been homosexual male IV drug users;

women, heterosexual men, and pediatric patients infected by the transfusion of blood or blood products, by sexual contact, or prenatally, in the case of infants, account for the bulk of the balance.

Polls indicate that AIDS has become the highest priority health concern of the American public, ahead of heart disease and cancer. It has already caused changes in a variety of public attitudes. Sexual abstinence, monogamous relationships, and the use of condoms are being widely promoted in the media by public officials and many private organizations. Intravenous drug abusers are being counseled to use clean needles and to avoid sharing needles. Education on the sexual transmission of the AIDS virus is being extended to schoolchildren. The nation is more sensitive to the rights of those afflicted with the disease to be free from discrimination, regardless of the manner by which they became infected.

Historical Control Measures for Infectious Diseases

A primary mode of transmission of AIDS is through sexual contact, and the

From the Board of Trustees, American Medical Association, Chicago.

This report was taken directly from Report YY, which was approved by the House of Delegates of the American Medical Association at the Annual Meeting, June 21 through 25, 1987.

Reprint requests to the American Medical Association, 535 N Dearborn St, Chicago, IL 60610 (James H. Sammons, MD).

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control efforts for sexually transmitted diseases (STDs) that have been instituted in the past are sources of analogies for prevention and control of AIDS. National programs to control STDs were established during the beginning of World War I. For the following 50 years, the focus was almost exclusively on the control of syphilis and its complications. During World War II, rapid-treatment centers for syphilis and gonorrhea were established. Public health officials instituted limited contact tracing, had the authority to close sex bars and clubs and to order tests for prostitutes, and, most important, had effective therapy to offer. Widespread availability of penicillin led to dissolution of the rapid-treatment centers and of the clinical specialty of syphilology. Every state in the Union at one time required all persons seeking marriage licenses to be tested for syphilis. During the 1950s and 1960s, federal assistance programs continued to support contact tracing, serological screening, and patient education.

In the late 1960s, public health officials were concerned about the rapidly escalating number of patients with gonorrhea, and projects were instituted to increase case-finding and contact tracing. In 1972, financial assistance for STD control by the federal government was dramatically increased, and by 1982 gonorrhea accounted for nearly three fourths of the federal STD dollar. During the 1970s, gonorrhea control efforts evolved through overlapping phases that included objectives to lower the incidence of disease and the occurrence of drug-resistant bacteria, that focused screening on high-risk patients, that intensified follow-up of treatment failures, and that used patient counseling as a means of increasing compliance with therapy and of improving contact tracing. The latter was deemed especially important since the large numbers of patients with gonorrhea precluded the intensive follow-up of each infected person that had been characteristic of the syphilis era.

In 1982, the World Health Organization/Pan-American Health Organization identified the following key objectives for intervention to reduce STDs: (1) to minimize disease exposure by reducing sexual intercourse with persons who have a high probability of infection; (2) to prevent infection by increasing the use of condoms or other

prophylactic barriers; (3) to detect and cure disease by implementing screening programs, providing effective diagnostic and treatment facilities, and promoting health-seeking behaviors; (4) to limit complications of infections by providing early treatment to symptomatic and asymptomatic infected individuals; and (5) to limit disease transmission within the community through the previously mentioned efforts.

These objectives were used as a framework for the current US program regarding STDs, which consists of the following components: health education and promotion, disease detection through testing and other means, appropriate treatment, contact tracing and patient counseling, clinical services, training, and research.

The Challenge of AIDS Control

It might seem reasonable to extend the experience in preventing the spread of other STD infections to the AIDS epidemic. The objectives established by the World Health Organization/Pan-American Health Organization and the components of the current national STD program are certainly applicable to AIDS. However, AIDS presents a much different social problem than other STD infections. Since there is no cure for AIDS and no protection beyond avoiding or making safer intimate contact with infected individuals, those infected with the virus must be sexually isolated from uninfected persons. A condom barrier offers some but not complete protection. Avoiding sexual contact and not sharing needles are the only sure protections.

Further, the stigma that accompanies a diagnosis of AIDS, based on fear and society's attitude toward IV drug abusers and homosexuals, presents a factor beyond the control of the infected individual or medicine. An HIV-seropositive individual who might live five years or much longer with no overt health problems, once identified in a community, may be subject to many and varied discriminations—by family and loved ones, neighbors and friends, employers and fellow employees, and other providers of services.

As with prevention and control of all contagious diseases, prevention and control of AIDS involves two, sometimes competing, concerns. First, the person who is afflicted with the disease needs compassionate treatment, and

both those who have the disease and those who have been infected with the virus should not be subjected to irrational discrimination based on fear, prejudice, or stereotype. Second, and of critical importance, the uninfected must be protected; those individuals who are not infected with the AIDS virus must have every opportunity to avoid transmission of the disease to them.

THE NEED FOR A NATIONAL POLICY ON AIDS

Given the growing dimensions of the crisis and given limited national resources, it is imperative that a national policy be developed jointly by the public and the private sectors. Such a policy must seek, in a cost-effective way, to achieve fundamental national goals: prevention, treatment, and cure—and adequate research in all three areas. A coherent national approach to this modern killer is needed: a comprehensive blueprint for a national response, not piecemeal solutions. Knowledge of the disease is now more than six years old, and the growing magnitude of the problem has been apparent for nearly that long.

Such a national policy must have certain characteristics:

- The policy must be comprehensive, proceeding simultaneously on the fronts of prevention, treatment, and research.
- The policy must be coordinated between public and private sectors and between the different levels of government. A national policy does not necessarily mean a federal policy: there are important roles at all levels of the health care systems and at all levels of government. Nor does it necessarily mean uniformity: on certain issues different approaches should be tried to determine efficacy.
- The policy must be carefully balanced. For example, concern for the person with the disease must be balanced with concern for those who do not have the disease but who may become infected. Similarly, careful consideration must be given to directing scarce resources toward increased prevention, even as increasingly large resources are necessarily devoted to research and treatment.
- The policy must be based on scientific information and medical judgments. Although policy choices must

inevitably be made, they should be formed using the best available information and using the extensive public health experience in dealing both with AIDS and with other contagious diseases.

- The policy should be nonpartisan. Although it may be tempting to play on fears and prejudices, public figures and officials both inside and outside the health community should avoid exploiting the crisis for partisan political advantage.

- The policy should be capable of continuous review and modification as more and better information becomes available.

Recommendation 1

A commission, modeled after the commission that made recommendations on the problems of Social Security financing in the early 1980s, should be formed with representatives from the executive branch of the federal government, the Congress, state and local governments, and the private sector and directed to develop a consensus position for consideration by the Congress, the Executive, state and local governments, and private associations and institutions. The presidential commission that has been announced, but not yet appointed, by the Administration could be broadened to implement this recommendation. A high-level body with representatives from the different branches and levels of government, but operating to the side of the more formal political processes, may have the best chance of forging the necessary national consensus that can then become the basis for concerted and coordinated action by both the public and the private sectors.

THE SPECIAL ROLE OF PHYSICIANS AND OTHER HEALTH CARE COUNSELORS

Because there is no cure for AIDS, effective preventive techniques are vital. This involves both those who are infected and those who are not. Those who are infected must be identified so that they will not unknowingly transmit the disease to others. Many who are not infected will need to change their behavior substantially to minimize their risk of infection by the AIDS virus.

The key to changed behavior is public education coupled with counseling, which must be given by physicians and other health care counselors.

Public Awareness

The public is well aware of AIDS in a general sense. The attention of the media has been intensively focused on the disease. Translating general awareness into modifications of behavior is the challenge.

The groups that are most at risk for AIDS, eg, IV drug abusers, homosexuals, bisexuals, and prostitutes, have reason to know they are at risk. Their contacts, however, may not know they are at risk, and, hence, spouses, unborn babies, and premarital and extramarital sexual partners may become infected. Education and counseling aimed at the high-risk groups must be the first priority. The education should urge immediate counseling with a physician or other health care counselor about the risk of AIDS, the uses of antibody testing, and preventive measures.

Also, it must be recognized that persons in these groups may not respond to education and counseling; when they do not respond, more aggressive programs, such as expanded methadone maintenance programs or penalties for knowingly exposing others, must be considered.

Education aimed at the more general population is difficult for at least two reasons. First, reaching all Americans with an effective message can be expensive, and not all people respond in the same way or to the same method of learning. Messages must therefore be tailored to the target audience in question. Second, preventive messages must necessarily deal with controversial subject matter. Widespread use of the electronic media—especially television—seems to be the most effective way to reach the general public. Accordingly, public service advertising (PSA) on the electronic media must be greatly increased, and these announcements must be shown at times and in places where they will be viewed by those who need the message most.

The AMA will continue its efforts to place its own PSAs on national television. The AMA's PSA with Tony Danza directed at teenagers about abstinence and condoms, and other PSAs that the networks have agreed to use, are significant first steps. But more must be done, and the campaign must be nationally coordinated.

Recommendation 2

The communications industry must develop voluntary guidelines for PSAs

regarding AIDS in consultation with the health care community and government officials. The AMA intends to be a catalyst in this effort to immediately bring the communications and health care communities together.

Counseling and Educating Counselors

Perhaps the greatest ~~need~~ at the present time is effective counseling of both low- and high-risk populations by physicians or other health care counselors. A massive education effort for physicians and other counselors is necessary as a first step. Complete and accurate information about the disease, the modes of transmission, the appropriate application of antibody testing, and effective ways to change behavior must be understood by counselors if it is to be properly communicated to patients. In conjunction with face-to-face counseling, printed materials—like the Surgeon General's recent 36-page report on AIDS—should be widely disseminated.

Even more challenging than preparing physicians and others for generic counseling on AIDS is preparing these counselors to assist those who test positive and are infected with the virus. It is at that time that a change of behavior on the part of the person infected is most critical, and it is then that the most sophisticated counseling is required, due to the emotional impact of the test results. There is no higher prevention priority than ensuring that the community of individuals who provide health care counseling be given adequate tools to be effective. And the AMA, as the largest organization of physicians in the world, must take a leading role in this undertaking.

Recommendation 3

A conference should be held immediately between the AMA, other physician organizations, and public health officials at all levels of government to determine (1) the types of education and training that are necessary for effective counseling; (2) the people in the health care community who should receive this education and training; (3) the current resources available for such education and training; (4) recommendations for providing additional resources, including consideration of the respective roles of medical associations and government at all levels; (5) recommendations on

how to update information continually as new scientific data are developed; and (6) recommendations for alternative measures to prevent the spread of AIDS where education and counseling are not likely to be effective, particularly among IV drug users, through such programs as expanded methadone maintenance. The AMA will promptly and widely report on the conference findings and assist in the implementation of the recommendations.

Voluntary and Mandatory Testing

Knowledge that a person is infected with the AIDS virus can be the crucial predicate to changing behavior. Thus, testing for an antibody to the AIDS virus, when used in conjunction with appropriate counseling (and when offered in the context of appropriate anti-discrimination and confidentiality protections discussed later herein), serves the important public health purpose of providing impetus for behavior changes that minimize the risk of transmitting the AIDS virus.

Clearly, the need for HIV antibody testing has expanded beyond its original purpose, the screening of blood donors. Guidelines for the appropriate use of HIV antibody testing must center on the following justifications: (1) to identify infected persons and offer treatment where possible and to protect uninfected third parties, (2) to offer education and counseling that would modify high-risk behavior, (3) to solicit patient cooperation for locating and referring sex partners, and (4) to obtain broadened epidemiologic statistics on the prevalence of HIV infection in the population.

In addition, in considering the merits of voluntary vs mandatory testing, these facts about AIDS must be kept in mind:

1. AIDS is caused by an infectious agent and, therefore, is an infectious disease. Appropriate precautions, procedures, and policies should be applied to protect the community from the spread of the disease.

2. The extent to which the AIDS virus already has spread into the general population is not completely understood. Current projections are based on a number of unverified assumptions.

3. The transmission of the AIDS virus does not occur through casual contacts. Sexual contact, contact with septic IV equipment, and the adminis-

tration of infected blood and blood products are the main modes of transmission.

4. Heterosexual transmission of the AIDS virus, especially from men to women, does occur.

5. Seropositive pregnant women will transmit the virus to their babies in a high percentage of cases.

6. Health care workers, especially those who perform invasive surgical procedures, and emergency department and laboratory personnel, are at some risk when caring for patients with AIDS.

7. No patient with a clinical case of AIDS has survived the disease. The disease has been uniformly fatal.

8. The disease, not its victims, is the threat from which society must be protected.

9. The confidentiality of the physician-patient relationship is vitally important but not absolute.

10. Physicians have an ethical and professional obligation to behave in a scientifically responsible manner.

All of these considerations guided the Board of Trustees as it considered the issues that have been raised by the wide variety of proposals for HIV antibody testing that are being discussed in society.

General Conclusions

Except for individuals in the limited categories listed in recommendation 5 later herein (blood, organ, and semen donors; immigrants; military personnel; and prison inmates), for whom testing serves well-established and well-accepted protection goals, mandatory national testing should not, at present, be broadly extended.

Military personnel have traditionally been subjected to mandatory immunizations, and our defense forces, of course, must be as strong as possible. Prison inmates, because they are confined and have a higher incidence of high-risk individuals than the general population, require special protection. Immigrants should be tested so that we can focus on the AIDS problem already here, and the nation certainly has the right to bar entrants with communicable diseases. The need to test donors of blood, organs, and semen has never been questioned.

Public health authorities have advanced a plausible premise for their opposition to mandatory testing of ho-

mosexuals and drug abusers: such testing will only drive people underground and away from the health care system. Public health authorities also have advanced a premise for not requiring mandatory testing of large segments of the general population, such as all those seeking marriage licenses or all those admitted to hospitals: such testing in low-prevalence populations would result in a high proportion of false-positive results and would not be cost-effective, given the demand for voluntary testing and the shortage of testing and counseling resources for those who voluntarily want them or who will want them following effective public awareness campaigns.

Until those premises are shown by superior studies to be incorrect, a policy regarding mandatory testing that has been rejected by the vast majority of public health officials, including the Centers for Disease Control (CDC) and the Surgeon General, cannot be recommended.

But certain high-risk groups should be regularly tested, with the right to informed consent and to refuse the test. Those groups are defined in recommendation 6.

In addition, physicians and other hospital personnel involved in invasive surgical procedures, who necessarily and unavoidably come in contact with the blood of patients, need to be aware of their risks. Limited regular testing of patients will ensure that the CDC guidelines for the protection of hospital personnel are followed rigorously and will further ensure that all patients receive prompt and full treatment. The Board emphasizes here that physicians have a long and honored tradition of tending to patients afflicted with infectious diseases with compassion and courage. That tradition must and will be continued throughout the AIDS epidemic.

Because the risk to health care personnel will be slight in most areas, any effort at mandatory testing of certain kinds of patients should be instituted after voluntary testing has failed and where a variety of factors, eg, the costs and availability of proper testing and counseling as measured against the risk presented by the relative presence of a high-risk patient population, weigh in favor of mandatory testing.

The AMA does not believe it appropriate at this time to extend regularly

offered testing to persons other than those listed, eg, recommended testing should not be extended to all individuals who are considering marriage or to all persons in hospitals. Decisions about whether there should be generally recommended testing of other types of individuals should, at this time, be left to the decision of the local community, depending on its own circumstances and the judgments of its own public health officials.

At present, each case of AIDS must be reported by the individual physician to state public health authorities either by name or identifier. Anonymous or carefully implemented confidential reporting should also be extended to all confirmed instances of persons infected with AIDS virus but not afflicted with AIDS-related complex (ARC) or AIDS. Individuals who are seropositive for the HIV antibody are infected with the virus and can spread the disease as certainly as those with symptoms of AIDS. A sound epidemiologic understanding of the potential impact of AIDS on society requires the reporting of those who are confirmed as testing positive for the antibody to the AIDS virus.

Testing Recommendations

Recommendation 4

Tests for the AIDS virus should be readily available to all who wish to be tested. The tests should be routinely subsidized for individuals who cannot afford to pay the cost of their test.

Recommendation 5

Testing for the AIDS virus should be mandatory for donors of blood and blood fractions, organs, and other tissues intended for transplantation in the United States or abroad; donors of semen or ova collected for artificial insemination or in vitro fertilization; immigrants to the United States; inmates in federal and state prisons; and military personnel.

Recommendation 6

Voluntary testing should be regularly provided for the following types of individuals who give informed consent: (1) patients at STD clinics, (2) patients at drug abuse clinics, (3) pregnant women in high-risk areas in the first trimester of pregnancy, (4) individuals seeking family planning services who are from areas with a high incidence of AIDS or who engage in high-risk behavior, and

(5) patients requiring surgical or other invasive procedures who are from areas with a high incidence of AIDS or who engage in high-risk behavior. If the voluntary policy is not sufficiently accepted, the hospital and medical staff should consider a mandatory program for the institution.

Recommendation 7

As a matter of medical judgment, physicians should encourage voluntary HIV testing for individuals whose history or clinical status warrant this measure.

Recommendation 8

Individuals who are seropositive for the AIDS virus should be reported to appropriate public health officials on an anonymous or confidential basis with enough information to be epidemiologically significant.

Recommendation 9

Physicians should counsel patients before tests for AIDS to educate them about effective behaviors to avoid the risk of AIDS for themselves and others. In public screening programs, counseling may be done in whatever form is appropriate given the resources and personnel available as long as effective counseling is provided.

Recommendation 10

Physicians should counsel their patients who are seropositive regarding (1) responsible behavior to prevent the spread of the disease, (2) strategies for health protection with a compromised immune system, and (3) the necessity of alerting sexual contacts, past (five to ten years) and present, regarding their possible infection by the AIDS virus. Long-term emotional support should be provided or arranged for seropositive individuals.

Recommendation 11

Patients should knowingly and willingly give consent before a voluntary test is conducted.

RESOURCES

Only recently has Congress and the Administration begun to seriously consider the vast resources needed to deal effectively with AIDS. Federal funding for 1988 is expected to reach \$1 billion. But that amount will not be enough. The AMA endorses the bill introduced by Congressman Waxman to increase

resources for testing and counseling.

Testing for HIV in America will require substantially more resources than are currently being made available. Trained counselors, materials for counseling, and research on effective counseling approaches, for the variety of population groups that need these services, are urgently required. Also, dependable testing facilities with sufficient capacity to respond to the epidemic are needed now. In addition, funds for research and care must be increased to fully exploit the nation's capacity to respond effectively to this crisis.

The key premise of a prevention strategy, when there is no vaccine, is behavioral change on the part of those infected and those at risk of infection by the AIDS virus. It is therefore crucial that there be immediate and systematic studies conducted of how behavior of affected groups may have changed in recent years, and, if possible, what factors caused the changes. Most particularly, it is necessary to study and evaluate the types of counseling that have been effective so that the techniques may be replicated widely. There can be little question that in a free society, suasion and voluntary change, if effective, are far preferable to compulsion.

Recommendation 12

Public funding must be provided in an amount sufficient (1) to promptly and efficiently counsel and test for AIDS, (2) to conduct the research necessary to find a cure and develop an effective vaccine, (3) to perform studies to evaluate the efficiency of counseling and education programs on changing behavior, and (4) to assist in the care of patients with AIDS who cannot afford proper care or who cannot find appropriate facilities for treatment and care.

PROTECTION AGAINST DISCRIMINATION **Antidiscrimination**

The AMA believes strongly that patients with AIDS and those who test positively for the antibody to the AIDS virus should not be treated unfairly or suffer from arbitrary or irrational discrimination in their daily lives. Last year, the AMA filed a friend-of-the-court brief in *School Board of Nassau County vs Arline*, a case before the Supreme Court that addressed the question of how the federal handicapped

antidiscrimination laws should apply to persons afflicted with contagious diseases. The AMA set forth a framework for the application of the law, which the Supreme Court adopted, quoting verbatim from the AMA brief in its key holding.

A sound antidiscrimination approach does not allow reflexive discrimination against patients with AIDS based on fear or stereotype or prejudice. Nor does it require that all employers or other federal fund recipients automatically accommodate a person afflicted with a communicable disease. Instead, based on an individualized analysis of the nature and duration of the handicap and the nature and duration of the communicability, a federal fund recipient must make a reasonable accommodation based on reasonable medical judgments, given the state of medical knowledge at the time. This sound framework for carefully balancing the two competing concerns—the right of the afflicted to be free from irrational acts of prejudice and the right of others to be protected against an unreasonable risk of disease—should also guide state antidiscrimination efforts.

A key question left open by the Supreme Court is whether a person who is not afflicted with AIDS or ARC, but who nonetheless tests positive for the antibody, is protected by the federal antidiscrimination law.

To encourage people to seek counseling, and testing if necessary, the AMA strongly urges that antidiscrimination laws at both the federal and state levels be clarified either by regulatory interpretation or by statutory amendment to cover those who test HIV antibody positive. Allowing irrational discrimination against those who test positive serves no useful purpose: it only has the destructive effect of removing those who are otherwise productive members of society from the work force or otherwise denying them access to an important aspect of normal life. While federal law should continue to apply only to federal fund recipients, state laws should be sought to prevent irrational discrimination by entities or individuals within those jurisdictions.

Recommendation 13

Antidiscrimination laws must be clarified or amended to cover those who test positive for the antibodies to the AIDS virus.

Confidentiality

The ability of the health care community to maintain the confidentiality of patient information and to restrict its use to only those purposes essential for maintenance of health is, like clarification of antidiscrimination laws, vital to an effective program of preventing and controlling AIDS. Even if antidiscrimination laws were completely effective, which unfortunately is not likely, persons who test positive (such as those with ARC or AIDS) will suffer stigma. Thus, confidentiality is crucial.

The basic principle should be that access to patient information should be limited only to health care personnel who have a legitimate need to have access to the information to assist the patient or to protect the health of others closely associated with the patient.

As with antidiscrimination laws, laws protecting the confidentiality of patient information should be on both federal and state agendas.

Recommendation 14

Model confidentiality laws must be drafted that can be adopted at all levels of government to encourage as much uniformity as possible in protecting the identity of patients with AIDS and AIDS carriers, except where the public health requires otherwise.

QUESTIONS FOR THE FUTURE

As the national debate on prevention and control of AIDS continues, other important issues will need to be addressed.

Research and Data

There is an urgent and critical need for more scientifically sound data on the prevalence and spread of virus in the general population. At the present time, only those cases that meet the current CDC surveillance definition of AIDS are reported to that institution. Since AIDS is the terminal and fatal stage of HIV infection, it represents only the tip of the huge HIV infection iceberg. There are protean manifestations of HIV infection ranging from infected asymptomatic to full-blown AIDS. How large the base of that iceberg really is—that is, how many people are actually infected—can only be estimated from the number of reported cases of AIDS. That has been done by using a multiple (50 to 100 times the number of AIDS cases) that has been

extracted largely from surveys done in high-prevalence areas. Yet, this same multiple has been used to estimate the number of current and potential HIV-infected persons in low-prevalence areas and, for that matter, in the entire country and even in the world. The CDC itself is unsure about the accuracy of its estimates. Yet, if economic and medical plans are to be made for the future, reliable projections must be available. How sufficient or exaggerated these plans may be depends on the accuracy of current and future estimates of the number of HIV-infected persons, particularly as to the extent of its spread into the low-risk heterosexual population.

Not only are accurate estimates of the number of HIV-infected persons needed, but so too are reliable data on the rate conversion of asymptomatic seropositive persons to clinical illness, including AIDS, requiring increased medical care. This information is important for the formulation of plans for the future of potentially hospitalizable patients and the economic consideration thereof. Infection with HIV has protean manifestations, and death can result not only from AIDS itself, but from severe ARC or progressive central nervous system disease as well. To obtain accurate information in HIV-infected persons on the rate of conversion from asymptomatic to clinically severe illness, baseline data on their serological status must be obtained as early as possible—not after clinically manifested disease is present. The presence of HIV antibodies indicates not only current infection with the virus, but also that the patient is potentially capable of transmitting the disease. This follows from the fact that HIV integrates its genome into the host cell genome, with the result that once infected, the patient remains infected for life and is, therefore, capable of lifelong transmission of the agent. The earlier the infected person is detected, the earlier he or she may be advised of this contagious state and counseled on how to avoid further transmission of this lethal virus.

Recommendation 15

Consistent with the proposal by the Secretary of Health and Human Services, a national study in various areas of the country must be immediately undertaken to determine the preva-

lence and conversion rate of the virus in the US population, and the study must be repeated at appropriate intervals to gauge the spread of the disease.

Warning to Third Parties

One of the more difficult issues for society is how to warn unsuspecting spouses or sexual partners of persons who test HIV positive. Such a warning would allow the third party to practice "safer" sex or to abstain from sexual relations with the infected person altogether. Given the life-or-death consequences, the unsuspecting third party should, as a general matter, be warned because there is no cure and because it may not be responsible to rely solely on the infected person to provide a suitable warning.

Physicians who have reason to believe that there is an unsuspecting sexual partner of an infected individual should be encouraged to inform public health authorities. The duty to warn the unsuspecting sexual partner should then reside with the public health authorities as well as the infected person and not with the physician of the infected person.

The AMA believes that mechanisms, analogous to those used by public health

authorities to warn sexual partners about other STDs, should be put in place to warn unsuspecting third parties about an infected sexual partner. Such warning may be appropriate whether the infected person is bisexual, heterosexual, or homosexual.

This problem raises the general question of whether anonymous reporting should continue to be the standard for persons who test seropositive. Our recommendation at this time is limited to situations where physicians or health officials already know the identity of the AIDS carrier and have reason to believe that a risk to third parties exists.

Recommendation 16

Specific statutes must be drafted that, while protecting to the greatest extent possible the confidentiality of patient information, (1) provide a method for warning unsuspecting sexual partners, (2) protect physicians from liability for failure to warn the unsuspecting third party but (3) establish clear standards for when a physician should inform the public health authorities, and (4) provide clear guidelines for public health authorities who need to trace the unsuspecting sexual partners of the infected person.

Sanctions for Reckless Disregard for the Safety of Others

A related question that must be explored is whether an infected person, who knows he or she is infected and who knowingly fails to warn a sexual partner of the infection, should be subject not just to tort suits, but to a proceeding brought by state authorities to sanction the individual.

Recommendation 17

Given the risk of infection being transmitted sexually, and given the dire potential consequences of transmission, serious consideration should be given to sanctions, at least in circumstances where an unsuspecting sexual partner subsequently discovers a partner's infection and brings a complaint to the attention of authorities. Preemptive sanctions are not being endorsed by this recommendation.

CONCLUSIONS

The Board intends to review its evaluation of the developing AIDS epidemic on a constant basis. Modifications of the AMA's positions will be made as the situation warrants.

MODEL LETTER TO THE SCHOOL COMMUNITY

Dear Colleague/Employee:

No public health issue in recent history has affected New York City more acutely than the current AIDS epidemic. As members of the (school) community residing in New York City, we are equally affected. Some of you know a great deal about AIDS; others may not be as familiar with the disease. During this crisis it is vital that all of us be informed for our personal and communal welfare. There are four major issues I would like to address. I have chosen to be very explicit. I do not wish to offend, only to clarify.

First I would like to assure you that AIDS is not highly contagious. AIDS cannot be contracted by:

- * Working with someone with AIDS
- * Living with a person who has AIDS
- * Sharing eating utensils with a person who has AIDS
- * Touching people
- * Hugging
- * Airborn germs
- * Using public toilets, water fountains, or pools

Simply put, AIDS cannot be contracted casually.

People become infected with Human Immunodeficiency Virus (HIV), the virus associated with AIDS, almost exclusively through sexual intercourse or intravenous drug use. These activities (vaginal, oral, or anal intercourse) involve the exchange of blood, semen, or vaginal secretions. When these body fluids of an infected person enter the body of another person the likelihood of infection is high.

Second, AIDS does not discriminate. In New York City, AIDS is the number one killer of all men between the ages of 25 and 44 and of all women between the ages of 24 and 34. Since the incubation period is 5-10 years, what people do today can have a tremendous impact on the length and quality of their lives. Anyone having unprotected intercourse or sharing needles is at risk of contracting AIDS.

Third, the most effective ways for people to prevent the transmission of HIV is to never use intravenous drugs, never have intercourse and to only engage in sexual activity that does not involve the exchange of blood, semen or vaginal secretions.

If people have intercourse, they should protect themselves and their partner. A condom should be used and used properly.

Our school is more than a place to work. It is a community of all kinds of people who work, learn, study, play, and often live together. Just as AIDS is a problem New York City must confront, it is also a problem we must face - every employee, student, and anyone who is part of our community.

Finally, I would like you to think about the role you play at our school and the impact you have on others, particularly students. With little hope for a cure or vaccine for AIDS in the near future, there is only one way to control the further spread of HIV infection - EDUCATION. I urge you to be open to discussing AIDS with your associates and students, and when appropriate, make referrals to resources listed on the attached page.

Throughout the year, our school will be sponsoring a variety of educational programs in response to the AIDS epidemic. I urge you to attend these functions and take the AIDS crisis seriously. Your opinion is highly regarded. If you take AIDS seriously, so will others.

Sincerely,

School President

For Further Information Call:
New York City Department Of Health AIDS Hotline (718) 485-8111

MODEL LETTER TO STUDENTS

Dear Students:

No public health issue in recent history has affected New York City more acutely than the current AIDS epidemic. As members of the (school) community of New York City, we are equally affected. Many students, perhaps yourself, have questions, concerns, and even fears regarding AIDS. Some people have asked their professors about the disease while others have spoken to me personally. I would like to address three major issues of importance to all of us. Because it is vital that we understand each other, I will be very explicit. I do not wish to offend, only to clarify.

First, I would like to assure you that AIDS is not highly contagious. AIDS cannot be contracted by:

- * Going to school with a person who has AIDS
- * Living with a person who has AIDS
- * Sharing the eating utensils of a person who has AIDS
- * Touching people
- * Hugging
- * Airborn germs
- * Using public toilets, water fountains or swimming pools

Simply put, AIDS cannot be contracted casually.

People do become infected with Human Immunodeficiency Virus (HIV), the virus that is associated with AIDS, almost exclusively through sexual intercourse or intravenous drug use. These activities - vaginal, oral, or anal intercourse - involve the exchange of blood, semen, or vaginal secretions. When these body fluids of an infected person enter the body of another person, the likelihood of infection is high.

Second, AIDS does not discriminate. In New York City, AIDS is the number one killer of all men between the ages of 25 and 44, and of all women between the ages of 25 and 34. Since the incubation period is 5 to 10 years, what you do now has a tremendous impact on the length and quality of your life. Anyone having unprotected intercourse or sharing needles is at risk of contracting AIDS.

Third, the most effective ways to prevent the transmission of HIV is to never use intravenous drugs, never have intercourse, and to only engage in sexual activity that does not involve the exchange of blood, semen, or vaginal secretions.

If you have intercourse, protect yourself and your partner. Use a condom and use it properly. If you choose not to be sexually active, know that there are many other people who have made the same choice, and that abstinence is a very valid approach to personal safety.

.../...

Our school is more than just a place to take classes and pick up a degree. It is a community of all kinds of people who learn, study, work, play, and often live together. Just as AIDS is a problem New York City must confront, it is also a problem we must face - each student, faculty member, and anyone who is part of our community.

Throughout the year our school will be sponsoring a variety of educational programs in response to the AIDS epidemic. I urge you to attend these functions and take the AIDS crisis seriously.

Sincerely,

School President

For Further Information Call:
New York City Department Of Health AIDS Hotline (718) 485-8111

8-19-87

B. Johnson

American College Health Assoc.
15879 Crabbs Branch Way
Fechville, Maryland, 20855

RECEIVED

AUG 24 1987

AMERICAN COLLEGE
HEALTH ASS'N

Dear Sirs (and Ma'ams) :

I picked up your brochure "Aids: what everyone should know" at my campus health center. I live with my grandparents & thus hear a daily diatribe on the declining morals of today & how AIDS is "what some people get for living so loosely." That may be, it seems to me that arguing is useless against moral conviction. Anyhow, I have many friends who are homosexual or bisexual and it was really nice to read the part about AIDS not being a "moral comment" and how people in higher risk groups need support.

I appreciate greatly the matter-of-fact, calm way you presented the information, and I really appreciate the manner in which you tried to calm down some of the fear & panic over AIDS. I realize that this was your purpose, of course, I just wanted to let you all know that here's one citizen who appreciates your efforts!

Sincerely,
B. Johnson

COMMUNICATION #3-10

To: All members of ACHA Task Force on AIDS

From: Rich Keeling

Date: October 23, 1987

Method: Express mail or first class

A lot has been happening since my last communication. So much that writing communications has been impossible, for which I have to apologize. I appreciate the many responses I got from you in the last mailing; they have been tremendously helpful in getting pamphlets rewritten and the statement redone.

First, the news report.

1. WE RECEIVED THE CDC COOPERATIVE AGREEMENT. We were funded almost at requested budget level, with the strong message that our proposal was excellent and that it is highly likely that we will be renewed for each of the next five years. This is wonderful news, obviously; the agreement provides ACHA with about \$92,000 for the first year to begin our series of educational workshops designed to increase the number of colleges and universities providing AIDS education. Several of you are on the review panel for the project, and many of you will be participating in the regional workshops that will begin in the second semester.

a. we hired a coordinator: Doug Conaway. The Agreement specifies the appointment of a national coordinator, who will organize and implement the workshops from the ACHA office in Rockville. We are fortunate indeed that we hired Doug Conaway into this position. Doug is a graduate of the law school at Berkeley, and completed a year in the journalism program there before taking this job. He has worked extensively with Cathy Kodama in the AIDS prevention program there, and has volunteered time with other AIDS groups as well. Doug thinks and writes very well indeed; he will provide us real strength in the position. Having worked with him for a couple of years now, I can say that he is a trusted colleague and a valued friend. All of you will be hearing from him soon. Doug has just started work at ACHA; you can reach him at the main office number, 301-963-1100.

b. we need to plan a meeting of the Review Panel. Doug will be contacting those of you on the Review Panel to set up a meeting sometime in December, probably in Washington, to get us started. Doug is now working on the weekend of December 10/11/12 as the most likely time.

c. Doug is beginning to look at sites and times for the workshops. We are committed by the agreement with CDC to provide at least the first four regional workshops during the current academic year. Reality being reality, these will have to happen in the spring semester. We have tentative arrangements with some people on the Task Force and others who are ACHA Regional Representatives which look like this:

[1] Upper Midwest Region: to be held on or near the campus of Illinois State, with assistance provided by Mary Haskell (Regional Rep), Wayne Ericson (AIDS TF), and Paul Grossberg (AIDS TF).

[2] Northeast Region: to be held on or near the campus of Clark University in Worcester, MA, with the assistance of Barbara Driscoll (ACHA Vice President), Susan Shearer (Regional Rep), and, I hope, the AIDS TF people in the area...like Sue Cowell, David Kersey, Chris Lyman, Lora Pinsky (see new members, below).

[3] Southeast Region: to be held on or near the campus of Clemson University in South Carolina, with the assistance of Sandy Smith (ACHA Regional Rep), Bob Cargile (U. of SC, President of Southern affiliate), and AIDS TF people nearby.

[4] Pacific Southwest Region: may be held in San Diego or Long Beach, with the assistance of Lee Wessel (AIDS TF), Rich Wolitski (AIDS TF), and others. Lee has been working with Kevin Patrick, the Director at San Diego State, and it looks like we will be clear for a workshop there.

Specific dates, times, facilities, presenters, etc., are completely unknown at this point. Doug, however, will be working on that hard over the next few weeks.

d. a prototype workshop is possible. Bob Wirag (now at the University of Texas in Austin) has been talking with folks from SWASPA (Southwest Association of Student Personnel Administrators) about tagging a model CDC-type workshop onto

their annual meeting in February. SWASPA is real interested. This might provide an opportunity to meet, to "dry run" some of the materials and elements of the workshops, and to assess effectiveness of some of the presentations. More later.

e. other regions will be done beginning in the fall. We plan to have workshops in the Mid-Atlantic, Pacific Northwest, southern Midwest, etc. next year.

2. PAMPHLET REVISIONS ARE COMPLETED. Details:

a. **What Everyone Should Know.** We revised only the "People of Color" paragraph in this pamphlet. Several members of the Task Force favored either deleting the paragraph entirely or incorporating it into one of the other sections of the pamphlet. Most, however, wanted to keep it as a separate section with the same title. Revised text is now being set at the ACHA office for reprinting; I have depended on some excellent suggestions from many of you in rewriting the paragraph. It is slightly longer than before, and we have the space to allow for that in the pamphlet as it is designed. We eliminated the word "should" and have used terms which don't sound pejorative. I "piloted" the new text on some folks at the Rocky Mountain College Health Association meeting in Greeley last week with good results.

Having said all that, let me point out again that the number of complaints or reservations about the previous text were fewer than five in number. I wouldn't want any of you to feel that there was widespread concern expressed.

b. **Making Sex Safer.** This pamphlet is extensively revised in format because of the addition of photographs which add diversity. Jo Anne Ciperson and Anne Higley at the ACHA office are working with the graphics designer on it. They have had photographs taken of models for use in this and other pamphlets; people of several different ethnic backgrounds are to be pictured. I haven't seen the results yet, but I have confidence that we'll be happy with it.

The other revision in *Making Sex Safer* is a new chart of safe/unsafe behaviors on the back panel. It is taken from the one developed for the revision of *Safe Sex*, with the exception that the panel on *Making Sex Safer* will define watersports rather than use that term; this occurs in

response to concern expressed in some places that people didn't know what watersports was (were).

c. Safer Sex. The old *Safe Sex* brochure is retitled *Safer Sex* now. On this issue, the Task Force was unanimous! The format, photographs, and panel layout is exactly the same, but there is extensive rewriting of the text in accordance with recommendations made by many of you. This rewriting results in a complete re-do of the condom section, some significant changes in specific behavior descriptions, and a revision of the risk chart...the same one now incorporated on the back panel of *Making Sex Safer*.

IF THERE IS TIME BEFORE THIS GOES OUT IN THE MAIL, I WILL ENCLOSE COPIES OF THE REVISED TEXT FOR THESE PAMPHLETS. THE PROBLEM, HOWEVER, IS THAT MUCH OF THE FINAL WORDING WAS WORKED OUT IN MULTIPLE PHONE CALLS BETWEEN ME, STEVE BLOM, JO ANNE CIPERSON, DEB BLOM, AND ANNE HIGLEY AT ACHA. IF TIME PERMITS, I WILL TRANSCRIBE THE LAST REVISION AND INCLUDE IT IN THIS PACKET.

3. REVISION OF THE GENERAL STATEMENT ON INSTITUTIONAL RESPONSE TO AIDS. I enclose for your review and comment my draft of the revised General Statement based on many helpful suggestions received. I have particularly appreciated Sue Cowell's idea that we needed to reorganize and simplify the guidelines section a little, and you will see that has been done. There are updated CDC/MMWR references for safety precautions to protect health care workers and for the revised surveillance definition. I have taken Jeff Gould's advice and added a paragraph concerned harassment and discrimination. As all of you requested, the name of the virus has been changed throughout. Many (Cathy, Jeff, others) noted the need to comment more directly about sensitivity to the diversity of students on a campus, and I have done so.

YOUR JOB NOW: IS TO READ THIS DOCUMENT CAREFULLY. NOTE ANY SUGGESTED CHANGES. MARK IT UP, AND RETURN IT TO ME AS SOON AS YOU CAN. I KNOW MANY OF YOU ARE AS BUSY AND OVERCOMMITTED AS I AM, AND I APOLOGIZE FOR LEANING ON YOU ABOUT THIS -- BUT THE GENERAL STATEMENT IS A REAL IMPORTANT PIECE OF WORK, ONE WHICH WILL BE USED AS A STANDARD IN HIGHER EDUCATION. I THEREFORE SOLICIT YOUR PROMPT ATTENTION TO IT. THANKS!

4. READABILITY OF OUR MATERIALS. Dr. Mark Hochhauser, who directs Health Education at the University of Minnesota's Student Health Service, has done a presentation and publication concerning the readability of AIDS education materials, noting that many are aimed at a reading level far beyond the capability of their

intended audience. Happily, he identifies the reading level of our materials at 11-12 grade, which is just about right for people in college.

5. ANNUAL MEETING -- DENVER, 1988. Believe it or don't, we are half way from the May meeting to the next one. At the Program Planning Group meeting in Denver at the end of September, it was decided that we would present the AIDS session as a Concurrent Session on Saturday morning, rather than as a Pre-Conference Colloquium. There are a tremendous number of papers submitted which have relevance to AIDS; most of them are in the area of Health Education, and Rick Guyton (Chairman of the Health Education Section of ACHA) and I will be working together to winnow them down into poster sessions and actual verbal presentations. The session will include an update general session, again, and at least some issue-related smaller group sessions as well. No real details yet -- but I wanted to let you know as early as possible what the planned date was. If you know already about your plans for the Annual Meeting, it would be nice to have that information.

6. CURRENT PROJECTS. Now that the brochure revisions are done and the General Statement is in process, it is time to turn serious attention back to our ongoing projects.

a. **Sexual Decision Making Pamphlet.** I had a wonderful message from Annie Lomax on my Voice Mail service about the progress she and Jeff are making. They ran into some troubles and snafus, but she thinks they are coming out of it and we can expect something to look at soon.

b. **Women's Issues pamphlet.** The demand for this much-anticipated piece is great everywhere I go. I know that Chris Lyman has been extraordinarily busy, and the combination of our two unreal schedules has made it hard for us to talk...but I hope progress is occurring. If anyone has ideas or help for Chris, let her know.

7. GMHC/ACHA RESIDENT STAFF EDUCATION SEMINARS. Our first seminar in New York, held for RA's in Manhattan, was a great success. Raymond Jacobs, David Winters, Mark Ostfield, Chuck McKinney, and Mark Hoch at GMHC have been extraordinary people to work with. There were between 150 and 200 RA's and about 50 counselling/student affairs faculty/staff people at the forum. Raymond and Mark Ostfield coordinated in a really amazing way a program directed very specifically at the issues and concerns of people in residence halls.

Problem: we are having troubles with logistics for the next seminar or two. We have to beg space from institutions, and that has been a problem. A seminar in November, ideally, should be held in the Bronx -- but there has been a real problem getting a place in spite of efforts by Raymond, David, myself, and Phyllis Vine (of Montefiore).

IF YOU KNOW ANYONE AT A COLLEGE/UNIVERSITY IN THE BRONX TO WHOM WE COULD REASONABLY TALK ABOUT SPACE FOR THIS KIND OF NEEDED PROGRAM, PLEASE LET ME KNOW RIGHT AWAY.

8. METROPOLITAN LIFE FOUNDATION PROJECT REACH. I completed our application for \$25,000 in Project Reach funds for MLF, those monies to be used for the printing and distribution of Volume II of the Special Report -- which is to contain the revised General Statement, revised information on Education, and some updated stuff in the administrative/confidentiality/risk assessment chapters.

I enclose a copy of the MLF proposal for your persual and comment. It's too late to change it, unfortunately, but I would really appreciate your feedback about it.

9. AMERICAN FOUNDATION FOR AIDS RESEARCH GRANT PROPOSALS. AmFAR has just notified me yesterday that our computer based AIDS information system for colleges was rejected in their final round. That's twice down for that proposal; I really don't regret redoing it, but I'm not going to be up for rewriting it a third time next year!

On the slightly more positive side: they have not notified me of any final decision on the inner city AIDS education project proposal. This may mean that we have still got a chance for that funding. Some language in their rejection letter for the other proposal reinforces that belief -- they emphasize interest in minority populations. We'll see. I'll keep you posted.

10. NEW MEMBER: I have accepted into membership on the Task Force a new member who will round out our abilities in some important areas. She is Laura Pinsky, who is a psychotherapist at Columbia and works with the Columbia Gay Health Advocacy Project. She and I have worked together periodically since the Montefiore Conference this past June, and she did presentations at the GMHC forum. She has particular interest in such issues as testing, protocols for medical follow-up of seropositive people, etc. Please join me in welcoming her.

11. NIDA HETEROSEXUAL TRANSMISSION CONFERENCE. You may recall that the last communication mentioned an intended conference dealing with heterosexual transmission, and I asked that you give me any information you had about cases, anecdotal or otherwise. I appreciate the information I got, but I didn't hear from some of you. Dr. Harry Haverkos at NIDA called and has now scheduled the meeting in Rockville in January; I am to make a presentation. So: please think again about this issue and send along any experience or ideas you have.

12. TRAVEL. My travel schedule this fall remains, well, aggressive. I've been to Dartmouth, to Florida, to the University of Oregon in Eugene, to Duke, to the Rocky Mountain meeting in Greeley, to American University in DC. I'm going to a New York City Public Health Department conference on AIDS in Colleges at the Cooper Union on October 23. Then to Stanford, UC-Irvine, SUNY/Purchase, Ohio State, Purdue, Creighton, UAB.

All of this travel is why it's hard to find me on the phone. I really appreciate all the messages that you've left on my Voice Mail service...which is really a much better way to get information to me in a way I can respond to helpfully. You can also tell dirty jokes. Paul Walters bragged about the weather in Palo Alto. We'll see; when I get there next week, it'll probably rain...

REMINDER ABOUT THE VOICE MAIL NUMBER FOR FUTURE USE:

2 0 2 - 3 8 9 - 0 8 5 6

I send along best wishes to all of you from colleagues far and near who've asked to be remembered to you: *Doryn Davis Chervyn*, who is now in Boston working for a health education production firm; *Beverlie Conant Sloane*, who is still working on safer sex at Dartmouth.

Please complete the return sheet, enclose your marked-up copy of the General Statement, and get it back to me ASAP. I hope the next communication will bring some details about the two new pamphlets, a final draft on the General Statement, and some word about the pending grants.

The weather, by the way, is beautiful in Charlottesville right now -- crispy nights and blue skies, glorious leaf color, and gentle winds. It was, peculiarly, just the same in Oregon, where the rainy season has never come this year. And I can hardly wait to report on the weather in Palo Alto.

COMMUNICATION #3-10
ACHA TASK FORCE ON AIDS
OCTOBER 23, 1987

8

Keep in touch...forgive my schedule, and take good care.

AMERICAN COLLEGE HEALTH ASSOCIATION
TASK FORCE ON AIDS

COMMUNICATION #3-10
RETURN SHEET

Return to: Rich Keeling
Student Health Service
University of Virginia
Box 378, Medical Center
Charlottesville, VA 22908

Your name: _____

1. Please enclose your draft of the General Statement on Institutional Response to AIDS with suggested changes noted. If you have any general comments about it, please note them here: _____

2. Do you know college health people, housing officers, or student affairs professionals at colleges in the Bronx, or Brooklyn? Yes _____ No _____

If yes, please note name, position, address, phone of that person and comment on how you know him/her.

Name: _____

Position: _____

Institution: _____

Address: _____

Phone: () _____

Your connection: _____

3. Any comments about the MLF Grant Proposal?

4. Concerning the CDC Workshops:

a. Are you willing to participate as a:

[1] planner? yes____ no____

[2] presenter? Yes____ no____

b. Which workshop would be geographically best for you?

c. Do you have materials you could share with me and Doug for review by the Panel as they select things for distribution? yes _____ no_____

IF YES, PLEASE ENCLOSE A COPY

d. What ideas do you have that would help Doug in his preliminary planning?_____

5. Do you know anything about plans for the Annual Meeting yet...

a. clearly will be there ____

b. will probably be there ____

c. would like to be there but don't know about funds____

d. have no idea yet ____

e. probably will not be there ____

f. certainly will not be there ____

6. Any ideas for me to pass on to Annie Lomax for the Decision Making pamphlet? _____

7. Any ideas for me to pass on to Chris Lyman for the Women's Issues pamphlet? _____

THANKS! PLEASE ENCLOSE YOUR COPY OF THE GENERAL STATEMENT AND PUT THIS IN THE MAIL.

List of Appendices
(Available on request from author)

1. "COYOTE Convention -- San Francisco, CA, May 30-June 2, 1985"
2. "Pacific Center AIDS Project Statement on Racism and AIDS Work"
3. AWARE research proposals for 1984-5 and 1985-6
4. Alternative Test Sites for AIDS Antibody Test
5. Syllabus -- Women At Risk: Strategies for AIDS Education and Prevention, Nov., 1985
6. "Women and AIDS" brochure
7. Women's AIDS Network membership form
8. "Current Support Groups and Assistance for Women exposed to AIDS -- San Francisco Area," May, 1985
9. "Rehabilitation Resources for Women with IV Drug Dependencies" February, 1985
10. Advertising for AIDS Hotline directed at women and/or general public
11. "Mujeres y AIDS" brochure
12. "AIDS Teenage Awareness Program: A Multi-ethnic Strategy"
13. "Women's Health Services Listing"
14. "Women and AIDS -- Straight Talk"
15. "San Francisco health crisis focus group with women at risk," Memo, Research and Decisions Corporation, June 21, 1985

COMMUNICATION #3-8

To: All members of ACHA Task Force on AIDS

From: Rich Keeling

Date: August 31, 1987

Method: Purolator express

FIRST, AN APOLOGY: I KNOW THAT IT HAS BEEN EXTREMELY HARD TO GET IN TOUCH WITH ME BY PHONE THIS PAST TEN DAYS. I'M TRULY SORRY. WE ARE INVOLVED IN ORIENTATION, RESIDENT STAFF TRAINING, THE ARRIVAL OF FIVE NEW STAFF MEMBERS HERE, AND THE LIKE...ALL COMBINED WITH A BUNCH OF HASSLES ABOUT OUR NEW BUILDING. BESIDES, I'M ATTENDING ON OUR MEDICAL SERVICE, TEACHING, ETC., AND, THEREFORE, A HARD MAN TO FIND. PLEASE DON'T FEEL OFFENDED OR NEGLECTED IF I'VE NOT BEEN ABLE TO GET BACK TO YOU YET...I WILL.

Tentatively, good news: The CDC has been in touch this past week with the ACHA office in Rockville with the news that they want to call this coming week and discuss details of the budget for the Cooperative Agreement proposal. Through-the-grapevine rumblings from the CDC have been positive, and we are hopeful that the phone calls and negotiations this week will have a great outcome and that we will receive this Cooperative Agreement.

Not only that: we have passed the first screen for the AmFAR proposals. Both the computer based updating system and the inner city college/university AIDS education project passed the initial screens and have been referred for final consideration by their prevention/education committee. Time line for final decision: probably about 5 weeks.

Watch GOOD MORNING, AMERICA: The people from ABC TV news and Good Morning, America came to the University of Richmond this past Wednesday when I did two presentations on AIDS to the entering freshman class. They taped a long interview with me and then recorded one entire talk, with questions, etc.; I hope it came across OK. It's supposed to be on GMA some morning this week, but as of the time this is written, we still did not know what day.

More Good News: So far, about 150 RA's and about 35 other people who work with RA's have signed up for the first GMHC/ACHA Residence Life AIDS Seminar in New York on September 22. We have had a great working relationship with the people at GMHC thanks to the wonderful support of Raymond Jacobs, their director of education, and Mark Ostfield, Chris Lyman's alumnus who is now working in the GMHC research section. A second presentation is now planned for the Bronx in October. I plan to be in New York for the first presentation in September, at least.

A question for you: the GMHC people have developed a new booklet/pamphlet about the use of condoms, which is designed

for both heterosexual and homosexual people. They have asked about using it as a handout at the session in New York. The reason for their concern, and mine, is that the pamphlet will contain very explicit illustrations of the proper methods of putting a condom on. This will include depictions of erect penises, for example. Some of the illustrations will be actual photographs. I have enough confidence in GMHC to know that the production will be tasteful, but since it involves a level of explicitness we have not used before, I wanted to get advice from all of you before responding to them. What do you think? -

Even more good news, and another request: Dr. Harry Haverkos of the National Institute on Drug Abuse called me to ask our cooperation and participation in a conference to be held early in 1988 concerning heterosexual transmission of HIV. They feel ACHA should be involved in this program and that we could contribute something meaningful. He is interested in anything from anecdotally established instances of heterosexual transmission among students to prospective studies involving college campuses. I need help. Do we have information we could pull together as a group to demonstrate a collection of heterosexually transmitted cases? Does anyone have other ideas? Talk to me. Write to me.

Revision of the General Statement: I've gotten suggested revisions and additions from about ten of you thus far. This is a pretty big priority, and it won't take that long to do, so I'd really appreciate getting the documents back from the rest of you. I recognize that this is an incredibly busy time on all college campuses, but please help. If it seems OK to you as written (except for changing the name of the virus), just drop it in the mail with that message written on the top and I'll know you've considered it.

College Satellite Network: on Friday we ran into some administrative problems with the program and the College Satellite Network which are extremely complicated. Suffice to say the organization has been through some major internal difficulties. The result of this for us is that we may not have as much control over the program as I want, and that may even lead us to withdraw endorsement...but I'd rather explain all that in more detail after I understand it better, which should happen after some discussions early this week. More to come.

"What Everyone Should Know" Revision: What, again? Well, at least to bring it up. REmember this past Spring we revised our flagship pamphlet. We added a section on minority issues which we called "People of Color and AIDS," and the group liked it. Hundreds of thousands of copies of the pamphlet have been sold. The ACHA has, however, received criticism from two sources about the paragraph on people of color. The State of Maine would not buy the pamphlet because the term people of color struck them as racist. Dr. Warren Wacker, director of the Health Service at Harvard, shares that reaction and feels that the paragraph is "badly written,

demeaning, patronizing, and racist." He does not feel we should be addressing the issue at all in the pamphlet, and, if we do, that we should rewrite the whole thing in a "more sensitive" way.

Note: this is part of a much bigger public debate these days. The critical need to give attention to the minority issues in AIDS has sparked vivid and acrimonious debate between those who want to surface the issue and those who feel that addressing the minority issue is inherently racist. At the recent CDC conference on minority issues, there was strong feeling on all sides; many in our minority communities fear being stigmatized by the disease. Others point out that the apparent predominance of minority racial groups may be a reporting difference, though they do not question the overwhelming statistics for women and children.

My personal feeling: is that we should address the minority issue, and that the pamphlet should. After discussing this with Steve Blom and Jo Ann, we would propose a re-writing of the minority text by expanding it slightly, allowing for a somewhat clearer description of the problem. If you agree with that strategy, we would then need suggestions for better text.

Obviously, I understand that we are not racist, that we are not insensitive, and that we did not demean. Dr. Wacker's criticisms are, perhaps, overstated. Most people reading the pamphlet have not been troubled by it. I disagree thoroughly with the idea that we should just drop the issue from the pamphlet entirely: that is to cooperate with the mythology, to be racist in another way.

PLEASE INDICATE YOUR FEELINGS AND SUGGESTIONS ON THE ACCOMPANYING RETURN SHEET AND SEND IT BACK TO ME AS SOON AS POSSIBLE.

Revision of "Safe Sex": please look at the Safe Sex pamphlet (copy enclosed) for revisions before its next printing. I think we would want to change the title to Safer Sex, which is easy to do. We might want to make adjustments in the risk table on the back panel. Again, please indicate your feelings and suggestions on the pamphlet or the return sheet and let me know.

Enclosures:

1. AmFAR nice news letters, numbers 1 and 2.
2. Safe sex pamphlet, for your perusal and consideration of revisions
3. Copy of "People of Color" text from the current edition of "What everyone should know."

4. Two wonderful articles from the British Medical Journal. First person stories called "Having AIDS" and "Being HIV antibody positive."

5. A fantastic revision of the resources and bibliography list from Jeff Gould, who has labored hard and long. This will be a major piece of our second book, which will come out this year.

6. Article on prevention of STD's from JAMA

7. A letter I wrote to some people at Wild Horse Enterprises, who market a "for amusement only" card-type "AIDS test" which they intend to try to sell to students...

8. The return sheet mentioned earlier.

I HOPE TO BE IN BETTER COMMUNICATION NOW.

OH: NEWS. I WILL BE TRAVELLING A LOT THIS FALL. TO REACH ME WHEN I AM AWAY, YOU CAN NOW CALL A SPECIAL ANSWERING SERVICE NUMBER WHICH WILL ALLOW YOU TO RECORD A MESSAGE THAT I WILL HEAR WHEN I CALL IN. WHEN I TRAVEL, I CHECK THE MESSAGES AT LEAST ONCE EVERY DAY. SO: WRITE THIS NUMBER DOWN, AND USE IT. YOU CAN ALSO LEAVE MESSAGES AT THIS NUMBER ANY OTHER TIME, EVEN WHEN I AM IN CHARLOTTESVILLE; I STILL CHECK IT ABOUT ONCE A DAY. THE NUMBER IS:

202-389-0856

YOU CAN LEAVE A MESSAGE UP TO FIVE MINUTES IN LENGTH, AND I WILL GET BACK TO YOU SOMEHOW. IT ALLOWS FOR MORE DETAILS AND PERSONAL TOUCHES THAN YOU CAN MANAGE LEAVING A NOTE WITH MRS. ANDERSON, AND IT ALSO ALLOWS ME TO GET THE MESSAGE SOONER. GIVE IT A SHOT.

Thanks to everybody for your patience during my hard-to-find period here. I think it will be easier soon. Take care, all, and my best.

P.S.: weather report....hot, humid, but no rain. And it's probably still gorgeous in Palo Alto.



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NEW YORK OFFICE

40 WEST 5TH STREET

SUITE 406

NEW YORK, NY 10019-4001

(212) 333-3118

August 24, 1987

Richard Powell Keeling, M.D.
Associate Professor
Division of Internal Medicine
Department of Student Health
University of Virginia
Box 378, Medical Center
Charlottesville, VA 22908

SUBJECT: AmFAR Letter of Intent No. 587278
"AIDS Education in Inner City Colleges"

Dear Dr. Keeling:

Your letter of intent referenced above has been approved for further consideration by AmFAR's Educational Policy Committee. I regret that I have no final word on the status of your request at this time.

The Educational Policy Committee is currently establishing a review process for AIDS education and prevention projects such as the one your letter of intent describes. You should be hearing from the Committee within the next six weeks.

If you have further comments or questions concerning the status of your proposal please contact Patricia Halleron, Director of Education, at the following address:

The American Foundation for AIDS Research
40 West 57th Street, Suite 406
New York, New York 10019-4001

Telephone: 212-333-3118

Thank you for your patience and your efforts towards the eradication of AIDS.

Sincerely,

Jay Theodore
Grants Department

c: P. Halleron



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NEW YORK OFFICE

40 WEST 57TH STREET
SUITE 406
NEW YORK, NY 10019-4001
(212) 333-3118

August 24, 1987

Richard Powell Keeling, M.D.
Director, Student Health Service
Department of Internal Medicine
American College Health Association
Box 378, Medical Center
Charlottesville, VA 22908

SUBJECT: AmFAR Letter of Intent No. 587394
"AIDS Education Compendium for Colleges"

Dear Dr. Keeling:

Your letter of intent referenced above has been approved for further consideration by AmFAR's Educational Policy Committee. I regret that I have no final word on the status of your request at this time.

The Educational Policy Committee is currently establishing a review process for AIDS education and prevention projects such as the one your letter of intent describes. You should be hearing from the Committee within the next six weeks.

If you have further comments or questions concerning the status of your proposal please contact Patricia Halleron, Director of Education, at the following address:

The American Foundation for AIDS Research
40 West 57th Street, Suite 406
New York, New York 10019-4001

Telephone: 212-333-3118

Thank you for your patience and your efforts towards the eradication of AIDS.

Sincerely,

Jay Theodore
Grants Department

c: P. Halleron

COMMUNICATION #3-7

To: All members of the ACHA Task Force on AIDS

From: Rich Keeling

Date: August 11, 1987

Method: First Class Mail



This communication brings several updates, some reading material, and a request. I hope it finds all of you enjoying the summer -- which, in Central Virginia, has been VERY hot and steamy. We had one of our very rare tornadoes the other night, to celebrate the end of July, and it's been quite sauna-oid. No doubt Paul Walters will tell me that the weather in Palo Alto is gorgeous, as usual.

I send along greetings to all from several of the gang. I was in Madison a couple of weeks ago, and spent an evening with Paul Grossberg (and Sean, who is now about eight months old, and even more charming than before). Paul says "hi" to everybody; he's working on an Apple-computer grant proposal. I enjoyed another evening with David Kersey in Greenwich on my way to one of the GMHC meetings in New York; it turns out that Chris Lyman's parents live there, so I hope Chris and David can get acquainted soon. Terry let me share his apartment in New York during one visit, and he sends love to all; he's adjusting smoothly to the Big Apple. And I've had good phone conversations with Chris, Annie, Doug, Lee, Rolan, and others, and nice letters from Joy, Rich Wolitski, and Paul Walters. Thanks for keeping in touch!

One piece of "other" news for you: Paul Walters informs me that Doryn Davis Chervyn, who has been a strong and effective voice for health promotion in ACHA, will be leaving her position in Stanford to move to the Northeast with her husband, who has accepted a job. She doesn't plan to stay in college health work at this point. I'm sure Doryn would appreciate a call or note expressing appreciation for all the work and leadership over the years. We'll all miss her.

Updates:

College Satellite Network program is going well. I've reviewed the Viewer's Guide drafts and have talked several times with the author and producer. We have a meeting in DC next week to go over all this. Production is planned for September 30.

CDC AIDS COperative Agreement Application was completed on time thanks to the extraordinary work of Gail Bassin and Jeri Shaw at the consulting firm. We had a thousand phone calls in the first couple of days of my vacation, and we shuttled lots of paper by FEederal Express between Orlando and DC, all to good ends: the proposal looks great as it went in, and you will find a copy enclosed for your perusal.

AmFAR Grants: both went in on time, and we await word as to whether we can prepare a complete and final application.

Metropolitan Life Foundation: application is due September 30. I sent you copies of the forms and letters with the previous mailing. I need to get from you suggestions, ideas, recommendations for the structuring of our proposal. Please. Paul Walters has gotten a grant from Metropolitan for his "Health Net" program, and may be able to help us with our effort.

Gay Men's Health Crisis/Residence Life Program: working on this with the very dedicated people from GMHC has been a wonderful experience. Fortunately, we have the services of Mark Ostfield, who now works for GMHC; his experience in college AIDS education has been invaluable. The invitations to the first ACHA/GMHC program (on September 22) went out last week. We're hoping for a positive response. Lawrence Biemiller, who has covered a lot of ACHA AIDS work for the *Chronicle of Higher Education*, will be coming to New York to cover the conference.

Task Force Reports: also enclosed is a copy of a report on our work over the summer written by Ann Higley at the ACHA office for inclusion in the next issue of ACHA Action (newsletter). She did a great job!

Women's Issues: Chris is working hard on thinking about the Women's Issues pamphlets and reports, has a line on some good ideas, and will be seeking help from some of you soon.

Sexual Decision Making: Annie is back to working on the pamphlet; I have a call from Jeff Gould, and I hope to talk to him soon to get updated.

Revision of "Making Sex Safer:" Jo Ann Ciperson at ACHA has been working on better (more diverse) photos and layout for the Making Sex Safer pamphlet, and is making progress. Hope to see the new one real soon.

Other matters:

1. **Americans Who Care:** I enclose a copy of the Americans Who Care announcement from Paul Kawata at the National AIDS Network. Please read through and make any nominations you care to from people you work with; send them on directly to NAN at the address shown.

2. **Revision of our General Statement:** please take a look at our old standby, the December 1985 General Statement on Institutional Response to AIDS, with an eye toward needed revisions. We need to re-issue it with the new name of the virus, and it's an opportunity to make any other needed changes. Please take a look and let me know. I include a copy of the general Statement with this in case you can't put your hands on one right away.

3. **Survey Instrument Review Request:** I enclose a copy of a proposed survey instrument developed by Sue Matthews, a graduate student in North Carolina. I met her and her mentor at a conference and agreed that I would send their proposed instrument out to all of you for your comments and review. I'd appreciate your accommodating them. Please mark it up as needed and send back to me for transmittal on to her.

Reading Material:

1. An insensitive point of view from Charles Krauthammer, in the Washington Post.
2. A summary of the III International Conference on AIDS from *Infectious Disease Alert*
3. A copy of the recent PEOPLE magazine article on AIDS, which has both good and bad features, but is overall pretty good.
4. The Executive Summary of a recent report from the AIDS Action Council in Washington.

Please do the following:

1. Take a close look at the General Statement and send suggestions for revisions.
2. Review the survey instrument for Sue Matthews and send it back to me.
3. Send any suggestions re: women's issues materials to Chris Lyman, and any re: decision making pamphlet to Annie Lomax.

4. Begin to think about the Metropolitan Life application. I will need help with concept, substance, and writing for that one.

5. Keep in touch. Your calls and letters prevent my feeling lonesome...

If you've not been on vacation, GO; if you have, I hope you had a great one. I'll look forward to hearing from all of you.

Thanks!
Rich

Charles Krauthammer

'Why Should AIDS Be a Privileged Disease?'

AIDS is public health enemy No. 1, says President Reagan. It is on every front page, on every candidate's lips. Everyone agrees: we need to do more. Sen. Robert Dole has the presidential candidate's standard AIDS formulation, calling for spending "whatever resources [are] necessary to get the job done."

"Whatever resources?" When politicians are unanimous on any issue, it is time to pause. Sen. Al Gore has called for a "Manhattan Project" on AIDS. Why should the fight against AIDS be the exclusive beneficiary of a massive government effort?

Because AIDS is fatal? Since 1981 AIDS has killed about 20,000 Americans. Heart disease kills 65,000 every month. Because AIDS strikes young people in the prime of their lives? Schizophrenia, which afflicts 1,650,000 Americans, is also a disease of young people. It destroys their minds. (Many of the wretched homeless are finishing long careers as schizophrenics.) Because AIDS is going to strike a lot of people in the future? The surgeon general estimates that by the end of 1991 a total of 270,000 AIDS cases will have occurred. This year alone there will be 965,000 new cancer cases.

It is not good politics to come out against an AIDS cure, but it is worth asking the question: Why should AIDS

"... the AIDS constituency has been adamant in demanding special protection."

be a privileged disease—federally protected, as it were—while other diseases, many of which cause suffering in many more Americans, are not?

The only possible answer is that AIDS is such an explosive threat to society that it must be stopped now. The key to this claim is that AIDS is breaking through to the general population. But the latest numbers from the Centers for Disease Control indicate otherwise. AIDS remains largely confined to two groups: male homosexuals and IV drug abusers. They continue to account for 9 out of 10 AIDS cases. Heterosexual transmission accounts for no more than 4 percent of cases.

A Berkeley study presented in Washington at the Third International Conference on AIDS demonstrates how difficult heterosexual transmission really is. It showed that women whose partners had AIDS needed a very large number of sexual contacts before con-

tracting the disease. For example, of women who had sex more than 600 times with an AIDS patient, only one in three contracted the disease. (If 1 percent of random males is an AIDS carrier, a woman would thus need 60,000 individual sexual contacts with American males to incur a one-third chance of contracting AIDS.)

It is true that in Africa AIDS is a heterosexual disease, but that simply is not so in America. There is nothing odd or startling about this. Many diseases have different epidemiologies in different parts of the world. In the United States, AIDS remains a disease principally of two major risk groups.

Of the two, drug abusers are not organized. Gays are. Gay rights groups have turned AIDS into a political issue. They have two principal demands on the government: immediate cure and no testing. And they have not been reticent about their wishes. During the Washington conference, there were many political demonstrations. A sit-down outside the White House featured chants of "Reagan, Reagan, too little, too late." Pamphlets distributed at the conference urged the booing of administration officials who proposed testing. And booted they were, despite the fact that the proposals they offered were tentative and moderate.

Vice President George Bush suggest-

ed testing aliens who seek entry to the United States. Boo. He proposed testing prisoners. (Also reasonable: you cannot stop all homosexual rape in prisons, but, by segregating those who are AIDS-positive, you can prevent a rape from becoming a death sentence.) Boo again. He proposed testing couples about to marry. (Also reasonable: it might prevent a finite number of children being born with AIDS.) More boos.

Gays have every right, of course, to lobby for AIDS. But the general public has an equal right to question their sense of entitlement. Other groups have other diseases, some just as terrible, some more so. Medical claims on society, like nonmedical claims, must be tested against each other. Yet the AIDS constituency has been adamant in demanding special protection.

And getting it. Last August, the District of Columbia made it illegal for insurance companies to require routine AIDS tests for people applying for life and health insurance. Normally, insurance companies want to know whether you are subject to a life-threatening illness. Getting insurance is difficult if you are. The callousness of the actuarial table is an argument perhaps for national health insurance. It is not an argument for giving a special exemption to those carrying the AIDS virus.

Where does this sense of entitle-

ment come from? After all, and to say, a brain tumor, AIDS is preventable. We know exactly how to contract it and exactly how to prevent it. Preventative measures are not particularly complicated. Moreover, they are all within the power of the individual to control.

With rare exceptions, contracting AIDS is like contracting lung cancer: it requires the collaboration of the victim. That is not true of many other catastrophic illnesses. This does not mean that AIDS victims deserve neither compassion nor our support. It does mean that those who claim that AIDS victims deserve special compassion and special support have some explaining to do. They have not done it.

On Capitol Hill, when money is preferentially funneled to a particular cause in the news, cynics call it "disease of the month club" syndrome. AIDS is turning into the disease of the decade. It is hard to speak dispassionately about AIDS without getting bored.

AIDS deserves funding and its victims our care. But AIDS is not a pandemic; its publicists would like to believe, nor does it merit its privileged position at the head of the parade line of human misfortunes that it claims on our resources, attention and compassion. It is a disease. You may not know it from reading the papers, but there are others.

Ted Stevens

No Public Funds for

Stephen S. Rosenfeld

Gulf Solution: Fairness to Iran?

The idea is gaining currency that somehow the United Nations should handle the crisis in

that not only engages Tehran but fits the security and political interests of Iraq and its fellow



General Statement on Institutional Response to AIDS

December 2, 1985

The recommendations and guidelines included in this Statement augment and extend those of the Preliminary Statement on Disease Transmission issued by the American College Health Association (ACHA) on September 25, 1985. They are based on the best currently available medical information and on recommendations of the Public Health Service and the Centers for Disease Control. As indicated herein, ACHA will make available more detailed guidelines and information in certain specific areas of concern to colleges and universities in a series of reports and statements to be released in the near future.

The American College Health Association acknowledges the valuable assistance of the American Council on Education in the development of guidelines pertaining to the legal issues and questions presented by AIDS.

The primary response of colleges and universities to the AIDS epidemic must be education. Because there is no specific therapy for AIDS or AIDS-related conditions, the most important goals for institutions will be those of increasing awareness and providing education to prevent further spread of the disease. The American College Health Association recommends that the organization and completion of effective educational programs about AIDS be an activity of the highest priority for all institutions of higher learning. Such programs must address not only undergraduate students, but also graduate and professional students; they must reach not only residential students, but also commuters. Educational programs about AIDS should also be available to students in junior and community colleges and in programs of continuing education. Furthermore, universities and colleges should provide AIDS education for institutional employees, faculty, and staff.

Such educational programs will address the major intervention currently possible in limiting the consequences of AIDS, which is *primary prevention*. They may also be of paramount importance in discharging the institution's responsibility to protect its student body and staff from the transmission of AIDS. Since the current medical evidence indicates that no actual safety risks are created in a normal academic or employment setting, the administration of effective AIDS education and training programs provides the best way for institutions to render enrollment or employment safe and healthful. The AIDS epidemic raises issues of liability that are of great concern to college and university administrators; the most effective means of addressing these issues at present is to educate students and employees about AIDS and to take reasonable precautions such as are suggested herein.

In order for educational programs to be effective, they must provide current information, use reliable, up-to-date materials, and be widely available. The Task Force on AIDS of the American College Health Association has revised the organization's educational brochure on AIDS and is distributing it to all institutions. Detailed recommendations for educational programming, including suggested formats and methodologies, will be forthcoming from the Task Force shortly.

The American College Health Association recommends that institutions not adopt blanket policies concerning students with AIDS or AIDS-related conditions. Instead, it suggests that certain guidelines be followed and that the institution analyze and respond to each case as required by its own particular facts. Recommended guidelines are included in this Statement and in subsequent statements by the Association. Colleges and universities will benefit from the maintenance of as much flexibility as possible in dealing with the issues AIDS raises; given the uncertain legal obligations and challenges involved, institutions are advised not to devise and implement detailed policies at this time. However, it seems appropriate for college and university officials to identify and designate a person, group, or department to assume a managerial role in providing consistent and reasonable analysis of each case.

Guidelines for institutions derive from the best currently available medical facts about AIDS.

Recommendations apply to all students or employees who are known to be infected with the virus thought to cause AIDS, Human T-Lymphotropic Virus, type III (HTLV-III); this includes those who have a condition meeting the surveillance definition of AIDS itself, those who have one of the lesser manifestations of infection (AIDS-Related Complex, or ARC), and those who are currently healthy but have evidence by the presence of a serum antibody to HTLV-III of exposure to and infection by the virus.

Current knowledge indicates that students or employees with AIDS, ARC, or a positive HTLV-III antibody test do not pose a health risk to other students or employees in an academic setting. AIDS is thought to be transmitted by intimate sexual contact or by exposure to contaminated blood. Although HTLV-III can be found in many body secretions of those who are infected, its presence there is not necessarily correlated with disease transmission by those fluids. There has been no confirmed case of transmission of AIDS by any household, school, or other casual contact. **The Public Health Service states that there is *no risk* created by living in the same house as an infected person; caring for an AIDS patient; eating food handled by an infected person; being coughed or sneezed upon by an infected person; casual kissing; or swimming in a pool with an infected person.**

These facts, derived from the best epidemiologic data currently available, are the basis for the following guidelines recommended by the American College Health Association.

1. Most college and university students who have AIDS, ARC, or a positive HTLV-III antibody test, whether they are symptomatic or not, should be allowed regular classroom attendance in an unrestricted manner as long as they are physically able to attend classes. See also Recommendation #12.
2. There is no medical justification for restricting the access of students with AIDS, ARC, or a positive HTLV-III antibody test to student unions, theatres, restaurants, cafeterias, snack bars, gymnasiums, swimming pools, recreational facilities, or other common areas. The ACHA is developing a statement that addresses such specific concerns as contact sports.
3. In the program of education that the institution provides, it should emphasize the following recommendations of the Public Health Service:
 - a. Even though they may be asymptomatic, persons with confirmed positive HTLV-III antibody tests may transmit infection to others through anal or vaginal sexual intercourse, the sharing of needles, and possibly, exposure to others through oral-genital contact or intimate kissing.
 - b. The efficacy of condoms in preventing infection with HTLV-III is unproven, but the consistent use of them may reduce transmission.
 - c. Toothbrushes, razors, and other implements that may become contaminated with blood should not be shared.
 - d. Persons with AIDS, ARC, or confirmed positive HTLV-III antibody tests should not donate blood, plasma, other body organs, other body tissues, or sperm. The American College Health Association also endorses the request of the American Red Cross that persons who fall into defined risk categories for AIDS not donate blood or plasma.
 - e. If persons with confirmed reactive (positive) antibody tests have accidents involving bleeding, contaminated surfaces should be cleaned with household bleach freshly diluted 1:10 in water.
 - f. When seeking medical, dental, or eye care, these persons should advise the practitioner of their positive antibody status so that appropriate evaluation can be undertaken and precautions can be taken to prevent transmission to others.
4. In colleges and universities with resident students, residence hall staff (both students and employees) should receive education about AIDS; in future years, the institution should provide that education prior to the arrival of new students.
5. Consideration of the existence of AIDS, ARC, or a positive HTLV-III antibody test should *not* be part of the initial admission decision for those applying to attend the institution.
6. The American College Health Association does not advocate the routine requirement that students be asked to respond to questions about the existence of AIDS, ARC, or a positive HTLV-III antibody test. It is, however, appropriate to encourage new students to inform campus health authorities if they have AIDS, ARC, or positive HTLV-III antibody test in order that the institution can provide them proper medical care and education. This, like all other medical information, must be handled in a strictly confidential manner in accordance with the procedures and requirements in effect in the institution.

7. College and university officials should not undertake programs of screening newly admitted or current students for antibody to HTLV-III; neither should mandatory screening of employees be implemented. Especially, institutions should not attempt to identify those in high risk groups and require screening only of them.
8. College and university health services should be familiar with sources of testing for antibody to HTLV-III, and should be able to refer students or employees requesting such testing. Health care providers should understand the capabilities and limitations of the test, and should be able to counsel those desiring to be tested or to refer them to counseling sources elsewhere. Testing should only be done where it is confidential or anonymous, where positive results can be confirmed by specific tests, and where both pre- and post-test counseling are available.
9. Decisions about residential housing of students with AIDS, ARC, or a positive HTLV-III antibody test must be made on a case-by-case basis. Those making such decisions should keep in mind the fact that AIDS is a condition present in an individual, not one that inhabits a building. **The best currently available medical information does not support the existence of a risk to those sharing dormitories with infected individuals; there may, however, be in some circumstances reasonable concern for the health of those with AIDS or ARC who might be exposed to certain contagious diseases (e.g., measles or chicken pox) in a close living situation.** Health officers in institutions with the flexibility to provide private rooms may wish to recommend that students with AIDS or ARC be assigned private rooms in the interest of protecting the health of those students. The American College Health Association recognizes that fear of AIDS may bring considerable pressure to bear on institutional housing officers, and will provide a more thorough discussion of options in the area of residential housing in a subsequent statement.
10. Guidelines concerning the handling of confidential medical information about students with AIDS, ARC, or a positive HTLV-III antibody test follow the general standards included in the American College Health Association's *Recommended Standards and Practices for a College Health Program*, Fourth Edition, 1984:

In general, it is recommended that no specific or detailed information concerning complaints or diagnosis be provided to faculty, administrators, or even parents, without the expressed written permission of the patient in each case. This position with respect to health records is supported by amendment to the Family Education Rights and Privacy Act of 1974.

Certainly no person, group, agency, insurer, employer, or institution should be provided any medical information without the prior specific written consent of the patient. Given the possibility of unintended or accidental compromise of the confidentiality of information, health officers should carefully weigh the importance of including any specific information regarding the existence of AIDS, ARC, or a positive HTLV-III antibody test in the medical record except in circumstances of medical necessity created by the evaluation of an illness. At minimum, the inclusion of any such information in the medical record should be discussed with the patient prior to its entry.

Health officials and other institutional officers must remember that all confidential medical information is protected by statutes and that any unauthorized disclosure of it may create legal liability. The duty of physicians and other health care providers to protect the confidentiality of information is superseded by the necessity to protect others only in very specific, threatening circumstances. The number of people in the institution who are aware of the existence and/or identity of students or employees who have AIDS, ARC, or a positive HTLV-III antibody test should be kept to an absolute minimum, both to protect the confidentiality and privacy of the infected persons and to avoid the generation of unnecessary fear and anxiety among other students and staff. The ACHA is now developing a statement specifically addressing the handling of confidential medical information about students with AIDS, ARC, or a positive HTLV-III antibody test in more detail.

11. There is no medical necessity for institutions to advise others living in a dormitory of the presence in the dormitory of other students who have AIDS, ARC, or a positive HTLV-III antibody test. The responsibility to provide a safe living environment is best dealt with by educational programming, as discussed earlier in this statement. Similarly, college and university officials should make no attempt in any other setting to identify those students or employees who have AIDS, ARC, or a positive HTLV-III antibody test.
12. College and university health policy should encourage regular medical follow-up for those who have AIDS, ARC, or a positive HTLV-III antibody test. Special precautions to protect the health of immunologically compromised individuals should be considered during periods of prevalence of such contagious diseases as chicken pox and measles.

13. Those who are known to be immunologically compromised should be excused from institutional requirements for certain vaccinations, notably measles and rubella vaccines, as those vaccinations may lead to serious consequences in those with poorly functioning immune systems.
14. All colleges and universities should adopt safety guidelines as proposed by the Public Health Service for the handling of blood and body fluids of persons with AIDS, ARC, or a positive HTLV-III antibody test. Those institutions which operate health care clinics and clinical laboratories providing services for students or employees should implement those Public Health Service guidelines and take measures to see that they are observed. In addition, the institution should provide educational programs about AIDS and the reduction of risk to health care providers for clinical personnel. The following articles in *Morbidity and Mortality Weekly Reports* provide detailed guidelines that should be generally followed:
 - A. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staffs. MMWR 1982; 31:577-580.
 - B. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): Precautions for Health Care Workers and Allied Professionals. MMWR 1983; 32: 450-452.
 - C. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): MMWR 1985; 34: 533-534.
15. College and university health services should use disposable, one-user needles and other equipment whenever such equipment will puncture the skin or mucous membranes of patients. Health care officials should not rely on students or employees to identify themselves as having AIDS, ARC, or a positive HTLV-III antibody test, since many infected persons are unaware of their status; safety precautions must be used in all cases. If disposable equipment is not available, any needles or other implements that puncture skin or mucous membranes should be steam sterilized by autoclave before reuse or safely discarded. Extreme caution should be exercised particularly in disposing of needles.
16. All colleges and universities should adopt safety guidelines for the handling of blood and body fluids of all students in other settings as well. Laboratories used in a teaching context, such as those required in biology courses, should be safe experiences. Given the fact that the existence and identity of those with AIDS, ARC, or a positive HTLV-III antibody test may not be known, procedures for the decontamination of environmental surfaces and objects soiled by blood or body fluids should be adopted and implemented. Laboratory courses requiring exposure to blood, such as finger pricks for blood typing or examination, should use disposable equipment and no lancets or other blood-letting devices should be re-used or shared. No student should be required to obtain or process the blood of others. The Public Health Service guidelines noted above include information about disinfection of environmental surfaces; a simple method they recommend is the cleaning of contaminated surfaces with a household bleach freshly diluted 1:10 in water.
17. College and university health services must strictly observe public health reporting requirements for AIDS. Patients who meet criteria for the revised surveillance definition of AIDS must be reported to the local public health authorities. The detailed surveillance definition is included in:

Centers for Disease Control: Revision of Case Definition of AIDS for National Reporting — United States: *Morbidity and Mortality Weekly Reports* 1985; 34: 373-375.

The Task Force on AIDS of the American College Health Association will release in the near future a series of further statements specifically addressing:

1. Residential life issues
2. Confidentiality of information and the "need to know"
3. Educational priorities
4. Administrative issues including athletic competition, institutional employees, and public relations
5. Testing, support and counseling for those at risk
6. Clinical issues for health services

Task Force on AIDS
American College Health Association
15879 Crabbs Way
Rockville, MD 20855
(301) 963-1100
Richard P. Keeling, M.D., Chairman

Dear AIDS Task Force Member,

My name is Sue Matthews and I am a health education graduate student at East Carolina University. Currently I am working on my thesis which focuses on knowledge and attitudes about AIDS and AIDS prevention among college students.

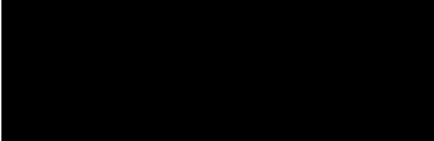
From my review of related literature, I did not find an appropriate assessment tool. For this reason, I have developed my own. The survey will be administered to students enrolled in a personal health course at East Carolina University.

I am requesting your assistance in determining the content validity of the enclosed survey. Based on your comments and suggestions, plus results from the field test, the survey will be revised. Items for each section will then be selected. Items for the knowledge section, which you will review, were selected from various references.

Please complete the check list and return it to Dr. Richard Keeling by Friday, August 21, 1987. Thank you for your time and assistance. If you have any questions, feel free to contact me at any time.

Sincerely,

Sue Matthews



Expert Panel Review

Please use the following criteria to judge each item for content validity:

1. Is the item clearly written for the intended group of examinees?
2. Is the item free of irrelevant material?
3. Is the element of knowledge clearly defined in the item?
4. Is there a correct or clearly right answer?
5. Is the element of knowledge accurate in regard to the topic?

Please rank each item on a scale from 1 to 5, one being the highest or most important, and 5 being the lowest or least important.

The following knowledge items will be answered with a TRUE, FALSE, or "I don't know" response by the examinees:

1. A person could be infected with the AIDS virus and not have signs or symptoms of infection.
COMMENTS:

RANK (1-5) _____

2. Condoms have been recommended as a preventive measure for oral-genital stimulation on a man.
COMMENTS:

RANK (1-5) _____

3. A person can become infected with the AIDS virus by donating blood.
COMMENTS;

RANK (1-5) _____

4. The fewer different sexual partners a person has, the less likely that one will be exposed to the AIDS virus.

COMMENTS:

RANK (1-5) _____

5. LAV, HTLV-III, and HIV, each represent the causative agent of AIDS.

COMMENTS:

RANK (1-5) _____

6. The AIDS virus can be transmitted through shaking hands, coughing, sneezing, or sharing meals with infected persons.

COMMENTS:

RANK (1-5) _____

7. The AIDS virus can be transmitted through sexual contact from men to women.

COMMENTS:

RANK (1-5) _____

8. The AIDS virus can be transmitted through sexual contact from women to men.

COMMENTS:

RANK (1-5) _____

9. The direct exchange of semen and/or blood is a known way that the AIDS virus can be passed from one person to another.
COMMENTS:

RANK (1-5) _____

10. Blood testing for AIDS virus infection identifies the presence of the actual virus.
COMMENTS:

RANK (1-5) _____

11. Presently there is no cure for AIDS.
COMMENTS:

RANK (1-5) _____

12. Mosquitoes cannot transmit the AIDS virus to humans.
COMMENTS:

RANK (1-5) _____

13. Men can become infected with the AIDS virus through vaginal intercourse with an infected partner.
COMMENTS:

RANK (1-5) _____

14. The AIDS virus is easily killed with soap, alcohol, hydrogen peroxide, or a household bleach solution.
COMMENTS:

RANK (1-5) _____

15. A positive AIDS blood test does not mean that the person will develop AIDS.
COMMENTS:

RANK (1-5) _____

16. AZT is a cure for AIDS.
COMMENTS:

RANK (1-5) _____

17. Once infected with the AIDS virus, antibodies are immediately produced and can be detected by a blood test.
COMMENTS:

RANK (1-5) _____

18. The proper use of condoms is 100% effective in preventing AIDS virus infection.
COMMENTS:

RANK (1-5) _____

19. Concentration of the AIDS virus makes some body fluids more efficient in transmission.
COMMENTS:

RANK (1-5) _____

20. Once inside the body, the AIDS virus is capable of reproducing itself.
COMMENTS:

RANK (1-5) _____

21. Eventhough antibodies are produced, they are unable to effectively neutralize the AIDS virus.
COMMENTS:

RANK (1-5) _____

22. The AIDS virus attacks and destroys the body's immune system.
COMMENTS:

RANK (1-5) _____

23. The use of certain drugs, such as "poppers," marijuana, or speed, may make a person more susceptible to AIDS virus infection.
COMMENTS:

RANK (1-5) _____

24. The risk of AIDS virus infection increases during the menstrual period.
COMMENTS:

RANK (1-5) _____

25. The health status of the immune system affects the risk of becoming infected with the AIDS virus.
COMMENTS:

RANK (1-5) _____

EXECUTIVE SUMMARY

SENATOR KENNEDY TAKES BIPARTISAN AIDS BILL TO MARK-UP IN THE SENATE: COMMITTEE PASSES BILL ON A 15-0 VOTE

On June 17, Senator Kennedy brought to the Senate Labor and Human Resources Committee a bipartisan bill, "the AIDS Research and Information Act of 1987", for mark-up by the Committee. The most substantial segment of the bill re-negotiated by the two parties was the service delivery portion. The original Kennedy version called for support and reimbursement of ambulatory and home care services for persons with AIDS as well as the establishment of innovative service delivery models. In the bill voted on by the Committee, this segment now only provides for reimbursement for services in the home.

SENATOR DOLE INTRODUCES THREE PART AIDS LEGISLATIVE PACKAGE

On June 16, Senator Robert Dole (R-KS) introduced a bill entitled "the AIDS Act of 1987". The bill is designed to help combat AIDS through the implementation of training programs, care delivery services and the dissemination of public information.

APPROPRIATIONS UPDATE

The House and the Senate have passed a 1987 Supplemental Bill which has several provisions for AIDS. The breakdown of these provisions is outlined below:

- \$20 million for a house to house mailing of AIDS information and education materials
- \$30 million to provide AZT for persons eligible under the labeling of the drug
- \$20 million to expand state testing programs
- \$ 7 million for targeted AIDS information to minorities

1987 SUPPLEMENTAL APPROPRIATION BILL PROVIDES FOR AZT

The Council has previously reported that an amendment appropriating \$30 million for AZT is included in the FY 1987 Supplemental Appropriation Bill. On July 1, this appropriation bill was passed by both the House and the Senate and subsequently signed by the President. The Human Resource Service Administration (HRSA) has set up a state by state distribution mechanism for these funds. Additional information will be forwarded to you.

CLINICAL TRIAL UPDATE

In the past several weeks, the Council has been working with staff at the National Institutes of Health to increase the dissemination of information regarding the 19 drug trials currently underway in AIDS Treatment Evaluation Units (ATEUs) across the country. The Council has learned that at many of the ATEUs there are only a few people enrolled in many of the clinical trials. On June 24, AIDS Action Council Executive Director, Ann McFarren issued a press release regarding the drug trials currently being conducted by the National Institutes of Health and urged PWAs to contact the nearest ATEU for information about the drug trials that they may be eligible to participate in. Please contact the AIDS Action Council office in writing if you are interested in obtaining a copy of the press release.

AIDS ACTION COUNCIL ARRANGES A MEETING FOR THE NATIONAL ASSOCIATION OF PEOPLE WITH AIDS WITH CONGRESSIONAL LEADERS

On June 3, the AIDS Action Council arranged a meeting with the Board Members of the National Association of People with AIDS (NAPWA) and Senator Lowell Weicker, Jr. At the meeting, NAPWA representatives and Senator Weicker were joined by Senators Grassley, DeConcini and Danforth. In closing the one hour meeting, Senator Weicker made a personal commitment to the PWAs. He pledged his "word, my guarantee that whatever I can do to guarantee you hope for the future, whether it is more money for research or whatever it takes, I'll do it. I am a very bad loser. Don't worry about this place (the Congress). There will be several of us that will refuse to give in, that will find answers to your problems. This base is covered. You worry about taking care of yourselves, let me worry about the Congress."

Prepared by:
AIDS Action Council
729 8th Street, SE
Washington, DC 20003
(202) 547-3101

DISTRIBUTE AT WILL

July 15, 1987

Leo A. Sanders, Chief
Grants Management Branch
Procurement and Grants Office
Centers for Disease Control
255 East Paces Ferry Road, N.E.
Room 321
Atlanta, Georgia 30305

REFERENCE: AIDS Education Program on Colleges and Universities
Application for CDC Cooperative Agreement

Dear Mr. Sanders:

The American College Health Association is pleased to propose this cooperative agreement to (1) expand AIDS education programs on higher education campuses and (2) reach large numbers of students with education strategies designed to change student knowledge, attitudes, and behavior regarding AIDS. ACHA will conduct four regional workshops and provide follow-up on-site technical assistance to 200 colleges and universities in Year 1.

The ACHA is pleased to offer the resources of its Task Force on AIDS and its Executive Board; these individuals have been intensely involved in developing campus AIDS education programs and all have agreed to volunteer their time and expertise to this project. In addition, the ACHA is happy to donate the use of its headquarter offices and equipment.

The project panel is comprised of members of the ACHA Task Force on AIDS. The panel is built into critical planning and review activities; this ensures that they have the opportunity to review, modify, and approve all educational materials--in outline and draft forms. For example, the panel meeting will define workshop topics; panel members then will review the proposed curriculum (content outline) and, subsequently, the draft workshop materials. ACHA will ensure that the panel's activities comply with CDC review requirements and will provide quarterly approval statements to CDC.

We believe the cooperative agreement offers a significant opportunity to develop the number and quality of campus AIDS education programs. We welcome the opportunity to discuss our proposal. On technical questions, please feel free to contact Dr. Richard Keeling, President-Elect and Chair of the Task Force on AIDS, at (804) 924-2670. For cost questions, please feel free to contact Mr. Stephen Blom, Executive Director, (301) 963-1100.

Sincerely,

Richard P. Keeling, M.D.

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I. NEED

The Acquired Immunodeficiency Syndrome (AIDS) is an insidious disease that threatens the lives of millions of Americans--just at the prime of their lives. Today, about 12 million people attend the nation's more than 3000 colleges and universities. Fortunately, few of these young adults have yet been diagnosed with AIDS. Undoubtedly, many more college age adults are probably infected with the AIDS virus. Certainly, people infected with the AIDS virus are capable of transmitting the virus to others through sexual intercourse or by sharing needles.

AIDS can largely be prevented by practicing safe abstinence, monogamy or safer sex practices--behaviors--and by refraining from intravenous drug use, especially unclean needle sharing. Teaching college students risk-reduction behaviors is a unique opportunity to halt the spread of the AIDS virus. Concomitantly, it poses substantial challenges. It involves intervention at a crucial developmental stage--often characterized by a desire for spontaneity, a new sense of freedom, and an urge for experimentation--by asking young adults to approach their sexual lives with caution, planning, consistency, and responsible decision-making.

The American College Health Association (ACHA) has made a strong commitment to educating and motivating college students to practice AIDS risk-reduction behaviors and to squelching irrational fear on the campus environment. Over the past few years, the ACHA, particularly through its Task Force. On AIDS, has developed national policy, prepared and disseminated educational materials, held conferences, implemented campus AIDS education programs, organized a network of college professionals and students, and collaborated with other organizations and professionals committed to preventing further spread of AIDS in this nation.

Under this proposed CDC grant, ACHA proposes to utilize its existing structure and network to expand the number of schools and students actively developing campus-wide AIDS education programs and ultimately, to increase the number of students practicing risk-reduction behaviors. The primary methods for achieving these goals will be the delivery of regional workshops to college student/faculty teams and the provision of follow-up consultation through on-site technical assistance and information dissemination.

This chapter discusses the special considerations of college student development, the need for innovative educational approaches, and the status of AIDS educational programs on campus.

1. SPECIAL CHARACTERISTICS OF COLLEGE STUDENTS

College students face a host of complex issues as they struggle to understand AIDS and adjust to new behaviors. Developmental issues of late adolescence focus on cognitive and moral maturation, the struggle for autonomy, the definition of self and sexuality, the acceptance of responsibility and accountability, and the urge for experimentation. College students share with other young adults a conviction of invincibility and the assumption of good health.

For college students, development of competence, autonomy, identity, and

integrity take place in an environment that stretches old boundaries of thought, action, and perspective. College life brings important new experiences for many students. They may be living away from home, often for the first time. Many share residences with a diversity of peers--many of whom have different world-views and life experiences--and sometimes share residences with both sexes. They are in constant social and recreational interaction with other students. They have easy access to peers with whom they can test and explore sexual identities and behaviors. And, they are confronted with the academic challenge to question assumptions and examine new research, values, and lifestyles.

Developmental struggles of college students, combined with new lifestyle experiences, may interfere with a commitment to responsible strategies to avoid contracting the AIDS virus. For example:

- Students often find it difficult to acknowledge and plan for sexual activity. Parental, peer, societal, and religious standards sometimes make choices around sexual activity uncomfortable for many. Students often regard sexual encounters as accidents or chance events for which they bear little responsibility or choice. College women may fear that obtaining condoms labels them as being promiscuous.
- Some students have not developed enough self-esteem, confidence, or assertiveness to say no to sex or demand the use of condoms. If a sense of autonomy and self-confidence remains elusive, it may be easier to give in to the demands or assurances of a sexual partner, especially if the relationship seems very valuable or the fear of rejection is more painful and immediate.
- To use condoms, many students must overcome peer pressure about the social unacceptability of condoms, embarrassment about purchasing condoms, and ignorance about how to use them. Reliance on oral contraceptives in heterosexual encounters further discourages the use of condoms by creating the attraction of convenience and spontaneity without the need for negotiation between partners.
- Experimental or recreational use of drugs and alcohol may be an "excuse" that allows students to avoid accountability. These substances can interfere with a student's ability to say no or insist on proper condom use.
- The widespread belief among students that the negative consequences of sexual encounters are reversible makes it difficult to acknowledge the need for precautions. False reassurances emanate from the availability of treatment for most sexually transmitted diseases and abortion for unplanned pregnancy.
- Struggles with sexual identity and orientation can interfere with taking precautions. Some students who identify themselves as heterosexual have homosexual encounters. The experimental nature of these encounters, combined with a sense of denial, lessens the likelihood of protected encounters.

Of course, college students are not a homogenous population, but rather, a

microcosm of our nation's melting pot. Religion, ethnicity, family, life experiences, and a host of other factors influence the college student's view of the world. Moreover, college experiences differ markedly for residential college students, commuters, part-time students, and others. Further, students attending schools in high AIDS incidence areas face different concerns and realities than students in low incidence areas.

If we are to successfully reach these divergent student populations, we must design AIDS educational programs that meet the unique needs of diverse college populations. The proposed workshops will be designed with a core curriculum but will be tailored for each event using local presenters and offering local model approaches.

2. THE NEED FOR INNOVATIVE EDUCATIONAL APPROACHES

Information alone is not sufficient to change health risk behaviors. That is the common conclusion of college campuses with experience in implementing educational programs on personal health topics, including AIDS, contraception, sexuality, alcohol and drugs. We must address attitudes and values, as well as equip students with the communication and decision-making skills to act responsibly.

These colleges have also learned of the critical importance of involving students and faculty members in the planning and implementation of AIDS and other behavioral health education programs. Students respond more openly and seem more willing to adopt new behaviors when educated by their student peers rather than by faculty members, health professionals, or other college professional counselors. At the same time, faculty leadership and sponsorship is vital in gaining institutional commitment, faculty cooperation, parent support, and funding resources. Further, faculty can help in networking with other campus and non-campus community resources and in providing advice to student leaders.

Accordingly, we have designed the workshops to be targeted to student/faculty college teams. The workshop will be structured not only to transfer information and skills but also to set the stage for team building between the faculty and student representative for each participating school.

3. THE CURRENT STATUS OF AIDS CAMPUS EDUCATION PROGRAMS

Of the more than 3000 colleges and universities nationwide, a small number, typically large schools situated in high AIDS incidence areas, have implemented very impressive and comprehensive AIDS education programs. These campus programs provide the "models" of effective approaches in various campus environments. The students and faculty members who led the efforts to develop and implement these programs form the core of the college AIDS education expertise. Our proposed workshops will be targeted to the vast majority of colleges and universities that have not yet implemented comprehensive AIDS education programs on campus.

II. CAPACITY

This chapter describes the ACHA structure, discusses its AIDS-related activities, and presents our proposed project team for mounting an educational and risk-reduction program on college and university campuses nationwide.

1. THE STRUCTURE OF THE ACHA AND ITS TASK FORCE ON AIDS

The American College Health Association (ACHA) is a 66 year old voluntary, non-profit organization of over 1,000 health care professionals, faculty, administrators, and students representing about 600 colleges and universities. The association promotes cooperative efforts among schools of higher education, shares knowledge on numerous school health issues, and is a central resource for networking, educational material, and professional development. It is organized into six regions; New York/New England, Mid-Atlantic, South/Southwest, Mid-America, Rocky Mountain, and Pacific Coast. A Regional Representative, who sits on the Executive Board of ACHA, is elected from each region.

The ACHA Task Force on AIDS, established in September 1985, provides nationally consistent guidelines for colleges and universities for addressing the medical, psychological, educational, and administrative issues raised by AIDS. The Task Force is comprised of 24 members who represent geographically dispersed schools, multi-disciplinary health fields, school administrators, and students. It also includes representatives of the American Council on Education (ACE), the Association of College and University Housing Officers International (ACUHOI), and the National Association of Student Personnel Administrators (NASPA). It also has members representing community-based AIDS service groups from New York, Washington D. C., Atlanta, and San Francisco.

2. ACHA TASK FORCE ON AIDS ACTIVITIES TO DATE

In late 1985, the ACHA Task Force on AIDS published a General Statement on Institutional Response to AIDS that has become the standard for comparison of institutional policies on AIDS. The statement was followed by a book, completed by the Task Force members in Spring 1986, AIDS on the College Campus, that includes chapters on education, confidentiality, risk assessment, antibody testing, and administrative policy issues. Since its inception, the Task Force has produced volumes of campus-oriented, AIDS-related educational tools that address the needs of both students and health educators.

The Task Force has prepared three brochures. AIDS: What Everyone Should Know, provides basic up-to-date information on epidemiology, transmission, and risk reduction and is updated every six months. Well over 1.5 million copies have been distributed to date. The Task Force has developed two risk reduction brochures for students that talk explicitly about safer sexual behavior. One brochure, Safe Sex, was produced for under \$1000 using volunteer labor and materials. Over a million copies of this brochure have been distributed. The second risk reduction brochure, Making Sex Safer, is for institutions that may be uncomfortable with the explicit photography in Safe Sex. Released this month, thousands of copies have already been disseminated.

Under a contract with the National Institute of Mental Health, the Task Force recently completed a handbook, Coping With AIDS And Other Forms Of HIV Infection: A Handbook For College And University Physicians And Counselors, that discusses the psychosocial aspects of AIDS and provides guidance on how to address the range of student concerns about AIDS. About fifty thousand free copies will be made available by the Government in the next few months.

The Task Force has produced two videotapes. The AIDS Dilemma, completed in April 1986, is aimed at managers and health professionals. It discusses the major AIDS issues and offers suggested approaches on college campuses. AIDS: Reducing the Risk, a 30-minute appeal to students, encourages responsible decision-making and safer sexual practices. This videotape was just released this month.

Currently, the Task Force Working Groups are developing additional AIDS education materials. For example, the Working Group on Psychosocial Issues is developing a workbook for college health services to use in developing and structuring support services for students and others with concerns about AIDS. The Working Group on Clinical Issues is preparing a guide for clinicians for responding to students' AIDS-related symptoms. The Working Group on Educational Programs is reviewing educational guidelines to take into account new epidemiologic and clinical information. The new Working Group on Women's Issues is preparing written materials and guidelines for health professionals and a brochure for students emphasizing the special needs of women. Finally, the Working Group on Decision Making is preparing a brochure that deals with choices around abstinence and safe sex practices.

All Task Force materials on AIDS will be made available to participants in the workshops. Materials for widespread campus distribution will be available through the ACHA at low costs. With the exception of the workshop curriculum and training materials, we do not anticipate the need to develop any other materials under this grant.

The Task Force has sponsored three national conferences on AIDS on the college campus. The first conference was held in New Orleans in May 1986 and was attended by about 800 participants. In January 1987, the Task Force co-sponsored a two-day conference at the University of California for more than 500 attendees. This spring the Task Force held a colloquium on AIDS in Chicago for 500 college health professionals and other participants.

Task Force members have consulted with hundreds of colleges and universities in constructing AIDS policy, risk-reduction strategies, clinical management, and support services appropriate for students and others in higher education. The members also have consulted on policy and program direction with the Federal Government and national associations.

The ACHA and its Task Force represent a broad network of AIDS experts and concerned professionals and students capable of mounting a national risk-reduction educational program on campuses and universities. This next section describes our proposed organization for this grant.

3. THE PROPOSED PROJECT ORGANIZATION

The proposed CDC grant will be directed by Richard Keeling, M.D., Chairperson of the ACHA Task Force on AIDS and Director of Health Services, University of Virginia. Dr. Keeling formed the Task Force and made it a leader on AIDS issues facing high education institutions. He directed all Task Force publications, conferences, and other activities, provided technical assistance to numerous higher education institutions, and consulted with the Federal Government, medical institutions, and other organizations on AIDS concerns among the college populations.

Dr. Keeling will volunteer fifteen percent of his time to direct the proposed grant. He will co-supervise a full-time National AIDS Workshop Coordinator (to be supported under this grant), chair the review panel meetings, review all grant materials, and participate in the regional workshop deliveries. He also will select members of the Task Force to serve as Regional Coordinators for each workshop delivery.

The Review Panel will consist of six members of the Task Force with support by grant project staff and consultants. This panel will convene a one-day meeting to discuss workshop curriculum and content. Thereafter, the members will review workshop materials by mail and conference call. The Task Force members who have volunteered to participate in the Review Panel for the first grant year include Cathy Kodama, M.P.H., Coordinator, Sexuality Programs, University of California Berkely; Anne Lomax, M.S., Coordinator, Health Education Program, University of Delaware; Christine Lyman, A.C.S.W., Director of Social Work, Student Health Services, University of Pennsylvania; H. Robert Wirag, H.S.D., Director of Student Health Services, University of Arkansas; Jeffrey Gould, Student, University of Maryland; Margaret Bridwell, M.D., Director of Health Services, University of Maryland and Leland G. Wessel, M.D., Physician, Student Health Services, San Diego State University. The panel will be chaired by Dr. Keeling.

We propose a local Planning Committee for each workshop delivery. This Committee will consist of the National AIDS Workshop Coordinator (a grant staff position), a Regional Representative (an ACHA Executive Board member), a Regional Coordinator (selected from the ACHA Task Force on AIDS), and a representative from the host campus. These individuals will plan, design, and arrange for the workshop together.

The ACHA plans to hire a full-time Workshop Coordinator for day-to-day activities on the grant. He or she will draft workshop and other grant materials; work with ACHA Regional Representatives (Executive Board members of the ACHA) to select host campuses and recruit workshop presenters and participants; work with the Regional Coordinator for each workshop delivery; coordinate the local Planning Committee; handle meeting and workshop logistics; organize assessment and follow-up consultation activities.

Supplementary consultants will be experts in training and workshop delivery, program evaluation, and risk-reduction methodologies. Among these consultants are Gail Bassin and Jerri Shaw, from Johnson, Bassin & Shaw, co-authors of the Coping With AIDS handbook for college physicians and counselors, and Larry Bye, an AIDS expert on risk-reduction and evaluation.

III. COORDINATION

From its formation, the ACHA Task Force On AIDS has collaborated with other national higher education organizations, national health and counseling organizations, and AIDS-specialty organizations in an effort to share resources and present consistent messages to the community of high education.

In fact, one important strength of the ACHA has been its previous and ongoing efforts to network with a wide range of organizations and individuals concerned about AIDS. As a result, the ACHA has been very successful in gaining acceptance of its recommendations and programs on AIDS for the community of higher education.

1. COLLABORATION WITH OTHER HIGHER EDUCATION ORGANIZATIONS

Recognizing the importance of speaking with a united voice to the community of higher education, the ACHA has continually sought to involve other higher education organizations. Upon formation of the Task Force, the ACHA invited representatives of other national higher education organizations including the American Council on Education (ACE), the Association of College and University Housing Officers-International (ACUHOI), and the National Association of Student Personnel Administrators (NASPA) to sit on the Task Force. In October 1985, Dr. Keeling, Chairperson of the Task Force, convened a meeting of 15 higher education organizations to advise them of the formation of the Task Force and seek their cooperation in developing and distributing materials. With the sponsorship of the ACE and the Teachers Insurance and Annuity Association, the Task Force sent statements and reports describing its efforts to all colleges and universities throughout the nation. In return, the ACHA supported the ACE in its distribution of a white paper on the legal issues of AIDS for universities and colleges in December 1985. Additionally, the ACUHOI adopted and published the ACHA statement on residential life issues.

Dr. Keeling, Chairperson of the ACHA Task Force, has delivered presentations at annual and regional meetings of ACE, ACUHOI, NASPA, and the National Association of State Universities and Land Grant Colleges, the Southeastern Association of Housing Officers, and the National Association of College and University Attorneys. He also authored an article on the issues of AIDS in higher education for the Association of Governing Boards of Colleges and Universities.

The ACHA Task Force on AIDS continues to collaborate with other higher education organizations. In July 1987, the ACHA will convene a meeting in Washington, D. C. with representatives of ACE, NASPA, and the American Association of Community and Junior Colleges to discuss current issues and priorities for addressing concerns about AIDS in the higher education community. In addition, ACHA is exploring the possibility of co-sponsoring an interactive satellite television broadcast on AIDS on the campus. This program will be produced by College Satellite Network and aired in September 1987, just prior to AIDS Awareness Month.

2. COLLABORATION WITH AIDS SERVICE AND TREATMENT ORGANIZATIONS

From the outset, the ACHA has continually sought the collaboration and participation of AIDS service organizations in the Task Force's policy and program development efforts. Representatives of community-based AIDS service providers in New York (Gay Men's Health Crisis), Washington D.C. (Whitman-Walker Clinic), Atlanta (AID-Atlanta), and San Francisco (San Francisco AIDS Foundation) are members of the Task Force. Dr. Keeling is a Director of the Board on the National AIDS Network. The ACHA and the Gay Men's Health Crisis will be co-sponsoring an AIDS education pilot project for residence hall assistants in the New York area this fall.

3. COORDINATION WITH OTHER NATIONAL ORGANIZATIONS

The ACHA has held preliminary discussions with other national organizations that have expressed an interest in developing AIDS education programs for the higher education community under the CDC cooperative agreements. The National Council of Churches plans to work through the network of campus ministers. The ACHA has offered to include campus ministers as members of the Regional Workshop Planning Teams and as presenters in workshop deliveries. The National YWCA is considering a program to sponsor peer education programs through its more than 50 campus chapters nationwide. The ACHA has discussed involving YWCA chapters in the ACHA workshops and has offered to assist the YWCA chapters in developing and conducting the YWCA training program. The American Red Cross plans to implement model projects on college campuses tied to local chapters. The ACHA has offered to work with the American Red Cross on these campuses. Letters of cooperative support from all three of these organizations are included in the Letters of Support.

4. COORDINATION WITH LOCAL TREATMENT AND SERVICE ORGANIZATIONS

The ACHA has always recognized the importance of networking at all levels when responding to concerns about AIDS. Accordingly, the workshops will include sessions on strategies for involving a wide range of organizations and treatment and service providers in planning and developing campus-based AIDS education programs.

IV. OBJECTIVES

The proposed cooperative agreement is designed to: (1) expand on-campus AIDS education activities significantly, and (2) build campus programs that reach large numbers of students, changing student knowledge, attitudes, and behaviors regarding AIDS.

OBJECTIVE 1: TRAIN STUDENT/FACULTY TEAMS FROM 200 UNIVERSITIES AND COLLEGES ON HOW TO IMPLEMENT AN AIDS EDUCATION/PREVENTION PROGRAM ON CAMPUS

Teams from 50 different universities and colleges will attend each workshop. Thus, the four workshops planned for year one will reach 200 campuses. Five factors influence achievement of this objective.

1. Few studies have evaluated specific AIDS education approaches. The workshops, however, focus on effective education strategies.

To date, few experimental design evaluations have focused on education/risk reduction strategies for HIV risk groups. ACHA will therefore stress that each education strategy (1) has been rigorously tested (e.g., the Stop AIDS peer education/counseling approach) or (2) has less rigorous but useful evaluation data indicating that it can galvanize student populations. ACHA also will teach workshop participants (1) how to combine strategies so the total program addresses information needs, attitudes, values, and decision-making skills--the critical ingredients for changing behavior, and (2) how to evaluate their programs so more data exists for future planning.

2. The workshop approach may limit the number of schools reached.

ACHA's survey of 600 campuses indicates that most campus communities are quite concerned about AIDS, yet few have ongoing AIDS education programs. This dearth of programs is probably not due to lack of information since ACHA and others have widely distributed material on campus strategies and policies. The lack of programs is probably linked to the lack of specific programming skills, lack of local leadership, and a need to tailor generic guidance materials to the specific campus. The workshop approach is particularly well-suited to these needs; it is an opportunity for students and faculty to develop skills and design programs specific to their campus.

3. The workshops target schools that have not yet developed programs. More effort may be needed to enroll these schools in the workshops.

ACHA has structured an intensive, multi-faceted recruiting approach: (1) Advance promotion articles and an invitation letter will stress needs for and benefits of campus programs and institutional involvement. (2) The Regional Planning Groups will participate in recruitment and have working relationships with many schools in their region. (3) Recruitment will employ multiple, diverse channels and reach all 3,000 colleges/universities in the U.S. (4) ACHA's work in this area shows that institutions will respond when presented with an opportunity.

4. We are asking schools to pay the travel and meal expenses for two people--a student and a faculty member.

ACHA believes that this request is not unusual and has minimized the

school's cost burden. The school hosting the conference will provide dormitory accommodations and access to cafeterias. ACHA will not charge a workshop registration fee. The request for faculty participation also may be an incentive for some schools to cover expenses, and the faculty member selected to attend can help garner support for the funding request. The Regional Planning Groups will work with schools to resolve problems.

5. Volunteer networks will help recruit participants and speakers and arrange meeting logistics.

Volunteers comprise the panel and Regional Planning Groups. ACHA has a vested responsibility in these groups for three reasons: (1) These volunteers are drawn from a strong, committed network of ACHA representatives and Task Force members. (2) They have successfully fulfilled similar roles for several years. (3) Many of these volunteers have commitments from their institutions for time spent on ACHA AIDS projects.

OBJECTIVE 2: IMPLEMENT AIDS EDUCATION PROGRAMS ON 160 CAMPUSES BY THE END OF YEAR ONE

Each student/faculty team will have primary responsibility for implementing a program on its campus. ACHA will provide continuous assistance to all teams through four support activities. One major factor affects achievement of this objective--Teams' time and effort for program development are constrained by their volunteer status and heavy academic demands. ACHA has three strategies to increase the likelihood that participants will actively develop programs: (1) The student/faculty team concept vests responsibility in two people (each with access to different resources) and creates a mutually supportive relationship. (2) The workshop design builds participants' motivation and commitment through active participation, application of new learnings to the participant's real situation, and action planning. (3) ACHA's four follow-up activities give faculty and students access to needed resources and structure frequent, regular contact for solving problems and providing encouragement.

OBJECTIVE 3: NETWORK WITH AT LEAST SIX OTHER NATIONAL ORGANIZATION IMPLEMENTING AIDS EDUCATION PROGRAMS TARGETED FOR HIGHER EDUCATION STUDENTS AND NON-STUDENTS

ACHA proposes to structure networking through joint development of detailed, concrete action plans with selected organizations. At least one factor influences achievement of this objective: other organizations may not be successful in funding or developing AIDS education programs for the proposed targeted population. The ACHA has engaged in cooperative discussions with several national organizations planning to mount AIDS education programs for higher education students and other college-age young adults not currently in school. However, the efforts of these organizations depend, at least in part, on funding from CDC or other funding sources. On the other hand, the ACHA workshops and follow-up assistance do not depend on the availability of other campus program resources. In any event, the ACHA plans to network with as many national and local organizations as possible that provide resources for or serve as gatekeepers for higher education students and other college-age young adults with concerns about AIDS.

V. ACTIVITIES

In Year One, ACHA plans to conduct four Regional Workshops, each targeted to 100 participants (50 student/faculty teams). Thereafter, the ACHA plans to hold six Regional Workshops annually for the remainder of the grant period. By the end of the fifth grant year, the ACHA expects to have trained at least 1400 student/faculty teams representing the same number of colleges and universities.

OBJECTIVE 1: TRAIN STUDENT/FACULTY TEAMS FROM 200 UNIVERSITIES AND COLLEGES ON HOW TO IMPLEMENT AN AIDS EDUCATION/PREVENTION PROGRAM ON CAMPUS

Activities supporting this objective can be grouped into five categories: formally appointing members of the panel and Regional Planning Groups, designing the workshop and developing training materials, recruiting student/faculty teams, arranging logistics, and conducting four regional workshops.

A. FORMALLY APPOINTING THE MEMBERS OF THE PANEL AND REGIONAL PLANNING GROUPS

Activities in Category A will be accomplished during the first month following the cooperative agreement award.

Activity 1: Appoint panel members.

Panel members are identified in this proposal. Upon award, the Coordinator will call each member to discuss panel roles and specific tasks and identify available dates for the panel meeting (Activity 3). A letter from ACHA will confirm this discussion.

Activity 2: Appoint Regional Planning Groups.

The project will set up four Regional Planning Groups during the first year--one for each of the four workshops. Each group will consist of the panel member from a university/college within the region, a member of the ACHA Executive Committee member from that region, a representative of the school hosting the workshop, and the National Coordinator.

The Project Director and National Coordinator will follow these steps to appoint each group:

- Call the panel member (or Task Force member) and Executive Committee member within the region to discuss the project, confirm their participation, and elicit suggestions for schools that could host the workshop.
- Confirm all Regional Planning Group member selections in writing.

B. DESIGNING THE WORKSHOP AND DEVELOPING TRAINING MATERIALS

The design activities are critical to reaching the objectives of enhancing student/faculty knowledge and expertise. A solid, effective design gives participants many opportunities to try on new skills and begin planning the specific program for the team's campus; the design also provides a comfortable environment for intensive learning. The training materials give student/faculty teams core resource materials for designing campus programs. The activities under Category B will be conducted during the second and third month following the cooperative agreement award.

Activity 3: Convene a panel meeting to develop a content outline for the workshop.

This activity ensures that the workshop's basic content addresses a full range of campus strategies and issues critical to the success of campus AIDS programs. The panel meeting offers a forum for drawing on the extensive, pragmatic experiences of people who have developed AIDS programs on diverse campuses.

Prior to the meeting, the National Coordinator will send panel members a briefing packet that includes workshop objectives (outlined earlier) and synopses of alternative campus education/prevention strategies. (Most synopses are already available ACHA materials.) He also will work out the meeting date and logistics with panel members.

The Project Director, Coordinator, and a training consultant will work with the panel in the one-day meeting. The meeting will be structured as follows:

- Briefly review workshop objectives, intended audience, and timeframes. Develop consensus on the objectives (i.e., the knowledge, skills, and attitudes to be acquired during the workshop).
- Brainstorm a list of issues that panel members believe are of most interest and concern for faculty and students. The recent ACHA survey highlighted issues such as:
 - How to get a campus AIDS education program started--how to reduce institutional resistance (as evidenced by trustees, the administration, and faculty); how to reduce resistance from parents and the community; how to raise program funds; and how to market the program to students (as consumers and as potential program staff)
 - What kinds of prevention to teach (e.g., ranging from abstinence to condom use to refusing to share needles)
 - How to ensure continuity of the program (i.e., how to build it into ongoing campus programs)

- Modify and expand a list of alternative campus education/prevention strategies, shown in Exhibit 1. (During the workshop, student/faculty teams will learn about these strategies through presentations and examples of applications within the region. Teams then will begin the process of selecting a combination of strategies suited to their campus needs.)
- Brainstorm the key factors in deciding what strategies are most appropriate for a campus. Factors include:
 - The size, location, type, and community values of student population
 - The level of commitment to AIDS education by campus administrators, faculty, staff, and students
 - Campus resources available for AIDS education (e.g., budget, staff, existence of peer education programs)
 - Community resources available for consultation and referral
 - Prior experiences with AIDS education activities on campus and responses to those activities
- Develop and sequence a list of workshop topics, and discuss presentation methods (e.g., small group discussions, lecture). Exhibit 2 reflects our preliminary thinking about the workshop flow.
- Decide which topics will constitute the core curriculum (i.e., will be offered at every workshop) and which topics will be modified within each region to reflect regional/local needs and values.

Activity 4: Draft the workshop curriculum.

This activity will translate basic content decisions into a detailed curriculum and training agenda. The National Coordinator will draft the curriculum--a detailed outline of each topic that identifies key points, case study examples, and primary reference sources. This document also will sequence the topics, based on the panel discussion.

The Coordinator and training consultant then will prepare the detailed training agenda. This involves:

- Grouping content items into workshop modules
- Matching each module (content piece) with training techniques

As shown in Exhibit 2, we envision using a range of training techniques, with an emphasis on (1) short lectures and frequent small group/team exercises--so that participants have repeated opportunities to apply new learnings; and (2) action planning

sessions--so that teams leave the workshop with specific plans for applying and disseminating new learnings when they return to their campuses.

- Laying out requirements for each module regarding time needed, visual aids, training and resource materials, and presenters/facilitators

Both the curriculum and training agenda will be sent to panel members for review and comment. We will ask them to check whether key learning objectives are allotted sufficient time and priority and whether training techniques are mixed appropriately.

Activity 5: Develop package of workshop materials.

ACHA has developed extensive materials (new materials are in progress) on AIDS for colleges and universities, and some institutions within the ACHA network have tested and refined materials for specific strategies (such as those listed in Exhibit 1). Thus, we expect that the major effort here will be to sort, sift, and sequence existing materials. New materials will be developed only as needed to fill the gaps.

The National Coordinator will send the package to each panel member for review and comment.

Activity 6: Activate the Regional Planning Groups.

Members of each Regional Planning Group will receive the curriculum, training agenda, and package of workshop materials. With that package will be a letter outlining next steps for each group:

- Review the materials.
- Hold a conference call to discuss:
 - Initial thoughts about how to configure the modules set aside for regional/local models and issues
 - Reactions to the materials
 - Potential presenters/facilitators available within the region
 - Logistics issues (e.g., confirmation of dates, site)
 - Recruitment strategies (See Activities 7-10)

The National Coordinator is a member of each Regional Planning Group and will "chair" the conference call and follow-up the call with a written summary of decisions and future actions. He will help each group work out a timetable and division of activities, and then will monitor progress and provide assistance.

C. RECRUITING STUDENT/FACULTY TEAMS TO PARTICIPATE IN THE WORKSHOPS

The National Coordinator and Regional Planning Groups have major responsibility for recruiting. Their goal is to identify 50 student/faculty teams (one team from each of 50 institutions) to participate in each regional workshop. Activities under Category C will be conducted during the third and fourth months following the cooperative agreement award.

Recruitment activities will encompass all 3,000 colleges and universities within the U.S. ACHA will work with coordinating national and regional organizations to reach the largest possible number of institutions.

Activity 7: Publish periodic announcements about the workshop from the time the grant is awarded.

ACHA will begin promoting the workshops as soon as the grant is awarded. The National Coordinator will:

- Talk with the national organizations cited in this proposal and others suggested by CDC to identify ways of alerting people to the upcoming workshops.
- Prepare copy for newsletters and mailing inserts (flyers that can be enclosed in routine mailings)
- Distribute this copy to coordinating organizations
- Place notices in the ACHA monthly newsletter and newsletters of regional ACHA affiliates

The initial round of notices will announce the grant and alert people to the upcoming workshops. A second round of notices will cite workshop dates, locations, and registration procedures.

Activity 8: Send out an announcement to all colleges and universities in the region.

ACHA will prepare a special invitation letter to all colleges and universities within the four regions where the workshops will be held. Steps include:

- Work with the American Council on Education (ACE) to obtain mailing labels sorted by region.
- Prepare an invitation describing the grant, workshop content, date, location, registration procedures, and costs. Include information about the importance of sending a student/faculty team.
- Mail invitations to two persons at each institution: (1) the Health Service or Health Officer and (2) the Chief Officer of student government.
- Mail invitations to the ACHA representative at the institution.

Activity 9: Make follow-up phone calls as needed to ensure sufficient number of participants.

The National Coordinator will work with each Regional Planning Group to monitor response rates. If all slots are not filled within two weeks after the registration cutoff date, the Regional Planning Group will identify a priority list of institutions and call either the Health Officer or ACHA representative to encourage their participation. If registrations exceed the workshop slots, we will set up a waiting list and let people know about the other workshops slated for year one of the grant.

Activity 10: Select and recruit regional speakers.

Some workshop sessions will involve presentations by student/faculty teams about their experiences in developing campus AIDS education programs. The Regional Planning Group is responsible for selecting the models to be presented, and will begin this process in its first conference call (Activity #6). The Regional Planning Group will also consult with the local campus ministers, the Red Cross chapter, and the AIDS service providers. Additional steps include:

- The Regional Planning Group will develop a list of presenters for selected sessions and the exhibits/displays.
- The National Coordinator will draft a sample invitation letter for presenters, which the Regional Planning group will tailor and send.
- Confirmed presenters will receive a packet on their session and instructions on submitting materials to be distributed or displayed at the workshop.

D. ARRANGING WORKSHOP LOGISTICS

Workshop logistics are not technically difficult; the problems lie in the number of details to be arranged and the possibilities for arrangements to go awry. The basic principles are to (1) set the date and location as early as possible; (2) confirm facility arrangements once, twice, and then again; and (3) to make sure all planners know who is to do what when. Activities under Category D will be completed during month five following the cooperative agreement award.

Activity 11: Develop and implement a logistics plan for each region.

A logistics plan lays out requirements, steps, and timeliness for the meeting and sleeping facilities, equipment, and materials (e.g., meeting room times and set-ups, sleeping room numbers and booking procedures, AV equipment needs and suppliers, message centers). The plan for each region will differ in accord with host facility resources.

Logistics planning will begin in the first month of the project for two reasons. First, finding available dates and sites can be time-consuming. Second, the invitations need to include registration and room reservation steps specific to the host facility.

Steps for developing the logistics plans follow:

- The National Coordinator will draft a master logistics plan and send that to the Regional Planning Groups and host facilities, with a list of questions to be resolved within each region.
- The host facility and a member of the Regional Planning Group will work out detailed arrangements (as indicated by the Coordinator's questions) and send that information back to the Coordinator.
- The Coordinator will prepare a final plan tailored to each regional workshop, making sure that each activity has a reasonable timeline and someone assigned to it.

The Coordinator will monitor progress on the plan, working with the Regional Planning Group and host facility to resolve problems. Logistics activities will increase significantly in the month before each workshop. Final preparations include distributing a logistics memo to all confirmed participants (e.g., lodging, directions, transportation); confirming site arrangements; and inserting regional/local materials into the final training package.

E. CONDUCT FOUR REGIONAL WORKSHOPS

The Project Director, National Coordinator, Regional Planning Group members, and training consultant will be on-site during the workshop. They will have both substantive and logistic responsibilities. The first year Regional Workshops will be held during the sixth through ninth months following the cooperative agreement award date. The fourth Workshop will be held in early May prior to the end of the school year.

Activity 12: Provide guidance and support during each workshop.

The workshop team's responsibilities will include:

- Making selected presentations, guiding the group through exercises and discussions, and facilitating small work group sessions
- Monitoring participants' reactions and learning process, and adjusting workshop content and schedule as needed
- Monitoring and trouble-shooting logistics needs
- Capturing information needed to define how ACHA can best support student/faculty teams as they begin implementing programs

OBJECTIVE 2: IMPLEMENT AIDS EDUCATION PROGRAMS ON 160 CAMPUSES BY THE END OF YEAR ONE

Student/faculty teams will leave the workshop with new knowledge, skills, tools, and an action plan for their campus. Follow-up is needed, however, to sustain their motivation, help them overcome obstacles, and make planned programs a reality. ACHA proposes five ways of providing continued support. The structures for accomplishing the Activities under Objective 2 will be designed during the first four grant months; implementation of these Activities will begin immediately following the first Regional Workshop delivery and continue through the end of the grant year.

Activity 13: Set up and operate a speakers/consultants bureau.

The bureau will increase local campus access to: (1) speakers for campus workshops, symposium, conferences, and special events such as an AIDS awareness day; and (2) persons with expertise and experience in developing AIDS education programs who can work with campus task forces, planning groups, and program people to resolve specific problems. The bureau will offer its services nationwide, but will concentrate the first year on developing operations within the four workshop regions. Steps to develop the bureau follow:

- The National Coordinator will draft a list of topics reflecting the range of anticipated requests, procedures for recruiting speakers/consultants, alternatives for advertising the bureau, and procedures for handling requests and cost-sharing.
- The Coordinator will send these drafts to the panel and Regional Planning Groups, obtain their suggestions by phone, and revise the materials.
- The Coordinator will ask the panel and Regional Planning Groups to nominate individuals who could serve as speakers/consultants on each topic, compile all suggestions, and distribute that list.
- After every workshop, the Regional Planning Group will add individuals to the list of bureau speakers/consultants.

Activity 14: Establish and operate a resource center.

Local campus programs can save precious time and effort by taking advantage of existing materials, needs assessment instruments, and training packages. ACHA already has collected a substantial amount of such materials and expects that much more will be identified through the workshops. The resource center will make that material available to local campus programs. Development of the center involves the following:

- The National Coordinator will compile a list of materials (written and AV) currently available to ACHA. Each item will be described in content, availability, cost, and ordering information. Items will be organized into categories.

The Coordinator will compile a second list of materials that are not currently available to ACHA but might be useful. The Coordinator will consult with CDC on items in its database and with other organizations.

- Members of the panel and Regional Planning Groups will review both list to add and delete items, and to answer questions about specific items.
- The Coordinator will draft procedures for advertising the resource center and handling requests, obtain suggestions from the panel and Regional Planning Groups, and finalize procedures.
- The Coordinator will work with the Project Director to define what inventory should be maintained in the center, and will monitor ongoing center operations.
- Resources will be added to the center's list and/or inventory after each workshop and as CDC adds to its database.

Activity 15: Conduct telephone follow-up with all workshop participants.

Six weeks after each workshop, the Coordinator and Regional Planning Group members will call the student/faculty teams. This call serves three functions--to gather evaluation data (described later), assist teams in identifying and resolving problems, and encourage continued efforts.

The Coordinator will develop a brief questionnaire for the call and refine it with input from the groups. It will be structured so that the caller can record progress, problems, advice offered, and needs for additional information, materials, or speakers/consultants.

The Coordinator and Regional Planning Groups will divide up the phone calls, agree on a schedule, and forward all completed questionnaires to the Coordinator. The Coordinator will respond to requests for assistance, using the resource center and speakers/consultants bureau wherever possible. In some cases, the Coordinator will need to follow-up in person with the local student/faculty team to clarify the problem/request and work out a solution.

Activity 16: Publish a newsletter on campus programs.

The newsletter will enhance networking and information sharing; it also will recognize accomplishments of local programs and identify additional resources for local programs. Accordingly, the newsletter will include descriptions of ongoing, model programs; innovative approaches to major activities (e.g., needs assessment) and constant problems; findings from the workshops (e.g., analysis of factors helping and hindering development of campus programs); new additions to the resource center; and ads for the resource center and speakers/consultants bureau. One option is to focus each edition on a particular topic; for example, the first edition would focus on needs assessment, the next on a particular type of strategy (e.g., working with the media), and so on.

The ACHA project will publish the newsletter twice a semester and distribute it to all workshop participants. The Coordinator will prepare the newsletter.

OBJECTIVE 3: NETWORK WITH SIX OTHER NATIONAL ORGANIZATIONS IMPLEMENTING AIDS EDUCATION PROGRAMS FOR HIGHER EDUCATION STUDENTS AND NON-STUDENTS

The networking effort is important for several reasons. (1) Students, faculty, staff, and others may seek education, counseling, and other services from a wide-range of gatekeepers. Thus, it is essential that campus-based AIDS education programs involve and tap into the diversity of potential resource organizations and individuals available to address concerns about AIDS. (2) It is equally important that consistent messages and information about AIDS be provided to students and others and that scarce resources be efficiently and effectively utilized. (3) There are excellent AIDS educational materials and effective models that can be shared by ACHA and other national organizations. Activities under Objective 3 will be carried out throughout the grant year.

Activity 17: Develop and maintain specific cooperative plans with at least six national organizations.

In preparation for this proposal, ACHA has obtained the support of six national organizations to share resources and learnings. The ACHA cooperative agreement project team will continue to network with these and other national organizations throughout the grant period. During the project start-up phase, the Coordinator will contact each organization to develop a plan for working together and periodically exchanging findings. For example, ACHA could offer the opportunities to attend an ACHA workshop, the training materials, and access to the bureau and resource center; another organization could offer models useful for the workshop, participants for the bureau, and materials for the resource center. The Coordinator will confirm arrangements with each organization in a written cooperative agreement.

EXHIBIT 1

A MENU OF AIDS EDUCATION STRATEGIES FOR COLLEGES AND UNIVERSITIES

Disseminate Materials

- Obtain free materials from resources such as the ACHA, local and State Health Departments, local and regional AIDS centers.
- Distribute these materials through gatekeepers (e.g., residence life staff, counselors, administrators, health care workers, student groups).
- Set up a resource center where students can obtain the materials.
- Put up posters in dorms, cafeterias, and student lounges.
- Purchase AIDS audio-visual materials.
- Develop and distribute materials specific to the campus.

Work With Campus And Community Media

- Obtain free ad copy or develop ad copy specific to the campus.
- Work with the campus newspaper to:
 - Run educational ads one time or on a continuing basis.
 - Publish an ongoing Questions/Answers column about AIDS.
 - Run "personals" ads on where to go for information and counseling.

Operate Peer Education/Counseling Projects

- Train students to provide information through a telephone service or a "drop-in" center.
- Train students in counseling techniques and make those services available through a hotline or "drop-in" center.
- Print and post phone stickers for information and hotline services.

Conduct Networking Efforts

- Set up a campus task force on AIDS, with representatives of major gatekeeper resources on campus.
- Develop a campus AIDS resource guide, in concert with campus and community groups.
- Share resources with community hospitals, information centers, and

Run Special Events

- Hold an AIDS awareness day.
- Offer theater and film presentations.
- Set up a condom awareness booth.
- Hold workshops, panel discussions, or a symposium on campus.
- Offer continuing education credits for college/university personnel.

EXHIBIT 2

FIRST DRAFT OF WORKSHOP TOPICS AND TRAINING TECHNIQUES

FIRST AFTERNOON (1:00 - 5:00)

- Overview of the CDC project, workshop objectives, workshop format, and campuses participating in this workshop
- Presentation: AIDS on campus (epidemiology, issues, alternative responses available to campuses)
- Exercise: Small groups (8 to 10 people) identify the most pressing issues about AIDS on their campuses and list these on newsprint. One group reports out its concerns to the total group, and other groups add to the list. ACHA facilitator summarizes concerns.
- Presentation: Steps in building a campus AIDS education program (an action planning model that includes assessing local needs, developing institutional support, identifying resources, setting priorities and selecting activities, and evaluating the program)
- Presentation: What you want to learn from a needs assessment and basic methodologies
Panel presentation: Ways to go about a needs assessment (Each panel member talks about how they assessed needs on their campus, with each person representing a different methodology.)
Exercise: The facilitator assigns each student/faculty team to a group with teams from similar campus settings. Each group discusses how they could assess needs on their campuses.
- Presentation: The menu of AIDS education strategies
Panel presentation/discussion: What these strategies look like (Each panel member talks about a different strategy--e.g., materials, media, peer education.

DINNER BREAK Exhibits of campus programs opens.

EVENING SESSION 7:00 - 10:00

- Concurrent sessions: Each session will be about a different type of strategy (e.g., peer education, networking). Several campus teams will start each session by showing how they implemented the strategy. Participants ask questions, clarify, and identify how strategies could be adapted for their campuses.
- Closing session (all participants together):
Presentation: The concept of force field analysis
Exercise: Each student/faculty team identifies factors supporting and hindering implementation of an AIDS education program on their campus.
Report out and discussion: Participants share factors. Facilitators group factors into categories during discussion.

MORNING SESSION 9:00 - 12:00

- Presentation: How some community education/prevention programs have changed attitudes and behaviors--the implications for campus programs
- Concurrent sessions: Repeat of evening sessions
- Presentation: Resources available for campus AIDS education programs
Exercise: Small groups brainstorm resources they might be able to tap and categorize them by some factor like importance or accessibility.

LUNCH Exhibits open.

AFTERNOON SESSION 1:00 - 5:00

- Presentation: Developing institutional support
Panel/exercise options: Could have a panel of success stories, force field analysis in small groups, concurrent sessions on different approaches
- Presentation: Action planning model revisited and setting priorities
Planning session: Each student/faculty team sets priorities about what most needs to be done on their campus, selects 2 strategies, identifies resources needed for those strategies, lays out implementation steps for one strategy, identifies what they will do in one month and six months after leaving the workshop. Workshop facilitators and panel members are resources for teams during planning session.
Concurrent sessions: Each session focuses on a different type of strategy. Teams self-select a session. Teams in each session share ideas, trouble-shoot potential obstacles, and work out ways to stay in touch with each other.
- Presentation/discussion: Evaluating the CDC project and campus programs
- Presentation/discussion: Where we go from here
Teams talk about what help is most needed. ACHA staff talk about resources available through the project and follow-up activities.

Close: Workshop evaluation

Possibly a special event (e.g., tribute, awards)

VI. ASSESSMENT

The assessment activities described here reflect an action research approach to evaluation. Evaluation data are not an end in themselves; rather, these data provide valuable information for program planning, further problem solving and, hence, improvement of the ACHA project and local campus programs. For example, assessment data about implementation of local campus programs will define new models, major obstacles, and needs for assistance; these findings are critical for redesigning the Year 2 workshops and improving follow-up support activities.

OBJECTIVE 1: TRAIN STUDENT/FACULTY TEAMS FROM 200 UNIVERSITIES AND COLLEGES ON HOW TO IMPLEMENT AN AIDS EDUCATION PROGRAM

Two types of assessment apply to this objective: (1) an examination of the process to identify whether each activity was completed, when, problems encountered, and changes needed for Year 2; and (2) an examination of participants' and others' responses to the workshop and the degree of knowledge/skill gains during the workshops. Each approach is described below.

(1) Assessment Of Individual Activities

Objective 1 includes Activities 1 through 12. Each activity yields a concrete product. Thus, part of the assessment focuses on whether the product was completed. Assessment also focuses on how the product was developed--problems encountered, solutions, reconfiguring of the product, time required, and so forth. These data are essential for monitoring Year 1 efforts and constructing subsequent annual plans (which repeat many Year 1 activities). Examples of a few activities illustrate the focus of this assessment approach.

Activity 2: Appoint Regional Planning Groups.

Product = 4 groups with 3 regional members.

Key aspects = Obstacles in recruiting group members; changes in composition from the original plan.

Activity 3: Convene a panel meeting to develop a content outline for the workshop.

Product = Panel meeting; completed all meeting tasks.

Key aspects = Changes in agenda; tasks not completed; areas of disagreement among members; decisions warranting different approaches than planned.

Activity 10: Select and recruit regional speakers.

Product = For each region: List of local campus models and person(s) who will present them during the workshop; list of campus programs participating in exhibits; local program materials submitted for final training package.

Key aspects = Degree of ease in identifying local models within the region; fit of models with workshop curriculum/agenda; willingness of model campus representatives to participate.

The National Coordinator will review progress on each activity monthly and document the following items, as appropriate: when the product was completed, how the final product differs from the intended one, problems encountered, solutions planned or implemented, and recommendations for next year. This report will be brief and given to the Project Director for review and comment.

(2) Assessment Of Responses To The Workshop And Knowledge/Skill Gains

Measuring the workshop's impact requires (1) short-term assessment of participant responses and knowledge/skill gains and (2) long-term assessment of whether participants actually apply skills and implement strategies learned in the workshop. This section focuses on the short-term assessment; evaluation efforts on objective 2 encompass the long-term assessment of the workshop.

ACHA will use three methods in the short-term assessment of the workshop's effectiveness:

- **Training team assessment**--Team assessments take two forms:
 - **Presenter/facilitator evaluations**--Each presenter and facilitator will complete an open-ended questionnaire on their perceptions of workshop strengths, problems, and needed changes.
 - **Training team debriefing meetings**--The team will meet twice (during the workshop and after the close) to review participant reactions and evaluations, identify problems with content or logistics, and decide on needed changes.

The training consultant at each workshop will document changes in workshop design and content and recommend changes for the next delivery.

- **Participant feedback**--Feedback is participants' attitudinal responses to the workshop (e.g., Did participants like the intervention? Did they find it interesting, useful, or beneficial?)

The training consultant will design and analyze a participant questionnaire to be completed at the end of each workshop. This questionnaire will collect data such as: respondent characteristics (e.g., faculty or student, age, sex, school affiliation); usefulness of each session (i.e., rankings); reasons why specific sessions were not useful; skills learned; changes recommended for the next workshop; and specific needs for follow-up help.

- **Participant skill development**--Documents developed by participants during the workshop will provide data for measuring skill gains. Each student/faculty team will construct an action plan for their campus program that identifies how they will assess needs, strategies they want to implement, available resources, and implementation steps to be achieved by months one and six after the workshop. Each plan will be analyzed against skill level criteria.

OBJECTIVE 2: IMPLEMENT AIDS EDUCATION PROGRAMS ON 160 CAMPUSES BY THE END OF YEAR ONE

This objective calls for three types of assessment: (1) assessment of ACHA support activities that focuses on process (e.g., when, what, where) and impact (e.g., usefulness to users); (2) assessment of the degree to which AIDS education programs are implemented following the workshop; and (3) the impact of campus programs on student behaviors. The third assessment will be possible if schools with required resources are willing to conduct such studies. Each type of assessment is described below.

(1) Assessment Of ACHA Support Activities

This portion of the assessment examines Activities 13 through 16. The process analysis focuses on whether the activity was completed, when, problems encountered, and changes needed for Year 2. The impact assessment focuses on user satisfaction and use of the resource. Below, we describe the focal points of assessment for each activity.

Activity 13: Set up and operate a speakers/consultants bureau.

Product = A list of speakers/consultants; operative procedures for recruiting speakers/consultants, advertising the bureau, handling requests, and documenting bureau use.

Key aspects of implementation = Difficulties in recruiting specific types of expertise; time and resources required to get bureau operational; experiences in negotiating acceptable cost-sharing or volunteer arrangements

Key impact variables = Number and type of requests; number requests filled successfully; reasons for requests not being filled; user characteristics; purpose of request; user satisfaction with speaker/consultant

Activity 14: Establish and operate a resource center.

Product = Inventory of materials; operative procedures for accessing materials not stored at the center, advertising the center, handling requests, and documenting center use.

Key aspects of implementation = Difficulties in accessing desired materials; time and resources required to get the center operational.

Key impact variables = Same as for the bureau except for last variable: user satisfaction with the resource center.

Activity 15: Conduct telephone follow-up with all workshop participants

Product = Completed telephone interviews with 80% of participants.

Key aspects of implementation = Time and resources required to complete calls; changes in questionnaire; problems in contacting participants.

Key impact variables = Participant assessment of the call's utility; number and type of problems identified and worked out; number and type of requests for assistance identified in calls.

Activity 16: Publish a newsletter on campus programs.

Product = 2 newsletters published Year 1

Key aspects of implementation = Time and resources required; degree of difficulty in identifying and describing model programs and innovative approaches.

Key impact variables = Readers' assessment of its utility; user characteristics; increase/decrease in distribution list.

The Coordinator will collect impact data with three methods:

- **Program utilization statistics**--Set up logs for documenting utilization rates for the bureau, center, and newsletter.
- **Six month survey of workshop participants**--Include a section on the survey questionnaire where workshop participants rate each ACHA support activity for its helpfulness, utility, and importance; suggest changes; rate speed of response for all support activities except phone calls.
- **Obtain user feedback**--Send a brief questionnaire to persons using a speaker/consultant (after each use), and to a sample of persons requesting materials and a sample of the newsletter mailing list (every 6 months).

The National Coordinator will document data monthly for the implementation, process assessment. The Coordinator and Project Director will review all assessment data and decide if changes are warranted during Year 1.

(2) Assessment Of The Degree To Which AIDS Campus Education Programs Have Been Implemented

This assessment focuses on progress, problems encountered, and achievements of local campus programs. It provides a description of what participants actually do to develop programs after the workshop and a measure of how well they do it. Many factors, like institutional responsiveness, will affect the team's progress and activities; thus, the assessment needs to identify barriers encountered by participants as they develop programs. The National Coordinator and training consultant will collect and analyze data from three sources:

- **Telephone interviews conducted six weeks after the workshop**--The National Coordinator and Regional Planning Group members will call each student/faculty team to discuss team activities, progress to date, current problems, and assistance needed. Each caller will follow a questionnaire guide, with all findings forwarded to the Coordinator. (These calls also have a technical assistance function and are one of ACHA's four support activities.)
- **Six-month follow-up survey**--This survey of a sample of workshop participants will target the same kinds of information as the 6-week telephone interviews. The survey simply gives us a longer-term vantage point.

- **Evaluation data generated by local programs**--Most campus programs developed after the workshops will include some evaluation activity. Evaluations conducted by and about campus education programs are likely to consist of:
 - Qualitative data from program staff, an advisory committee, and students regarding their perceptions of the program's efficacy
 - Program utilization statistics such as numbers of students, staff, and faculty reached through presentations; utilization rates of a telephone information service; numbers of written materials, distributed, etc.
 - Pre- and post-tests on the extent of knowledge change attributable to workshops and lectures
 - Participant evaluations of educational activities

(3) Assessment Of The Impact Of The Campus AIDS Education Programs On Student and Non-Student Behaviors

The workshops will present models for conducting behavioral impact studies and emphasize their importance. Not all campuses will have the resources needed for these studies, but we are confident at least a selected number of colleges and universities will be interested and willing to support such studies on their campuses.

For those student/faculty teams willing to take on behavioral impact studies, we will offer on-site and telephone technical assistance. We will monitor progress in implementing impact studies through our six-week calls and six month survey. We will also set up a mechanism for obtaining data summaries and reports on impact studies and share findings through the newsletter.

OBJECTIVE 3: NETWORK WITH AT LEAST SIX OTHER NATIONAL ORGANIZATIONS IMPLEMENTING AIDS EDUCATION PROGRAMS FOR HIGHER EDUCATION STUDENTS AND NON-STUDENTS

ACHA will monitor networking efforts by tracking progress against the detailed cooperative plan developed with each organization and by documenting problems, accomplishments, and modifications to each plan. ACHA will assess the impact of networking efforts by documenting the number and type of products transferred from one organization to the other, and by examining data on contacts at the campus level between local programs (to explore the degree to which national contacts influenced local contacts).

VII. EVIDENCE OF SUPPORT

As a national organization, the the ACHA will be invaluable in its support of the project with existing personnel, material, and resources. Dr. Keeling, the six Task Force members on the proposed Review Panel, and the regional planning groups (except for project staff) all will volunteer their time and expertise. The association's abundance of literature on AIDS, its networking resources, as well as the administrative and technical capabilities of its Rockville office, will be at the project's disposal.

Six major national organizations, namely The American Council on Education (ACE), the National Association of Student Personnel Administrators (NASPA), the National AIDS Network (NAN), the National Council of the Churches of Christ, the National Board of the YWCA, and the American Red Cross, have pledged their support and volunteered their resources in cooperating with the ACHA on this CDC project. Enclosed with this proposal are their letters of endorsement.

VIII. TRANSFER OF TECHNOLOGY

ACHA plans to contribute to and draw on the CDC Combined Health Information Database throughout the project period. For example:

- During project start-up, we will provide CDC with a description of the project and copies of existing ACHA educational materials on AIDS. We also will obtain a Database listing of educational materials for use in building the resource center.
- During the first year, we expect that the ACHA workshops and resource center activities will surface additional materials pertinent to the Database; the National Coordinator will routinely forward such materials to the Database.
- During project years two through five, we expect campus programs to generate effectiveness data and will forward those findings to the Database. In turn, as campus programs develop and try new approaches, we will draw on the Database for additional resource materials.

ACHA plans to develop similar technology transfer efforts with other national organizations, as described earlier. ACHA needs to identify more effective strategies because the scarcity of program effectiveness data is a significant impediment to development and maturation of campus AIDS education programs. Findings about diverse education programs developed by other groups may be relevant because campuses can employ a wide variety of strategies. Accordingly, ACHA will provide other organizations with descriptions of its program and resource center holdings, and will request similar information.

FEDERAL ASSISTANCE

1 TYPE OF SUBMISSION
☐ NOTICE OF INTENT (OPTIONAL)
☐ PREAPPLICATION
☒ APPLICATION

2 APPLICANT'S APPLICATION IDENTIFIER

a. NUMBER

b. DATE

Year month day
 1987 7 15

3 STATE APPLICATION IDENTIFIER

NOTE TO BE ASSIGNED BY STATE

a. NUMBER

b. DATE ASSIGNED

Year month day
 19

Leave Blank

4 LEGAL APPLICANT/RECIPIENT

a. Applicant Name The American College Health Association
 b. Organization Unit
 c. Street/P.O. Box 15879 Crabbs Branch Way
 d. City Rockville,
 e. County Montgomery
 f. State MD
 g. ZIP Code 20855
 h. Contact Person (Name & Telephone No.) Stephen Blom (301) 963-1100

5 EMPLOYER IDENTIFICATION NUMBER (EIN)

36-2681352

6. PROGRAM

(From CFDA)

a. NUMBER

MULTIPLE ☐

b. TITLE

7. TITLE OF APPLICANT'S PROJECT (Use section IV of this form to provide a summary description of the project.)

AIDS Education Program On Colleges and Universities

8. TYPE OF APPLICANT/RECIPIENT

A—State
 B—Interstate
 C—Substate
 D—County
 E—City
 F—School District
 G—Special Purpose District
 H—Community Action Agency
 I—Higher Educational Institution
 J—Indian Tribe
 K—Other (Specify):

Enter appropriate letter ☐ I

9. AREA OF PROJECT IMPACT (Names of cities, counties, states, etc.)

Nationwide

10. ESTIMATED NUMBER OF PERSONS BENEFITING
 12 million

11. TYPE OF ASSISTANCE

A—Basic Grant
 B—Supplemental Grant
 C—Loan
 D—Insurance
 E—Other

Enter appropriate letter(s) ☐ A

12 PROPOSED FUNDING

a. FEDERAL \$ 100,000.00
 b. APPLICANT .00
 c. STATE .00
 d. LOCAL .00
 e. OTHER .00
 f. Total \$ 100,000.00

13. CONGRESSIONAL DISTRICTS OF:

a. APPLICANT

b. PROJECT

15. PROJECT START DATE Year month day
 19

16. PROJECT DURATION Months
 19

18. DATE DUE TO FEDERAL AGENCY Year month day
 19

14. TYPE OF APPLICATION

A—New
 B—Renewal
 C—Revision
 D—Continuation
 E—Augmentation

Enter appropriate letter ☐ A

17 TYPE OF CHANGE (For 14c or 14e)

A—Increase Dollars
 B—Decrease Dollars
 C—Increase Duration
 D—Decrease Duration
 E—Cancellation
 F—Other (Specify):

Enter appropriate letter(s) ☐

19. FEDERAL AGENCY TO RECEIVE REQUEST

CDC

20. EXISTING FEDERAL GRANT IDENTIFICATION NUMBER

a. ORGANIZATIONAL UNIT (IF APPROPRIATE)

b. ADMINISTRATIVE CONTACT (IF KNOWN)

Lynn Dixon

c. ADDRESS

21. REMARKS ADDED

☐ Yes ☐ No

22 THE APPLICANT CERTIFIES THAT

To the best of my knowledge and belief, data in this preapplication/application are true and correct, the document has been duly authorized by the governing body of the applicant and the applicant will comply with the attached assurances if the assistance is approved.

a. YES, THIS NOTICE OF INTENT/PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON: DATE

b. NO, PROGRAM IS NOT COVERED BY E.O. 12372 ☒ OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW ☐

23. CERTIFYING REPRESENTATIVE

a. TYPED NAME AND TITLE

JoAnne Ciperson, M.S.P.H.
 Assistant Director - Program Services

b. SIGNATURE

24 APPLICATION RECEIVED

Year month day
 19

25. FEDERAL APPLICATION IDENTIFICATION NUMBER

26 FEDERAL GRANT IDENTIFICATION

27 ACTION TAKEN

☐ a. AWARDED
☐ b. REJECTED
☐ c. RETURNED FOR AMENDMENT
☐ d. RETURNED FOR E.O. 12372 SUBMISSION BY APPLICANT TO STATE
☐ e. DEFERRED
☐ f. WITHDRAWN

28. FUNDING

a. FEDERAL \$.00
 b. APPLICANT .00
 c. STATE .00
 d. LOCAL .00
 e. OTHER .00
 f. TOTAL \$.00

29. ACTION DATE

Year month day
 19

31 CONTACT FOR ADDITIONAL INFORMATION (Name and telephone number)

30. STARTING DATE Year month day
 19

32. ENDING DATE Year month day
 19

33 REMARKS ADDED

☐ Yes ☐ No

PART II
PROJECT APPROVAL INFORMATION

Item 1.

Does this assistance request/require State, local, regional, or other priority rating?
_____ Yes X No

Name of Governing Body _____
Priority Rating _____

Item 2.

Does this assistance request/require State, or local, advisory, educational or health clearances?
_____ Yes X No

Name of Agency or Board _____
(Attach Documentation)

Item 3.

Does this assistance request/require State, local, regional or other planning approval?
_____ Yes X No

Name of Approving Agency _____
Date _____

Item 4.

Is the proposed project covered by an approved comprehensive plan?
_____ Yes X No

Check one: State ☐
Local ☐
Regional ☐
Location of Plan _____

Item 5.

Is the project in a designated flood hazard area?
_____ Yes X No

See instructions for additional information to be provided.

Item 6.

Will the assistance requested serve a Federal installation?
_____ Yes X No

Name of Federal Installation _____
Federal Population benefiting from Project _____

Item 7.

Will the assistance requested be on Federal land or installation?
_____ Yes X No

Name of Federal Installation _____
Location of Federal Land _____
Percent of Project _____

Item 8.

Will the assistance requested have an impact or effect on the environment?
_____ Yes X No

See instructions for additional information to be provided.

Item 9.

Will the assistance requested cause the displacement of individuals, families, businesses, or farms?
_____ Yes X No

Number of:
Individuals _____
Families _____
Businesses _____
Farms _____

Item 10.

Is there other related assistance on this project previous, pending, or anticipated?
_____ Yes X No

See instructions for additional information to be provided.

PART III - BUDGET INFORMATION

SECTION A - BUDGET SUMMARY

Grant Program, Function or Activity (a)	Federal Catalog No. (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1.		\$	\$	\$	\$	\$
2.						
3.						
4.						
5. TOTALS		\$	\$	\$	\$	\$

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	- Grant Program, Function or Activity				Total (5)
	(1)	(2)	(3)	(4)	
a. Personnel	\$ 36,500.04	\$	\$	\$	\$ 36,500.04
b. Fringe Benefits	9,125.01				9,125.01
c. Travel	15,678.00				15,678.00
d. Equipment	—				—
e. Supplies	600.00				600.00
f. Contractual					
g. Construction Consultants	25,000.00				25,000.00
h. Other	13,016.40				13,016.40
i. Total Direct Charges	99,919.45				99,919.45
j. Indirect Charges	-0-				-0-
k. TOTALS	\$99,919.45	\$	\$	\$	\$99,919.45
7. Program Income	\$	\$	\$	\$	\$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) APPLICANT	(c) STATE	(d) OTHER SOURCES	(e) TOTALS
8.	\$	\$	\$	\$
9.				
10.				
11.				
12. TOTALS	\$	\$	\$	\$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$99,919.45	\$24,979.86	\$24,979.86	\$24,979.86	\$24,979.86
14. Non-Federal					
15. TOTAL	\$	\$	\$	\$	\$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b) FIRST	(c) SECOND	(d) THIRD	(e) FOURTH
16.	\$	\$	\$	\$
17.				
18.				
19.				
20. TOTALS	\$	\$	\$	\$

SECTION F - OTHER BUDGET INFORMATION

(Attach additional Sheets If Necessary)

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

PART IV PROGRAM NARRATIVE (Attach per instruction)

The American College Health Association proposes to (1) expand AIDS education programs on higher-education campuses, and (2) reach large numbers of students, changing student knowledge, attitudes, and behaviors regarding AIDS. Four regional workshops and follow-up on-site and telephone technical assistance will be provided to 200 colleges and universities in Year One.

SUPPLEMENTAL TO PART III, SECTION F
KEY PRSONNEL

NAME AND POSITION TITLE	ANNUAL SALARY RATE	NO. MOS. BUDGET	% TIME	TOTAL AMOUNT REQUIRED
	(1)	(2)	(3)	(4)
Richard Keeling, M.D. -- Project Director	N/A	12	15	N/A
To Be Hired --	27,500.04	12	100	27,500.04
National Coordinator	18,000.00	12	50	9,000.00
FRINGE BENEFITS (Rate <u>25</u>)				
		CATEGORY TOTAL \$36,500.04		

Proposed ACHA Grant Budget
College AIDS Education Program

Cost Category	Rate	Number Of Units	Unit Basis	Amount
Direct Labor				
National Coordinator	2291.67	12	month	27500.04
Support Staff	1500.00	6	month	9000.00
Total Direct Labor				36500.04
Fringe Benefits	25%			9125.01
Other Direct Costs				
Panel Review Meeting				
Air Transport				
Keeling	118.00	1	trip	118.00
Kodama	514.00	1	trip	514.00
Lyman	98.00	1	trip	98.00
Lomax	136.00	1	trip	136.00
Wirag	243.00	1	trip	243.00
Wessel	514.00	1	trip	514.00
Ground Transport				
5 members	50.00	6	trip	300.00
4 members(Coor, Gould, Bridwell, JBS)	10.00	4	trip	40.00
Subsistence				
Kodama, Wirag, Wessel	100.00	3	day	300.00
Other	20.00	8	trip	160.00
Subtotal Panel Meeting				2423.00
Regional Workshop 1: DC				
Air Transport				
Keeling	118.00	1	trip	118.00
Regional Rep (RR)	100.00	1	trip	100.00
Regional Coor (RC)	200.00	1	trip	200.00
2 Presenters	200.00	2	trip	400.00
Ground				
5 people	75.00	5	trip	375.00
2 people	20.00	2	trip	40.00
Subsistence				
Keeling, RR, RC	100.00	6	day	600.00
Workshop Materials(.07/pg)				
Curriculum	1.40	125	copy	175.00
Training Design	3.50	50	copy	175.00
Recruitment Letters	.25	500	letter	125.00
Logistic Letters	.25	150	letter	37.50
Mtg Materials	3.50	120	copy	420.00
Evaluation Instrument	.21	120	copy	25.20
Postage				
Recruitment Letters	.22	500	letters	110.00
Logistics Letters	.22	120	letters	26.40
Other Mtg Expenses	8.00	120	people	960.00
Subtotal Workshop 1: ODCS				3887.10

Regional Workshop 2: LA

Air Travel

Keeling	554.00	1 trip	554.00
Coor, JBS Con.,	362.00	2 trip	724.00
RR, 2 Presenters	200.00	3 trip	600.00
Ground Trans	50.00	7 trip	350.00
Subsistence	200.00	6 trip	1200.00
Workshop Materials			1094.10
Other Mtg Expenses			960.00

*see ab

Subtotal Workshop 2: ODCS	5482.10
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Regional Workshop 3: Atlanta

Air Travel

Keeling	382.00	1 trip	382.00
Coor, JBS Con.,	280.00	2 trip	560.00
RR, 2 Presenters	300.00	3 trip	900.00
Ground Trans	50.00	6 trip	300.00
Subsistence	200.00	6 trip	1200.00
Workshop Materials			1094.10
Other Mtg Expenses			960.00

Subtotal Workshop 3: ODCS	5396.10
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Regional Workshop 4: Chicago

Air Travel

Keeling	420.00	1 Trip	420.00
Coor, JBS Con.,	416.00	2 trip	832.00
RR, RC, 2 Presenters	300.00	4 trip	1200.00
Ground Trans	50.00	7 trip	350.00
Subsistence	200.00	7 trip	1400.00
Workshop Materials			1094.10
Other Mtg Expenses			960.00

Subtotal Workshop 4: ODCS	6256.10
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Other Grant Costs

Postage	100.00	12 Month	1200.00
Telephone	100.00	12 Month	1200.00
Duplication	200.00	12 Month	2400.00
Consultants	525.00	48 Day	25000.00
Supplies	50.00	12 Month	600.00
Travel	150.00	3 trip	450.00
Subtotal Other Grant Costs			30850.00

Total Project Grant Costs	99919.45
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APPENDIX A
RESUME OF RICHARD KEELING, M.D.

CURRICULUM VITAE

Richard P. Keeling, M.D.

Social Security # [REDACTED]

Position: Director, Department of Student Health, University of Virginia
Associate Professor of Internal Medicine,
University of Virginia School of Medicine

Address: Office: Box 378, University of Virginia Medical Center, Charlottesville, VA 22908
Telephone: 804 924-2670

Home: [REDACTED]

Personal: Wife: Arlene W. Keeling, R.N., B.S.N., M.S.N.
Children: [REDACTED]

Education: 1965-1969 B.A., University of Virginia,
Charlottesville, Virginia
Honors: Phi Beta Kappa
Williams Prize for Honors Thesis
English Honors Program
Bachelor of Arts with highest honors degree

1969-1973 M.D., Tufts University School of Medicine, Boston Massachusetts
Honors: Alpha Omega Alpha
Alumni recognition Award in Anatomy

Postdoctoral Training:

1973-1974 Intern in medicine, University of Virginia, Charlottesville
(Dr. E. W. Hook)
1974-1976 Resident in medicine, University of Virginia, Charlottesville
(Dr. E. W. Hook)
1976-1977 Chief Resident in medicine, University of Virginia, Charlottesville
(Dr. E. W. Hook)
1977-1979 Fellow in hematology, University of Virginia, Charlottesville
(Dr. M. S. Wheby)

Board Certifications: Diplomat/Internal Medicine, American
Board of Internal Medicine 1976

Diplomat, Hematology, American Board
of Internal Medicine 1983

Licensure: Virginia

Academic and Administrative Appointments:

1979 - present Associate Professor of Internal Medicine
(Hematology/Oncology), University of Virginia

Director and Chief Student Health Physician,
Department of Student Health, University of
Virginia, Charlottesville, Virginia

Attending Physician, University of Virginia
Hospital, Charlottesville, Virginia

Consultant, U.S. Veterans' Administration
Hospital, Salem, Virginia

Scientific Societies and Professional Memberships:

American College of Physicians
American Society of Internal Medicine
Virginia Society of Internal Medicine
Albemarle County Medical Society
American College Health Association
Southern Medical Association
Mid-Atlantic College Health Association
(secretary, 1981-82)
Virginia Society of Hematology-Oncology

Offerships

President-Elect, American College Health
Association

National Committees and Boards

Chairman, Task Force on AIDS, American College
Health Association, 1985 -
Ad Hoc Advisory Committee on AIDS, United States
Public Health Service, 1985 -
Executive Board, American College Health
Association, 1987 -
Executive Board, National AIDS Network, 1987 -

Local and Regional Committees and other Activities:

Chairmanships

Student Health Committee, University of
Virginia, 1979 -
Committee on Resident Staff, University of
Virginia, 1981 -
Committee on AIDS, Mid-Atlantic College Health
Association, 1983 -
University of Virginia Task Force on Alcohol
Abuse, 1979 - 1981
Committee on Clinical Competence, Department of
Internal Medicine, University of Virginia,
1986 -
Charlottesville AIDS Resource Network, 1985 -

Vice-Chairmanship

Region X Community Services Board, Committee on
Alcohol and Drug Abuse, 1981 - 1984

Other Memberships: Medical School and Hospital Committees

Medical Advisory Committee, University of
Virginia, 1979 -
Ambulatory Care Committee, University of
Virginia Hospital, 1979 -
Medical Student Promotions Committee, University
of Virginia School of Medicine, 1979 -
Resuscitation Committee, University of Virginia
Hospital, 1982 - 1985
Residency Selection Committee, Internal Medicine,
University of Virginia, 1980 -

Other Memberships: University Committees

Housing Committee, University of Virginia, 1979 -
Committee on Residential Life, University of
Virginia, 1981 -

Consultancies

Advisory Council to the Office of University Health
Services, Princeton University, 1986 -

Advisory Committee on AIDS, Charlottesville City Schools

Advisory Committee on AIDS, Medical Society of Virginia

Advisory Committee on AIDS, Episcopal Diocese of Virginia

Consultant to colleges and universities regarding AIDS,
including:

Arizona State University
Bryn Mawr College
University of California at Berkeley

Dartmouth College
University of Delaware
Duquesne University
Eastern Kentucky University
Eastern Shore Community College
George Mason University
University of Georgia
Georgia Technical College
Hampden-Sydney College
Haverford College
Hollins College
Iowa State University
James Madison University
Kansas State University
Kansas University
Longwood College
University of Louisville
University of Maine
Mary Baldwin College
Murray State University
University of Nebraska
University of North Carolina at Charlotte
University of North Carolina at Wilmington
Northeast Missouri State University
Northern Virginia Community College
Old Dominion University
Oklahoma State University
Piedmont Virginia Community College
Princeton University
Randolph Macon College
University of Rochester
University of the South
Southern Seminary
University of Tennessee at Knoxville
University of Vermont
Virginia Commonwealth University
Virginia Tech
Washington and Lee University
University of Wisconsin at Platteville
Virginia Western Community College
Wichita State University

Consultant to public and private secondary schools
concerning AIDS, including:

Charlottesville High School
Friends School, Baltimore, MD
St. Anne's - Belfield, Charlottesville, VA
Tandem School, Charlottesville, VA

Honors:

Phi Beta Kappa (1969)

Thesis, University of Virginia (1969)
 Williams Prize for Honors Thesis, University of Virginia (1969)
 Recognition Award in Anatomy, Tufts University (1970)
 Omega Alpha (1972)
 Society Distinguished Faculty Award, University of Virginia (1983)
 University recognition, University of Virginia (1983)
 Teaching of the Year Award, Department of Internal Medicine, University of Virginia (1983)
 Distinguished Service Award, American College Health Association (1986)
 William O. Presson Lecturer, Murray State University (1987)
 Teaching of the Year Award, Department of Internal Medicine, University of Virginia (1987)

Activities:

Community Services Board, Subcommittee on Alcoholism, 1981 - 1986
 "Health Update" Charlottesville, Virginia, "Health Update" project, 1987
 Member, Advisory Committee on AIDS, Charlottesville, 1985
 Member, Steering Committee, Community Advisory Committee on AIDS, Charlottesville, 1987 -

BIBLIOGRAPHY

Richard P. Keeling, M.D.

- (article) Keeling RP, Zirkle JW, Hook EW: The diagnosis of bacterial endocarditis. Practical Cardiology, September, 1977
- (article) Hillard JR, Lobo MC, Keeling RP: Bulimarexia and Diabetes Mellitus, Psychosomatics 1983; 24: 292-295
- (article) Merriam SC, Keeling RP: Streptococcal pharyngitis is uncommon in infectious mononucleosis, South Med J. 1983; 76: 574 - 576.
- (article) Ross SR, Keeling RP, Gingold M, Pinkerton JV: Dyskeratosis congenita with pancytopenia and horseshoe kidney. South Med J. 1984; 77:527 - 528
- (article) Keeling RP: Grand Rounds: Pathogenesis of infectious mononucleosis. Virginia Med. 1984;111
- (article) Hillard JR, Kitchell CL, Turner UG, Keeling RP: Knowledge and attitudes of college students about genital herpes: Implications for patient education and counseling. J AM College Health, 1985; 33:111 - 117
- (article) Keeling RP, AIDS on campus: AGB Reports (Association of Governing Boards of Colleges and Universities). March 1986.
- (article) Keeling RP, Childress JF, O'Connell J, Rein MF: AIDS: Public Health and Private Rights - panel discussion. Pharos 1986; 49:32-37.
- (article) Keeling RP, Introduction: AIDS on the College Campus J AM College Health 1986; 35:123-126.
- (article) Cavan L, Keeling RP: Organizing an AIDS Educational Forum. VASPA Interchange, Spring 1987.
- (article) Keeling RP, AIDS Education on the College Campus, in Nahmias A, Scirazi RF (editors), Prevention of AIDS in Children, Adolescents, and Heterosexual Adults: An Interdisciplinary Approach. New York: Elsevier Science Publishing Co., 1987., in press.
- (article) Keeling RP, Survival or Sensibility? Helix - University of Virginia Medical Center Quarterly. 5 (2): 40-41, Spring, 1987
- (article) Keeling RP. Effect of AIDS on Young America. Medical Aspects of Human Sexuality., in press.

- (article) Keeling RP, AIDS Education of Campus (book review). Focus. University of California at San Francisco, in press.
- (chapter) Keeling RP, Bone marrow aspiration and biopsy, in Gibson RS, Surratt P. Handbook of Medical Procedures CV Mosby, 1982.
- (chapter) Keeling RP, Hemolytic anemias. In Edlich R. Spyker DA. Emergency Medical Therapy - 1985. Rockville, MD: Aspen Systems 606 - 612.

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- (chapters) Keeling RP: Chapters IV. Differentiation, biochemistry and physiology of the granulocyte; V. Differentiation, biochemistry, and physiology of Monocytes and Macrophages; XVI. Non-neoplastic disorders of granulocytes; XVII. Non-neoplastic disorders of lymphocytes; XXVII, Transfusion Therapy, Thorup OA, Fundamentals of Clinical Hematology. Philadelphia: Saunders, 1987
- (book) Keeling, RP (editor), AIDS on campus. Rockville, MD: American College Health Association, 1986.
- (booklet) Keeling, RP, General statement on institutional response to AIDS. Rockville, MD: American College Health Association, 1985.
- (videotape) Keeling, RP, The AIDS Dilemma: Higher Education's response to AIDS. Rockville, MD: American College Health Association, 1986.
- (videotape) Keeling RP, Thompson C: AIDS Alert. Charlottesville, VA: Creative Media, Inc., 1986.
- (videotape) Quesenberry PQ, Keeling RP: Blood Transfusion, Hazards and AIDS. New York, NY: The Leukemia Society, 1986.
- (videotape) Quesenberry PQ, Keeling RP: Aspects of Acute Leukemia. New York, NY: The Leukemia Society, 1986.
- (videotape) Thompson C, Import R, Keeling RP, et al: Cocaine and the student athlete. Charlottesville, VA: Creative Media, Inc., 1986.
- (videotape) Keeling RP: AIDS - Reducing the risk. Rockville, MD: American College Health Association, 1987.
- (videotape) Keeling RP, Thompson C: AIDS Alert-Second Edition. Charlottesville, VA: Creative Media, 1987.

APPENDIX B
LETTERS OF SUPPORT

AMERICAN COUNCIL ON EDUCATION

Office of Women in Higher Education

July 9, 1987

Richard P. Keeling, M.D.
Chairman, Task Force on AIDS
American College Health
Association
Box 378
University of Virginia
Charlottesville, VA 22908

Dear Rich:

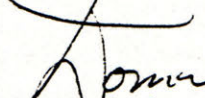
The American Council on Education is proud to endorse the proposal of the American College Health Association to increase the number of higher education institutions providing AIDS education.

The Council has been very pleased with its association with the ACHA. We have worked jointly with ACHA on the provision of materials on AIDS and other health-related campus issues.

The quality of the work you provide is excellent--informative and compelling. I am especially impressed that you always meet all deadlines with dispatch and make the most of your resources. I know that you can be counted on to make wise use of this grant and that the program will meet your usual high standards.

As you know, the Council has a membership of 1400 colleges and universities and 200 associations of higher education and related organizations. We are very pleased with this project and fully endorse it.

Best wishes,


Donna Shavlik
Director

cc: Ms. Gail Bussin

NASPA

NATIONAL ASSOCIATION OF STUDENT PERSONNEL ADMINISTRATORS, INC.
1700 18th St., N.W. ■ Suite 301 ■ Washington, D.C. 20009-2508 ■ 202/265-7500

July 9, 1987

Richard P. Keeling, MD
Chairman, Task Force on AIDS
American College Health Association
Box 378
University of Virginia
Charlottesville, VA 22908

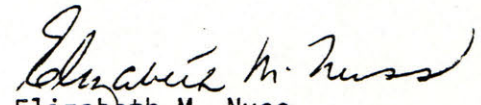
Dear Dr. Keeling:

As Executive Director of NASPA, I am pleased to write in support of ACHA's proposal for a cooperative agreement with the Centers for Disease Control to increase the number of colleges and universities providing AIDS education to students.

As you know, NASPA members are chief student affairs officers and other professionals at approximately 1100 colleges and universities. We are concerned about developing effective ways to inform students about AIDS and helping students make informed choices about AIDS prevention. The regional workshops proposed will be accessible to our members and will enable them to develop campus programs consistent with their institutional mission.

NASPA has greatly appreciated the leadership and cooperation we have received from ACHA in the past and will be pleased to assist you in this venture. We are all particularly grateful to you for your leadership and commitment to this important matter.

Sincerely,


Elizabeth M. Nuss
Executive Director

EMN:js

CC: Dr. Larry Ebbers, President, NASPA

NATIONAL AIDS
NETWORK

Paul Kawata, Executive Director

Board of Directors

Chairperson:

Paula Van Ness
Executive Director
AIDS Project Los Angeles
Los Angeles, CA

Members:

Edward Brandt
Chancellor
University of Maryland
Baltimore, MD

Curtis Dickson
Executive Director
AIDS Foundation Houston
Houston, TX

Richard Dunne
Executive Director
Gay Men's Health Crisis
New York, NY

Larry Kessler
Executive Director
AIDS Action Committee
Boston, MA

Peter Laqueur
Executive Director
HERO
Baltimore, MD

Luis Maura
Co-Chairperson
National Assoc. of People with AIDS
San Francisco, CA

Julian Rush
Executive Director
Colorado AIDS Project
Denver, CO

Ken South
Executive Director
AID Atlanta
Atlanta, GA

Constance D. Wofsy
Co-Director, AIDS Ward
San Francisco General Hospital
San Francisco, CA

Tim Wolfred
Executive Director
San Francisco AIDS Foundation
San Francisco, CA

7 July 1987

Richard Keeling, M.D.
American College Health Association
Task Force on AIDS
Medical Director
University of Virginia
Department of Student Health
Medical Center
Box 378
Charlottesville, VA 22908

Dear Dr. Keeling;

As the Executive Director of the National AIDS Network I am pleased to endorse your proposal to the CDC for the Cooperative Agreement for a National Organization Representing College and University Health Services for AIDS Education Programs.

As you may know, NAN is very concerned about AIDS education. I was very pleased to work with you on a NIMH contract that reviewed similar issues for college counselors. I know that you will do an excellent job with this proposal.

Please keep free to call on me for any support you may need. Keep up the good work!

Sincerely,



Paul Kawata
Executive Director



NATIONAL COUNCIL OF THE CHURCHES OF CHRIST IN THE U.S.A.

EDUCATION IN THE SOCIETY

A unit of the Division of Education and Ministry

475 Riverside Drive, Room 705, New York, NY 10115 (212) 870-2278

Philip R. Cousins, President

Arie R. Brouwer, General Secretary

Robert Rue Parsonage
Executive

Margaret L. Shafer
Staff Associate

July 6, 1987

Dr. Richard Keeling, Director
State Health Service
University of Virginia
Box 378
Charlottesville, VA 22908

Dear Dr. Keeling,

We are glad to know of your work with AIDS prevention education on college campuses. We are eager to develop ways to collaborate with you through our campus ministry networks. And where community advocacy is necessary, we will help develop linkage with church leaders who will support educational efforts.

There are many interlocking points in your plans and ours for AIDS awareness and we look forward to working in concert.

Sincerely,

Margaret L. Shafer

MLS:pt

National Board YWCA of the U.S.A.

726 Broadway
New York, NY 10003
212-614-2700
Cable: Emissarius, NY

July 8, 1987

President
Glendora McIlwain Putnam

Vice President
Rita Mannho Moniz

Vice President at Large
Lavera Lynch Brown

Regional
Vice President at Large
Stella Borrego Edmondson

Vice President
Eva Low Verplanck

Vice President
Helen Robinson Graham

Vice President
June Chan Quan

Vice President, Ex Officio
Andrea Emily Stumpf

Secretary
Mary R. Brown

Treasurer
Helen Anson Gamble

Assistant Treasurer
Marilynne Tarbet Keyser

Executive Director
Gwendolyn Calvert Baker

Mr. Richard P. Keeling, M.D., Chairman
American College Health Association
Task Force on AIDS
Box 378, Medical Center
University of Virginia
Charlottesville, VA 22908

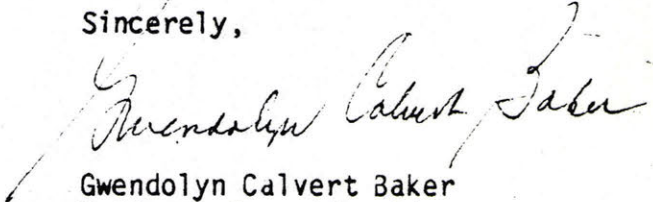
Dear Dr. Keeling:

The YWCA of the U.S.A., National Board is pleased to endorse the American College Health Association's (ACHA) application for funding for a Cooperative Agreement from the Centers for Disease Control to further the work in AIDS education nationwide.

We look forward to being able to work with ACHA on this important initiative reaching students, faculty, and staff on college and university campuses. The YWCA of the U.S.A. has a network of Student Associations situated on 40-50 university campuses across the country, through which programs of education and service to the college community are developed. The implementation of programs in student YWCAs in AIDS education, in conjunction with and complementary to ACHA's proposed AIDS peer project, will help support the educational efforts needed with this population.

The YWCA of the U.S.A. recognizes that AIDS represents a national emergency, and that we must develop effective prevention strategies aimed at college and university populations. We anticipate that we will continue our collaborative work with ACHA in AIDS education through our student and community Associations.

Sincerely,

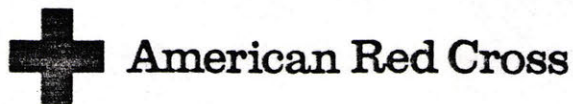

Gwendolyn Calvert Baker
National Executive Director

GCB:jah



Affiliated with the World YWCA

...in the struggle for peace and justice, freedom and dignity for all people



National Headquarters
Washington, DC 20006

July 6, 1987

Dear Dr. Keeling,

The American College Health Association's plan to increase the number of institutions providing AIDS education to college and university students appears to be an appropriate and effective response to the threat of AIDS for this audience. I am pleased to know that the ACHA is seeking to provide this education and training as a national representative for college and university health services.

The outline of your proposal suggests that the ACHA would seek to reach college and university students through regional workshops and peer education. Training student/faculty teams in areas such as needs assessment, methodologies for initiating AIDS education programs, and strategies for recruiting and training campus peer AIDS educators would be an important first step in bringing AIDS education to our nation's college and university population.

We at the American Red Cross are ready and willing to consult with and support you in this endeavor. Because of our experience in AIDS public education, we believe that we could make a valuable contribution to your efforts in developing and implementing a program to reach the college and university audience.

I look forward to working with you on this important project.

Sincerely,

Sigrid G. Deeds

Dr. Sigrid G. Deeds
Director
Educational and
Instructional Programs
American Red Cross
National Headquarters
17th & D Streets, N.W.
Washington, D.C. 20006

Richard P. Keeling, M.D., Chairman
Box 378, Medical Center
University of Virginia
Charlottesville, VA 22908

APPENDIX D
CHECKLIST

PHS SUPPLEMENTARY INSTRUCTIONS

CHECKLIST

NOTE TO APPLICANT: Complete and forward this sheet with your application.

Type of Application

☒ New

☐ Noncompeting
Continuation

☐ Competing
Extension

☐ Supplemental

CHECKLIST

- ☒ Proper Signatures and Dates (Item 23 on face page)
- ☒ Human Subjects Certification (when applicable)
- ☒ Staff and Position Data (biographical sketch(es) with job description when required).
- ☐ Intergovernmental review under E.O. 12372 if required by the State.
- ☐ Health Systems Agency review if required.
- ☐ Civil Rights Assurance of File with HHS (45 CFR 80)
- ☐ Assurance Concerning the Handicapped on File with HHS (45 CFR 84)
- ☐ Assurance Concerning Sex Discrimination on File with HHS (45 CFR 86)

A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence:

- ☐ (a) A reference to the organization's listing in the Internal Revenue Service's most recent cumulative list of organizations.
- ☒ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- ☐ (c) A statement from a State taxing body or the State Attorney General certifying that the organization is a nonprofit organization operating within the State and that no part of its net earnings may lawfully inure to the benefit of any private shareholder or individual.
- ☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- ☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date must be indicated.

Previously filed with: Internal Revenue Service on March 25, 1970
(date)

Name, title, address and telephone number of official in business office to be notified if an award is made.

Stephen Blom

American College Health Association

15879 Crabbs Branch Way Rockville, MD 20855 (301) 963-1100

Name, title, address and telephone number of official responsible for carrying out the proposed project.

Richard Keeling, M.D.

University of Virginia

Department of Student Health

Medical Center Box 378 Charlottesville, Virginia 22908 (804) 924-5362

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported; or (3) a negative certification.

ASSURANCE OF COMPLIANCE WITH TITLE IX OF THE
EDUCATION AMENDMENTS OF 1972 AND THE
REGULATION ISSUED BY THE DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE IN
IMPLEMENTATION THEREOF

(PLEASE READ EXPLANATION OF HEW FORM 639 A (3/77)* BEFORE COMPLETING
THIS DOCUMENT)

Pursuant to 45 C.F.R. 86.4:

<u>The American College Health Association</u> (Name of Applicant or recipient)
<u>15879 Crabbs Branch Way</u> (address)
<u>Rockville, MD 20855</u> (city, state, zip code)
<u>36-2681352</u> (identifying code-FICE, OE, or IRS)

(hereinafter the "Applicant") gives this assurance in consideration of and for purpose of obtaining Federal education grants, loans, contracts (except contracts of insurance or guaranty), property, discounts, or other Federal financial assistance to education programs or activities from the Department of Health, Education, and Welfare (hereinafter the "Department"), including payments or other assistance hereafter received pursuant to applications approved prior to the date of this assurance.

ARTICLE I - TYPE OF INSTITUTION SUBMITTING ASSURANCE.

A. The Applicant is (check the following boxes where applicable):

1. ☐ A state education agency.
2. ☐ A local education agency.
3. ☐ A publicly controlled educational institution or organization.
4. ☒ A privately controlled educational institution or organization.
5. ☐ A person, organization, group or other entity not primarily engaged in education. If this box is checked, insert primary purpose or activity of Applicant in the space provided below:

*HEW Form 639 A (3/77) This form supersedes HEW Form 639 (7/76). HEW Form 639 (7/76) submitted prior to this revision are valid and recipients need not submit a new assurance.

8. () Claiming a religious exemption under 45 C.F.R. 86.12(b).
(If religious exemption is claimed, attach statement by highest ranking official of Applicant identifying the specific provisions of 45 C.F.R. Part 86 which conflict with a specific religious tenet of the controlling religious organization.)

C. The Applicant offers one or more of the following programs or activities (check where applicable):

- | | | | |
|----------|---|--------|--------------------------------|
| 1. { } | Pre-school | 6. (X) | Undergraduate (including |
| 2. { } | Kindergarten | | junior and community colleges) |
| 3. { } | Elementary or Secondary | 7. { } | Vocational or Technical |
| 4. { X } | Graduate | 8. { } | Professional |
| 5. { } | Other (such as special programs for the handicapped even if provided on the pre-school, elementary or secondary level). If this box is checked, give brief description below: | | |

ARTICLE II-PERIOD OF ASSURANCE. This assurance shall obligate the Applicant for the period during which Federal financial assistance is extended to it by the Department.

ARTICLE III-TERMS AND CONDITIONS. The Applicant hereby agrees that it will:

1. Comply, to the extent applicable to it, with Title IX of the Education Amendments of 1972 (P.L. 92-318), as amended, 20 U.S.C. 1681, 1682, 1683, and 1685 (hereinafter, "Title IX"), and all applicable requirements imposed by or pursuant to the Department's regulation issued pursuant to Title IX, 45 C.F.R. Part 86 (hereinafter, "Part 86"), to the end that, in accordance with Title IX and Part 86, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives or benefits from Federal financial assistance from the Department. (This assurance does not apply to sections 904 (proscribing denial of admission to course of study on the basis of blindness) and 906 (amending other laws) of Title IX, 20, U.S.C. 1684 and 1685.)

2. Assure itself that all contractors, subcontractors, subgrantees or others with whom it arranges to provide services or benefits to its students or employees in connection with its education program or activity are not discriminating on the basis of sex against these students or employees.

3. Make no transfer or other conveyance of title to any real or personal property which was purchased or improved with the aid of Federal financial assistance covered by this assurance, and which is to continue to be used for an education program or activity and where the Federal share of the fair market value of such property has not been refunded or otherwise properly accounted for to the Federal government, without securing from the transferee an assurance of compliance with Title IX and Part 86 satisfactory to the Director and submitting such assurance to the Department.

4. Submit a revised assurance within 30 days after any information contained in this assurance becomes inaccurate.

5. If the Applicant is a state education agency, submit reports in a manner prescribed by the Director under 45 C.F.R. 80.6(b) as to the compliance with Title IX and Part 86 of local education agencies or other education programs or activities within its jurisdiction.

ARTICLE IV-DESIGNATION OF RESPONSIBLE EMPLOYEE AND ADOPTION OF GRIEVANCE PROCEDURES. (Check the appropriate box.)

A. 1. () Pursuant to 45 C.F.R. 86.8, the Applicant has adopted grievance procedures and designated the following employee to coordinate its efforts to comply with Part 86 and has notified all of its students and employees of these grievance procedures and the following name, address and telephone number of the designated employee:

2. Stephen Blom, Executive Director
(name of employee)
- The American College Health Association
3. 15879 Crabbs Branch Way
(office address)
- Rockville, Maryland 20855
4. (301) 963-1100
(telephone number)

B. 1. () The Applicant is not presently receiving Federal financial assistance subject to Part 86 and, consequently, has not designated a responsible employee or adopted grievance procedures pursuant to 45 C.F.R. 86.8 but will do so immediately upon award of such assistance and will immediately notify the Director, its students and employees of the name, office address, and telephone number of the employee so designated.

ARTICLE V - SELF-EVALUATION. (Check the appropriate box.)

A. (X) The Applicant has completed a self-evaluation as required by 45 C.F.R. 86.3(c) and has not found it necessary to modify any of its policies and practices or to take any remedial steps to come into compliance with Part 86.

B. () The Applicant has completed a self-evaluation as required by 45 C.F.R. 86.3(c) and has ceased to carry out any policies and practices which do not or may not meet the requirements of Part 86 and is taking any necessary remedial steps to eliminate the effects of any discrimination which resulted or may have resulted from adherence to such policies and practices.

C. () The Applicant has not completed the self-evaluation required by 45 C.F.R. 86.3(c) but expects to have it completed by _____
insert date

D. () The Applicant is not required to conduct a self-evaluation under 45 C.F.R. 86.3 since it did not receive any Federal financial assistance to which Part 86 applies prior to July 21, 1976.

Date: 7/15/87

The American College Health
Association

(Insert name of Applicant)

By

JoAnne Ciperson

(This document must be signed by
an official legally authorized
to contractually bind the Applicant.)

Assistant Director - Program Services
(Insert title of authorized official.)

**ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF
HEALTH AND HUMAN SERVICES REGULATION UNDER
TITLE VI OF THE CIVIL RIGHTS ACT OF 1964**

The American College Health Association (hereinafter called the "Applicant")
Name of Applicant (type or print)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this Assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this Assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this Assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance, and that the United States shall have the right to seek judicial enforcement of this Assurance. This Assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the Applicant.

Date July 15, 1987

The American College Health Association
Applicant (type or print)

By Assistant Dir. Program Services
Signature and Title of Authorized Official

15879 Crabbs Branch Way
Rockville, Maryland 20855
Applicant's mailing address

NOTE: If this form is not returned with the application for financial assistance, return it to DHHS, Office for Civil Rights, 330 Independence Ave., S.W., Washington, D.C. 20201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSURANCE OF COMPLIANCE WITH SECTION 504 OF THE
REHABILITATION ACT OF 1973, AS AMENDED

The undersigned (hereinafter called the "recipient") HEREBY AGREES THAT it will comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulation (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto.

Pursuant to §84.5(a) of the regulation [45 C.F.R. 84.5(a)], the recipient gives this Assurance in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other Federal financial assistance extended by the Department of Health and Human Services after the date of this Assurance, including payments or other assistance made after such date on applications for Federal financial assistance that were approved before such date. The recipient recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States will have the right to enforce this Assurance through lawful means. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

This Assurance obligates the recipient for the period during which Federal financial assistance is extended to it by the Department of Health and Human Services or, where the assistance is in the form of real or personal property, for the period provided for in §84.5(b) of the regulation [45 C.F.R. 84.5(b)].

The recipient: [Check (a) or (b)]

a. (☒)

b. () employs fifteen or more persons and, pursuant to §84.7(a) of the regulation [45 C.F.R. 84.7(a)], has designated the following person(s) to coordinate its efforts to comply with the HHS regulations:

JoAnne Ciperson

Name of Designee(s) (Type or Print)

The American College Health Association

Name of Recipient (Type or Print)

15879 Crabbs Branch Way

Street Address or P.O. Box

36-2681352

(IRS) Employer Identification Number

Rockville

City

MD

State

20855

Zip

I certify that the above information is complete and correct to the best of my knowledge.

July 15, 1987

Date

Assistant Dir. Program Services

Signature and Title of Authorized Official

If there has been a change in name or ownership within the last year, please PRINT the former name below:

NOTE: If this form is not returned with the application for financial assistance, return it to DHHS, Office for Civil Rights, 330 Independence Avenue, S.W., Washington, D.C. 20201.



STATE OF MARYLAND
COMPTROLLER OF THE TREASURY
RETAIL SALES TAX DIVISION
EXEMPTION CERTIFICATE

ACCOUNT NUMBER

EXPIRATION DATE

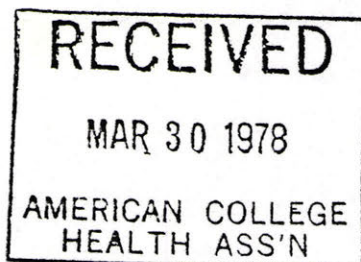
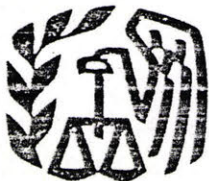
3100363 6

09/30/87

NAME

AMERICAN COLLEGE
HEALTH ASSOC
152 ROLLINS AVE STE 208
ROCKVILLE MD 20852

Department of the Treasury



District Director

Internal Revenue Service

Date:

29 MAR 1978

In reply refer to:

EP/EO Div., Tech Staff

E. Longstreet 353 3211

American College Health Association
2807 Central Street
Evanston, Illinois 60201

Form Number: 990 and 990-T
Periods Ended: 7606

We are pleased to tell you that as a result of our examination for the above periods we will continue to recognize your organization as tax-exempt.

We have indicated below whether there is a change in your liability for the unrelated business income tax as provided by sections 511 through 515 of the Internal Revenue Code.

- ☒ There is no change.
- ☐ You will receive an examination report explaining the proposed adjustments.

Thank you for your cooperation.

Sincerely yours,

District Director

Department of the Treasury



District Director
Internal Revenue Service

Date: ..

MAY 25 1970

In reply refer to:

CHI-EO-70-241

A:F:412:MM

American College Health Association
2807 Central Street
Evanston, Illinois 60201

Gentlemen:

Purpose: Educational and Scientific

Accounting Period Ending: June 30

On the basis of your stated purposes and the understanding that your operations will continue as evidenced to date or will conform to those proposed in your ruling application, we have concluded that you are exempt from Federal income tax as an organization described in section 501(c)(3) of the Internal Revenue Code. Any changes in operation from those described, or in your character or purposes, must be reported to the District Director, at the above address, for consideration of their effect upon your exempt status. You must also report any changes in your name or address.

In this letter we are not determining whether you are a private foundation as defined in new section 509(a) of the Code. Your attention is invited to new section 508(b) of the Code which sets forth requirements for establishing that an organization exempt under section 501(c)(3) is not a private foundation. When procedures are developed to implement these new requirements, we will advise you how to proceed to notify the Internal Revenue Service if you do not believe yourself to be a private foundation.

For years beginning prior to January 1, 1970, you are required to file the annual information return, Form 990-A. For each subsequent year, please refer to the instructions accompanying the Form 990-A for that particular year to determine whether you are required to file. If filing is required, you must file the Form 990-A by the 15th day of the fifth month after the end of your annual accounting period.

You are not required to file Federal income tax returns (Forms 1041, 1065 or 1120) so long as you retain your exempt status, unless you are subject to the tax on unrelated business income imposed by section 511 of the

Code, in which case you are required to file a Form 990-T. In this letter we are not determining whether any of your present or proposed activities is unrelated trade or business as defined in section 513 of the Code.

Contributions made to you are deductible by donors as provided in section 170 of the Code. Bequests, legacies, devises, transfers and gifts to or for your use are deductible for Federal estate and gift tax purposes under the provisions of sections 2055, 2106 and 2522 of the Code.

You are not liable for the tax imposed under the Federal Insurance Contributions Act (social security taxes) unless you file a waiver of exemption certificate as provided in such act. You are not liable for the taxes imposed under the Federal Unemployment Tax Act. Inquiries about the waiver of exemption certificate for social security taxes should be addressed to this office. Any questions concerning excise, employment or other Federal taxes may be directed to the nearest Internal Revenue Service office in your District.

This is a determination letter.

Very truly yours,

E. P. Trainor

District Director

See Page 3 for additional information.

RECEIVED

1971
JAN 14
1971

American College Health Association

3

The ruling letter dated August 4, 1953 issued to your predecessor American College Health Association of Cambridge, Massachusetts holding it exempt from Federal income tax under the provisions of the section corresponding to 501(c)(3) of the 1954 Internal Revenue Code is terminated as of February 19, 1968, the date of incorporation.



To all to whom these Presents Shall Come, Greeting:

Whereas, Articles of Amendment to the Articles of Incorporation duly signed and verified of

AMERICAN COLLEGE HEALTH ASSOCIATION

have been filed in the Office of the Secretary of State on the 11th day of May A. D. 1970, as provided by the "GENERAL NOT FOR PROFIT CORPORATION ACT" of Illinois, approved July 17, 1943, in force January 1, A. D. 1944;

Now Therefore, I, PAUL POWELL, Secretary of State of the State of Illinois, by virtue of the powers vested in me by law, do hereby issue this Certificate of Amendment, and attach thereto a copy of the Articles of Amendment to the Articles of Incorporation of the aforesaid corporation.

In Testimony Whereof, I thereto set my hand and cause to be affixed the Great Seal of the State of Illinois.

Done at the City of Springfield this 11th day of May A. D. 1970 and of the Independence of the United States the one hundred and 94th



Paul Powell
SECRETARY OF STATE

21 167 303

ARTICLES OF AMENDMENT
to the
ARTICLES OF INCORPORATION
under the
GENERAL NOT FOR PROFIT CORPORATION ACT

To PAUL POWELL, Secretary of State, Springfield, Illinois.

The undersigned corporation, for the purpose of amending its Articles of Incorporation and pursuant to the provisions of Section 35 of the "General Not For Profit Corporation Act" of the State of Illinois, hereby executes the following Articles of Amendment:

1. The name of the corporation is: American College Health Association

2. There are 554 members, having voting rights with respect to amendments:
(Insert "no" or "some")

(Strike paragraphs (a), (b), or (c) not applicable)

3. (a) At a meeting of members, at which a quorum was present, held on April 14, 19 70 same receiving at least two-thirds (2/3) of the votes entitled to be cast by the members of the corporation present or represented by proxy at such meeting.

(b) By a consent in writing signed by all members of the corporation entitled to vote with respect thereto,

(c) At a meeting of directors (members having no voting rights with respect to amendments) held on

 , 19 same receiving the votes of a majority of the directors then in office, the

following amendment or amendments were adopted in the manner prescribed by the "General Not For Profit Corporation Act" of the State of Illinois:

~~XXXXXXXXXXXX~~
~~Article # 4: The Board of Directors shall be thirteen in number,~~
~~to be designated as the Executive Board of the~~
~~Association.~~
~~XXXXXXXXXXXX~~

Article # 5: "The purpose or purposes for which the corporation is organized are: The purpose of this Association is to provide an organization in which institutions of higher education, other organizations, and interested individuals may work together to promote health in its broadest aspects for students and all other members of the college community. Notwithstanding any other provision of these Articles, said corporation is organized exclusively for charitable, religious, educational, and scientific purposes as defined under Section 501(c)(3) of the Internal Revenue Code of 1954, as amended. In the event of the dissolution of the Association its assets will be distributed exclusively to organizations exempt from Federal Income Tax under the same Section of the Internal Revenue Code."

IN WITNESS WHEREOF, the undersigned corporation has caused these Articles of Amendment to be executed in its name by its _____ President, and its _____ Secretary, this 18th day of April, 1970.



American College Health Association
(Exact Corporate Title)

By Frank J. Kilpatrick
Its _____ President

James W. Miller
Its _____ Secretary

STATE OF Illinois
COUNTY OF Cook } ss.

I, Ruth L. Trudela, a Notary Public, do hereby certify that on the 4th day of May, 1970, James W. Miller (acknowledgment by either officer is sufficient)

personally appeared before me and, being first duly sworn by me, acknowledged that _____ he signed the foregoing document in the capacity therein set forth and declared that the statements therein contained are true.



IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year before written.

Ruth L. Trudela
Notary Public.

FORM NP-35

Box 4844 File 577-2

ARTICLES OF AMENDMENT

to the

ARTICLES OF INCORPORATION

of

FILED

MAY 11 1970

Paul Powell
Secretary of State

Filing Fee \$10.00

(6885-10M-3-69) 14

RECEIVED
JAN 10 1960
STATE OF ILLINOIS

Certificate of
Amendment
to the articles of Incorporation
of

AMERICAN COLLEGE HEALTH ASSOCIATION

MAIL TO NEW
MAIL TO NEW

2807 Central St
Evanston, Ill 60201

800

MAIL

STATE OF ILLINOIS

Office of the

Secretary of State

2167303

1 JAN 20 1960
MAIL-26-10 75397 • 2167303 • A - P.O.



STATE OF ILLINOIS

DEPARTMENT OF REVENUE

160 NORTH LA SALLE STREET

CHICAGO 60601

THEODORE A. JONES

DIRECTOR

SAM KEYS

ASSISTANT DIRECTOR

March 1, 1968

American College Health Association
2807 Central Street
Evanston, Illinois

Attention: Mr. James W. Dilley, Executive Secretary

Gentlemen:

We have received your recent letter concerning the tax exempt status of the American College Health Association.

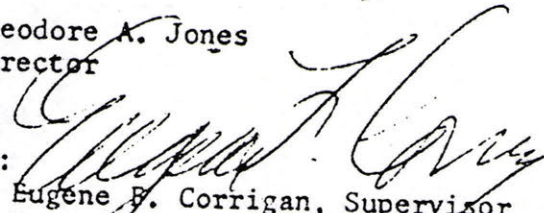
This is to acknowledge that yours is an exempt organization within the meaning of the Retailers' Occupation Tax Act in that your organization is organized and operated exclusively for charitable purposes.

Suppliers of your organization will not, therefore, incur any state or local "sales tax" liability on their receipts from sales of tangible personal property to your organization.

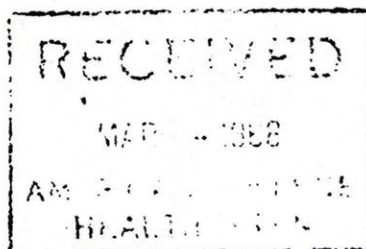
We do not issue exemption numbers; but you may exhibit this letter or photocopies of it as evidence of the exemption acknowledged herein.

Sincerely,

Theodore A. Jones
Director

By: 
Eugene B. Corrigan, Supervisor
Rules & Regulations Division
Chicago Office
Phone: 346-2000, Ext. 441

EFC/JJT/pr



Other infectious diseases can be spread as a consequence of the AIDS epidemic. Illnesses such as HBLV, EBV, cytomegalovirus, or hepatitis B may increase due to this illness. Even increases of tuberculosis are expected because of AIDS.

The economic burden of this illness is growing and may well define the future of the dwindling health dollar. The AIDS epidemic has created tremendous demand for participation in studies testing the efficacy of potential therapy. The use of regional AIDS evaluation centers is appropriate, and therapeutics still require controllable trials. Funding for clinical trials should be linked to primary care AIDS centers so that appropriate resources such as social work, home care, and pharmacy can be linked together. (*Farber B.F., and Kaplan M.H.: J. Inf. Dis. 155:1097-1099, 1987.*)

III INTERNATIONAL CONFERENCE ON AIDS: OF PANDEMICS, POLITICS, AND PEOPLE

Arlington Cemetery and the Kennedy Memorial all beckoned their somber tones to the serious nature of the third international congress on AIDS, in Washington, D.C. The disease that began as a sporadic, bizarre set of cases relegated to gay males suddenly included > 100 countries and both sexes. There can be found no further exceptions to this illness; even infants at birth are no longer under protection from this slow retrovirus which lies asymptomatic for years at times before eventually claiming its victim.

The mood of the congress began with a dinner whose keynote speaker was the president of the United States. He spoke to a jeering audience about mandatory testing without mentioning adequate counseling nor true security and privacy of information. At one point he spoke of the innocent victims of this illness, implying that there was a guilty party as well. Upon the hills surrounding the tent of the speech flickered candles of those who protested in the night.

The first morning of sessions began no better with the vice-president commenting about the presence of some gays booing in the audience. However, the politicians finally gave way to the rhetoric of what has evolved in the world of AIDS. The disease is now truly pandemic and involves almost every area of the world. The epidemiology of the illness demonstrates continued growth in the U.S.; other infected populations remain static, although some increases occur in the heterosexual population. AIDS in Europe and Africa remains a heterosexual disease. Brazil has perhaps the most rapidly growing population of AIDS cases.

The transmission of this illness remains through blood products and intimate sexual relationships. Oral routes or transmission through other bodily fluids remain unlikely ways of spreading this illness. Inactivation of the virus by antibody in the oral cavity, pH in the stomach, or low levels of inoculum of the virus itself offer little to encourage this as a significant route for contracting this illness.

The heterosexual nature of the illness in Africa appears to have occurred by any of several factors: malnutrition helps to increase susceptibility to this virus, hundreds of insect vectors may again weaken the populace and offers a probable low level route for transmission, and diseases such as malaria are clear immune suppressants and act as significant cofactors in increasing the likelihood of transmissibility. Many of these cofactors act through T cell stimulation, allowing easier access for the virus; there is also immune suppression which heightens the infection and allows for viral proliferation.

Male-to-female sexual transmission of the AIDS virus appears to occur more easily than female-to-male, although over time the percentages equalize. Less common female-to-male transmission may reflect a lower inoculum effect that actually

simply delays but does not reduce the eventual clinical expression of the full-blown disease. Anal intercourse is an important factor which greatly increases the chance of infection. The anal canal and lower colon are particularly susceptible to traumatic bleeding and penetration of virus through immunologically poor tissue.

Transmission in household contacts still almost never occurs and the risk of AIDS on casual contact is remote at best. Seropositive mothers, on the other hand, transmit this disease to their children *in utero* in about 50% of cases. Cases of infant AIDS are increasing in cities like New York where there is a large IV drug abuse area wherein female infection is quite frequent.

The current pandemic of AIDS is caused by a reverse transcriptase-producing retrovirus which can remain in the cell for long periods of time as either a replicative or nonreplicative form. It is now known that the disease can remain asymptomatic for ≥ 7 years. The illness can begin without any symptoms or present as a form of mononucleosis with fevers and transient lymphadenopathy. HIV disease can also present as primary interstitial pneumonia or rarely as primary central nervous system (CNS) disease in the form of mild encephalitis or dementia. HIV can infect without presenting antibody to the host for ≤ 6 months although IgM antibody to this illness can develop even within days of the onset of infection. HIV can also go through periods of antigen negativity with only antibody as a marker. HIV antigen appears usually within 12-18 months of the full clinical expression of this illness. The trigger for antigenemia may be other cofactors such as the presence of other sexually transmitted illnesses such as hepatitis B, cytomegalovirus, Epstein-Barr infection, or drugs which both stimulate and suppress certain parts of the immune system. Many other unknown factors appear to trigger this response and may relate to actual genetic tissue type of the host. Another factor is the antibody pattern which is developed. Some individuals develop more neutralizing antibody which seems, along with certain core antibody, to be more protective to the host than does envelope antibody.

The vaccine for this disease appears to be at least 5-10 years away according to the members of this congress. The optimism in such a vaccine rests with the finding that there is a conserved part of the envelope glycoproteins which can be similarly common to all AIDS strains and which would act as a good focus for vaccine development.

The struggle for a vaccine pales before the knowledge put forward concerning the presence of various other types of retroviruses. An HTLV-5 was introduced which has characteristics of AIDS in man and simian. This may not spread as rapidly as HIV but can cause devastation of the cellular immune system. HTLV-1, a leukemia virus, may spread more easily through casual contacts and is being recognized more in the Western world. The disease is yet another example of a virus which should be screened for in blood in the near future. HTLV-2 appears not to produce immune deficiency and is also poorly transmissible. There is evidence that an HIV-2 infection exists already within Europe and in the U.S., which once again condemns the use of blood products. Other than distribution and frequency, HIV-2 shares many of the clinical characteristics of HIV. HBLV is another uncovered virus which may be etiopathologically associated with the development of B cell lymphomas.

Trials of new antivirals were addressed by the congress. AZT has some efficacy although it is also associated with significant toxicity. Newer therapeutics such as dideoxycytidine (DDC) offer similar efficacy with fewer side effects although this has yet to be proven. The use of AZT in combination with acyclovir and other agents may allow synergy and a reduction of side effects. Another emerging therapeutic target appears to be that of those agents which effect viral receptors both on the virus and on target cells. Drugs such as peptide T and AL721 may have effect on both bloodborne HIV and CNS infection. Both agents affect the lipid

moiety which is involved in receptor attachment and penetration of the virus. These drugs appear to reach the CNS and affect the disease in the CNS. Both agents appear to have modest toxicity and deserve broader trials. Evidence is growing which suggests that CNS AIDS may well represent immune reaction and protein toxicity rather than purely invasion by the HIV virus itself.

The use of combination therapy with antiviral plus immune stimulant appears to be yet another avenue of trial worth pursuing. The belief in early therapeutic intervention in the asymptomatic or mildly ill individual also suggests an evolution from early recognition of AIDS to its more subtle manifestations. There was also an expectancy in the presentations that time would reveal yet further faces of this illness.

Control of this disease is left in the hands of educators who need to teach how to avoid contracting the illness. Safer sexual practices have to be promoted. Counseling of positive cases is mandatory. The testing and restriction of blood products is yet another important step in this control. There is yet to be a truly useful approach to IV drug abuse, and this is one of the core problems. Control also means better diagnostics; presentations at the meetings suggested that IgG and IgM indirect fluorescent antibody assay (IFA) might be superior to enzyme-linked immunosorbent assay (ELISA) for early detection of HIV. Cytotoxic assays also may become strong markers of illness. Following T cell activation, assays also appear to predict severity of the illness. Profiling core vs. envelope vs. neutralizing antibody also may give characteristics of an infection and help define which patient will evolve to what state of illness and how soon. Although the congress gathered thoughts and reports about AIDS, it overflowed with important works in a variety of other areas. AIDS-related diseases including opportunistic fungal and viral infections were dealt with in many investigations which cited new approaches for tuberculosis, *P. carinii*, and various bacterial infections as well. New protocols for treatment of lymphomas and Kaposi's sarcoma were also discussed, and the relationship of these and other malignancies can only shed further light on the immunology and treatment of related diseases.

Robert Gallo and Luc Montagnier were honored at the American Foundation for AIDS Research as two of the pioneers in this field. From a few dozen interested individuals to 8,000 who gathered from around the world, the AIDS congress meetings have become the most significant health meeting in the world. Pioneers such as Gallo and Montagnier represent core work in the area of AIDS related retrovirology. Their work has formed the central theme for the investigations to come. The streets of Washington remained political and moral battlefields for those who wished to dissent during the meetings. Some were briefly arrested as they pleaded for sensitivity to illness without judgment or moral arrogance. They also begged the government to wake up and recognize its responsibility to support the efforts in the war against the pandemic. Although some money is forthcoming, it's not enough. Considering that 1.5-2 million people in the United States are probably infected with AIDS and that about 80% of these will eventually die of the disease, only then can the magnitude of this problem begin to reveal itself. (*Galpin J.E., Director of Porton Medical Laboratory and Clinics.*)

ERRATUM

A reader noticed an omission in the June 1 issue of *IDA* (6:65). The first sentence of the second paragraph of **ACELLULAR VERSUS WHOLE CELL PERTUSSIS VACCINE** should read "The American Academy of Pediatrics continues to recommend diphtheria-tetanus toxoids-whole cell pertussis (DTP) vaccination at 2, 4, and 6 months of age, with booster injections at age 18 months and 4 to 6 years." *IDA* apologizes for the error and welcomes reader comments.

What They Did on Their Summer Vacations:

The AIDS Task Force Keeps on Cookin'

Most of us got a breather this summer. Somewhere amidst the long hot days, most ACHA members and staff found a week or two or more (that's already enough to turn some of us green with envy) for beach basking or climbing mountains or just reading through those steamy, riveting back issues of Action you've always wanted to peruse (to each his own).

The ACHA Task Force on AIDS, however, was busy. Task force members and chairman, Richard Keeling, M.D., staggered their summer breaks enough to make substantial progress on several projects "all of which," Dr. Keeling recently bemoaned in a letter to task force members, "seem to have deadlines at about the same time." Meeting the simultaneous, mid-summer deadlines, however, enabled the task force leader, who is also ACHA's new president-elect, to enjoy a well-deserved family vacation himself.

Since many of you out there in college health have asked to be kept aware of upcoming AIDS publications and programs, the following is a brief overview of the task force's most recent activities, adopted from Dr. Keeling's pre-vacation communication to the task force.

Proposals in the Works

In the coming months we hope to have good news to report regarding the status of the ACHA Task Force on AIDS proposal to the Centers for Disease Control (CDC). The proposal for a \$100,000-cooperative agreement with the CDC was submitted in final form on July 15. It details an ACHA plan to establish regional workshops on AIDS in order to supply college and university faculty and peer educators with the knowledge and techniques needed to in turn provide support and teach people on their own campuses about the disease.

According to Dr. Keeling's outline of the proposal, the ^{two-}~~2~~-day workshops would include:

- * ways to initiate AIDS education programs
- * current information about AIDS
- * strategies for recruiting and training campus peer AIDS educators
- * guidelines for educational sessions
- * strategies for promoting and preserving behavior changes
- * practical suggestions concerning funding, trouble-shooting, and public relations.

Discussions with the CDC about the proposal began in April ~~May~~ and continued during the ACHA annual

meeting in May, when Dr. Keeling shuttled from Chicago to Washington, D.C. to speak with CDC officials and back again to Chicago. Talks with the CDC have resulted in a plan which has the respect and encouragement of other associations and organizations, such as the Red Cross, the National YWCA, and the National Council of Churches.

AIDS Task Force members are optimistic regarding the success of the proposal for several reasons. First, the proposed regional workshops could be set up within the existing ACHA regional affiliate structure.

Workshops could coincide with scheduled affiliate meetings and could be promoted via Action and affiliate newsletters.

Second, ACHA's national office in Rockville could be used as the base for a workshop coordinator, who would work with Dr. Keeling, ACHA Executive Director Stephen Blom, and members of the task force to develop the curriculum and resources needed based on ^{regional} values and ^{requirements} ~~needs in each of the workshop regions.~~

Furthermore, ACHA and AIDS Task Force experience in producing effective, quality educational materials for the college population has already earned a national reputation for the association and could be another strong factor for a positive response from the CDC.

Development of the materials and format for the workshop program would begin in the fall of 1987. If the CDC approves, the first six regional workshops will then

begin in the spring of 1988.

In addition to the CDC blueprint, ACHA and the AIDS Task Force are also awaiting word from the American Foundation for AIDS Research (~~AmFAR~~) on grants for two proposed projects. The first, if accepted, would enable ACHA to develop and distribute AIDS educational materials to campus "health care providers, mental health professionals, health educators, student affairs administrators, personnel officers, and communications offices" via a desktop publishing updating system.

Specifically designed to meet the needs of students in the nation's inner cities, the second proposed Amfar project involves an ACHA-sponsored model conference for faculty and staff members of publicly-funded inner city colleges and universities. The conference will result in the creation and distribution of an inner city schools resource guide/program manual which addresses issues -- such as race, culture, drugs, and gender-- that are critical to many inner city students.

Abstracts and letters of intent were sent to Amfar for both plans. If approved, the task force proceeds to step two, which is the development of full-fledged proposals.

The Metropolitan Life Foundation has also invited the AIDS Task Force to apply for funding through the Metropolitan Life's "Project Reach," which would help support existing educational programs. The September

deadline will give task force proposal writers a slight breather.

Other Projects

Also as the result of a series of summer meetings and discussions, ACHA is endorsing a production of the College Satellite Network (CSN) titled, "Sex on Campus." The program will be broadcast to CSN subscribers September 30, 1987, from 8:00 to 10:00 p.m. and will feature Dr. Keeling and other medical authorities as well as moderator Hodding Carter, entertainers, politicians and celebrities.

ACHA is working directly with CSN, the American Council on Education, and the National Association of Student Personnel Administrators on program content for both the viewers' guide and the broadcast, which campuses can receive live or on videotape. For more information about the program, phone CSN at 800-323-4222.

Another project in the hopper involves an educational program for residence hall advisors at schools in New York City. NYC's Gay Men's Health Crisis (GMHC) is responsible for the program development and organization. Dr. Keeling contacted GMHC to see if ACHA could work with them on the project, and they have included him in the initial planning for the five

seminars planned for September and October. The program is good exposure and experience for ACHA and enables the task force to add GMHC to their roster of influential contacts.

Publications

The ACHA/National Institutes of Mental Health (NIMH) booklet, "Coping with AIDS," is due for publication sometime this fall. Copies of the draft were distributed at the annual meeting in Chicago and have received favorable, complimentary responses. For those of you who are awaiting the real thing: so are we. Action will keep you informed about the actual release date from NIMH.

The task force's Working Group on Women's Issues in AIDS, chaired by Christine Lyman, M.S.W., A.C.S.W., is developing a student brochure to alert them to the special issues now associated with women and AIDS. Other members of the task force are working on a Sexual Decision Making brochure, clinical evaluation materials, and a revision of the education resource section of the "AIDS on the College Campus" special report. The highly acclaimed and very popular pamphlet "Making Sex Safer" is now undergoing a needed facelift. A new version, which includes photographs of both black and white couples, is due out soon.

Dr. Keeling and task force members also welcomed two new members to their ranks this summer: Richard Wolitski, a graduate student at California State University at Long Beach, and David Kersey, a resident in psychiatry in the Yale University training program at Greenwich Hospital in Connecticut. The entire association joins in the welcome.

Because of the number of projects and publications now being developed by the task force, this fall should bring news of a variety of programs and services for college campuses across the nation. Thanks to the AIDS task force and their deadline diligence in the midst of a long hot summer, we can look forward to an exciting, educational 1987-1988 school year.

AIDS

A DIARY OF THE PLAGUE IN AMERICA

Ryan's Day (continued from cover)

At the moment, Ryan is sitting on the couch watching TV. He's wearing a jacket, a sweater, his huge, furry "Bigfoot" slippers. A woolen blanket is draped over his shoulders for warmth, but it isn't enough. He shuffles into the kitchen again and turns the front burner of the electric stove to high.

"Only way I can keep my hands warm," he explains, holding his tiny blue fingers over the red-hot coil. "Sometimes I burn 'em," he adds, showing a nasty scar on one hand.

Ryan is tired all the time. He spends most of his days sleeping, reading comics or watching TV. Sometimes he plays with the Casio keyboard Elton John sent him. John has been a friend. He calls or writes about once a month. Last summer he flew the Whites—Ryan, his sister Andrea, 13, and Jeanne—to L.A. and took them to Disneyland. There Ryan got to meet Brooke Shields and Elizabeth Taylor. Ryan seldom gets out now because he throws up so often.

Despite the fact that AIDS is laying waste to Ryan's 60-lb. body, he has all the cravings of a normal teenager. His appetite, for example, is voracious, and tonight, when Jeanne suggests they have dinner out, he eagerly agrees. An hour later Jeanne, Andrea and Ryan, his heavy denim jacket buttoned to the neck, are walking into Grindstone Charley's, 10 minutes away. First, Ryan rushes to the bathroom to vomit. Then he spends 10 minutes warming his fingers under the hand dryer.

As he heads back to the table, he barely notices the

stares. "I ignore everything," says Ryan. He learned that from his hometown and its grassroots hate campaign against him; on radio talk shows, he heard himself vilified as a "homo," a "queer" and a "faggot." Once he was readmitted to school in Kokomo, his classmates "backed away from me and called me names," he remembers.

Compared to that, these stares in a restaurant are nothing.

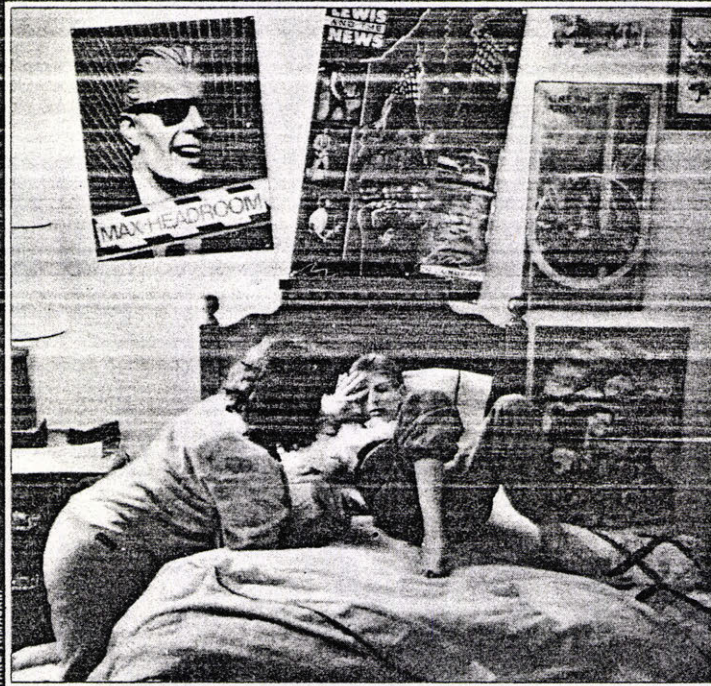
Ryan orders some nachos, a steak and a salad. By the time the food arrives, he can't eat. Slumping, he seems swallowed up by the restaurant chair. "Mom, I'm sick," he whispers. Ryan's head slumps forward. The fork slips from his hand. "I'm too tired to eat," he says miserably. Back home, he goes directly to his bedroom. Jeanne collapses on the couch. Neither she nor her son complain about the hand life has dealt them. First hemophilia, then AIDS. "We don't dwell on things," she says. "If we did we'd go crazy."

In a while Jeanne goes off to the bedroom. It's time for prayers. She tucks her child into bed and kneels beside him. She holds his hands in hers as

they bow their heads together and pray in unison: "Thank you, dear Lord, for another day."

Soon Ryan's eyes begin to close. "I love you, Mommy," he murmurs.

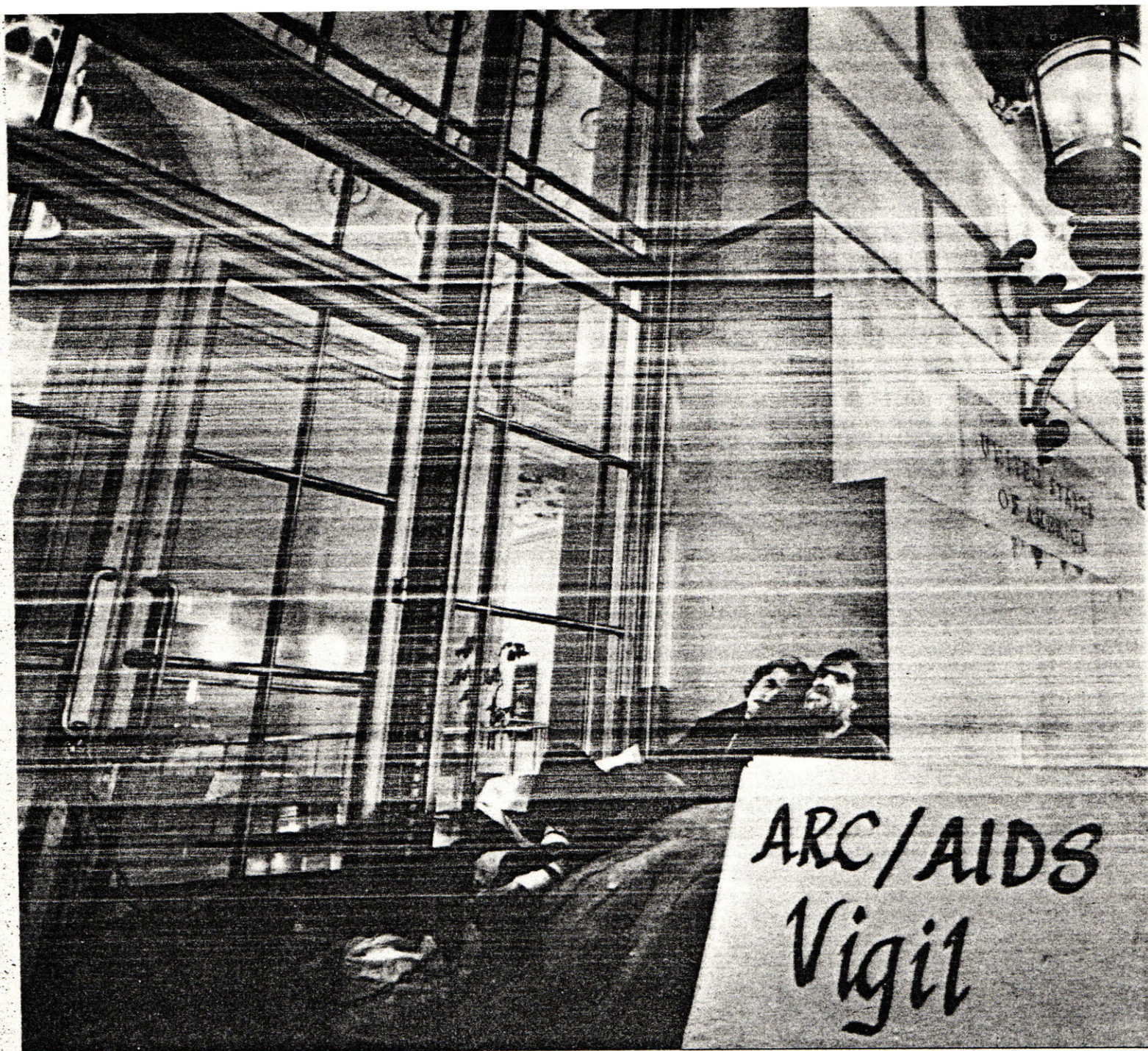
Jeanne White gets up, turns the lights off and closes the door. Then, in the hallway, her strength seems to leave her in a rush. She sags against the wall. "I'm okay," she says through her tears. "I'm okay," she says, as if trying to make herself believe it.



After their prayers, Jeanne White says goodnight to her son.

Ryan White is one of 16,000 Americans who have AIDS. On these pages is a portrait of one day in their lives: Friday, June 19, a day very much like every other.

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Dawn. New Orleans

The lights are still shining on Bourbon Street. A man and woman waver out onto the sidewalk from Cafe Lafitte in Exile, and swirling around them come gusts of cool bar air and hot singing: *Won't You Take Me to Funky Town*. A street sweeper cruises along, trying to scoop up the thousands of discarded "go cups," tall plastic containers provided by the local bars so that customers can take their bourbon or beer out to the sidewalk if they want to.

At the corner of Bourbon and St. Ann streets, a row of waist-high yellow traffic markers define a pedestrian zone in New Orleans' centuries-old pleasure district, but they do more than that. They mark the precise spot, which everybody calls the "Lavender Line," where the jazz joints and strip houses give way and the

gay bars begin. The gay bars, many open 24 hours, are famous in New Orleans: the Great American Refuge, the Mississippi River Bottom, the Rawhide Mining Co. and the Bourbon Pub, flying the flags of the U.S., the Confederacy, France and the State of Louisiana in chauvinistic celebration of a love that, here at least, dares to unfurl its name.

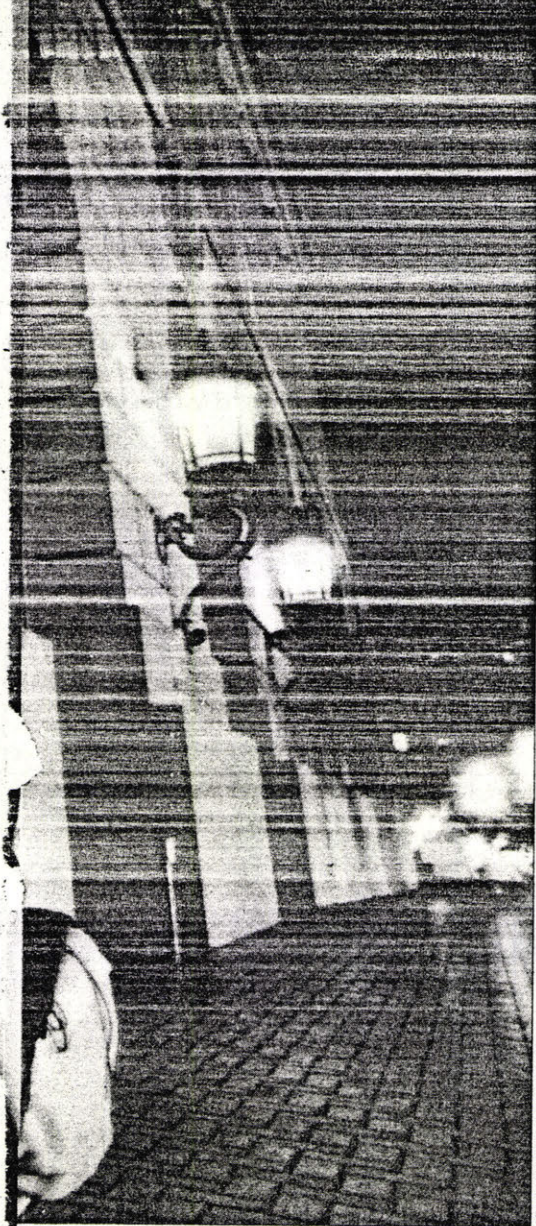
But things have changed on Bourbon Street. Ten years ago there would have been a dawn river of cavorting couples, a cascade of men singing, yelling, flirting, buying, selling, flowing on from bar to bar. Even five years ago there would have been hundreds of them. Now a few faded looking hustlers lean on the brightly colored stoops, looking without much luck for lonely strays. A shirtless man driving a sleek white car cruises up and down, up and down; but he finds no takers.

If you want to know why, wait outside Cafe Lafitte. Wait for Dusty and Eric to waltz up. They have been dancing down Bourbon Street together: Dusty is 22 and just out of the closet, Eric is 29. They stop here on Bourbon Street, a little out of breath, and stand beneath a balcony that girds Cafe Lafitte. But they are looking across the street at an office front that seems out of place here: a plain white stucco facade amid the jumble of neon and porch lights, hanging flowerpots and faux-French ironwork. The shinglelike sign on its plain wooden door says a great deal more about the future of this street and these people than all the legendary gaudiness on the strip. It reads: AIDS INFORMATION CENTER.

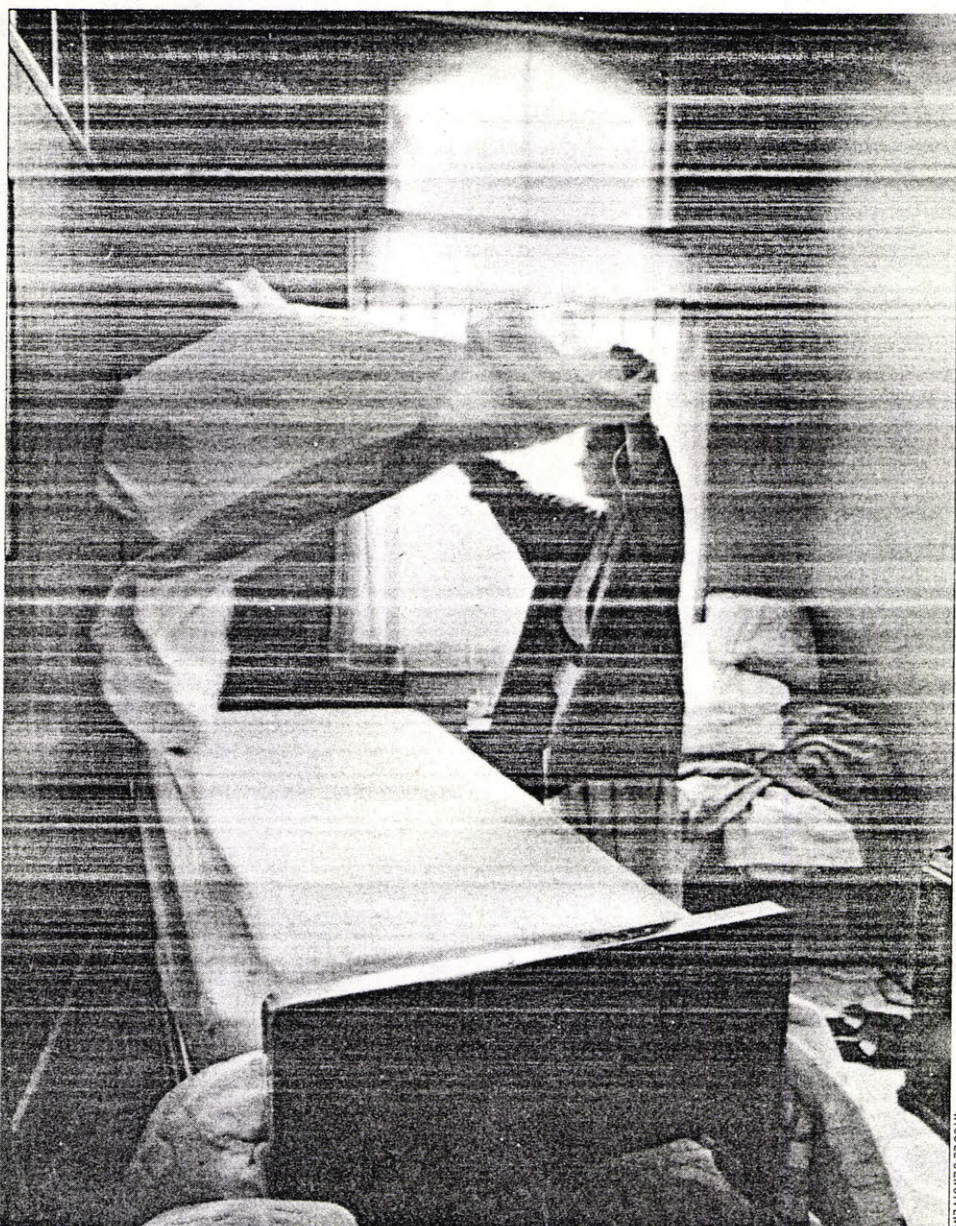
It stands for death, 21,915 deaths in the last six years, God knows how many more to come. It has stopped Dusty and

In the chill of daybreak Randy Welch (left) and Garth Ferguson take part in a two-year-old, 24-hour vigil at the Old Federal Building in San Francisco.

At Lazarus House, in a remote part of New Orleans, a hospice with five terminally ill people who have AIDS, volunteer Taryn Lindhorst changes the bedclothes.



P.F. BENTLEY/PHOTOREPORTERS



NICOLE BERGIERO

Eric's dancing. And every once in a while, another reveler, stumbling out of some bar, will find himself standing in front of it, staring at it, numbed by fear and grief, staring for a long, long time.

All along Bourbon Street now, the porch lights on the yellow, blue, purple, pink and green houses are being turned off, to greet the new day.

8:40 a.m. On Rounds with Dr. Michael Gottlieb, Santa Monica, Calif. Dr. Michael Gottlieb is credited with recognizing AIDS as a new disease in 1981, and his first patient today, a 41-year-old oral surgeon from New York whom we shall call Mickey, is dying of it. The scene appears grim—he lies in a room with all the curtains drawn and the lights off—but despite the catheter that has been driven above his heart to assure a direct line for

his drugs, despite the pneumocystis that is trying to kill him and the seborrhea and ringworm that merely make his life miserable, Mickey banter with everybody as best he can. He makes fun of the nurses, himself, even his AIDS.

"Rock Hudson was that way," says Gottlieb, 39. "He always had a cheerful word for me."

Gottlieb first glimpsed the death's head that is AIDS behind five cases of pneumocystis, an unusual form of pneumonia, in previously healthy gay men. He was the first to study the drug AZT, now being widely tested as a way to retard the disease's progress. He was a co-founder, with Elizabeth Taylor and Dr. Mathilde Krim, of the American Foundation for AIDS Research. He is a celebrity of sorts now. He drives a Jag and dresses like a professor. But he is still at the front,

still researching, still making his rounds at Santa Monica Hospital.

His second patient this morning is Andy, a hairstylist from Los Angeles. In his room two huge metal bins stand against a wall: One is for infectious linens, the other for infectious wastes. AIDS can take three forms: a blood status of HIV-positive, which means a person has been infected with the AIDS virus antibody, has at least a 30 percent chance of developing the disease and probably can infect others; ARC, or AIDS-Related Complex, whose symptoms include weight loss, swollen lymph glands, chronic diarrhea and night sweats, and an estimated 5 percent of whose victims each year develop AIDS; and the full-blown AIDS syndrome, with its ghoul- ish, opportunistic diseases and 100 percent fatality rate. Andy has the last; he

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Buddy, in the racking final stages of debilitation at Providence House in Long Beach, Calif., finds solace in a teddy bear.



JEFF ALLEN

At 10 a.m. in Salt Lake City, Rose, a former prostitute and addict, says goodbye to her 5-year-old son. She is HIV-positive and must turn him over to her mom and grandfather while she's in rehab. "I don't know what's going to happen," she says.

weighs 104 lbs.; his eyes are glazed. A hole has been cut in his throat so he can breathe, and he can hardly whisper to Gottlieb that he thinks the tubing on his IV is kinked. Then he reaches for a Kleenex, and the effort is too great. He doubles over and emits a deep gurgling noise as mucous wells from his tracheotomy. Minutes later, when Gottlieb, leaving, tells him, "Hang in there, you're doing better," Andy shakes his right foot wildly, as if to say, "I am not. I'm dying."

There will be 17 more patients in the course of this Friday: At 9:12 a well-known fashion illustrator, who says he's feeling strong enough to go to Paris for a photo shoot; at 10:13 a nephew of Lyndon Johnson's, whose right hand is useless and black from his treatment but whose sickness caused a reunion with his famous family; at 11:32 a young mother whose husband is bisexual—she is in for tests; at 11:41 an HIV-positive tennis jock who swears, "If I am going to drop dead, I'm going to drop dead healthy." Of his time with these patients Gottlieb says, "I continue to marvel at the sturdiness of the human spirit."

Gottlieb thinks his greatest contribution may not be made here, at bedside, however, but in his lab. At the moment he is especially optimistic for his work with DDC, an AZT relative he hopes will be available for testing in two months. In the long run, he is sure AIDS will be conquered. "If we can put a man on the moon," he says, "we can outfox this virus." In the short run ... how many of his former patients are now dead?

"I've lost count," he says.

9:30 a.m. The Calico Club, Battle Mountain, Nev.

Brigitte, in her transparent teddy, sits at the bar with two truckers. Jeri, in a nightie, is working the CB in a sultry voice, promising free coffee and showers at "Nevada's friendliest legal brothel." "That's all the state allows us to say over the airwaves," Jeri says, between announcements. "So I make it as inviting as possible." They all are discussing the monthly Nevada inspections, compulsory for the past 14 months, which the girls call "doctor day."

"If a girl tests positive for AIDS antibodies, she loses her license," says Penny, the manager.

"A positive result means she wasn't using condoms," says Madam Ginger.

"For a while business slowed down because the guys were afraid," Penny says. "Now word is getting around about how safe the brothel workers are and business is picking up again."

"I'm just not using lot lizards anymore," one trucker from Arizona says. He means the prostitutes who work the truck stops.

"If there's any question at all about a customer, I've instructed the girls to refuse to continue the party," Madam Ginger says firmly.

"It's not worth it," Brigitte, in the teddy, agrees. "Just like it's not worth extra money not to use a condom. Get infected and you're out of work for days, weeks—maybe forever. Anyone that stupid shouldn't be in this industry. It gives us all a bad name."

"That's why I come here," the other trucker says. "I don't want to bring anything home to my wife."

"Most of our men are married," explains Madam Ginger.

The Morning Paper, Spokane

Today's edition of the *Spokane-Review* includes an endorsement of several recommendations by a year-old citizens task force. The group hopes to rid the streets of prostitutes in ways that are "fair, humane and realistic," and one of its proposals is to put up billboards in the parts of town that prostitutes especially favor. The billboards would read: DO YOU KNOW IF THAT WOMAN YOU JUST PICKED UP HAS AIDS OR IS AN AIDS CARRIER?

9:45 a.m. A Hotline in Detroit

Scott Walton, 33, is staring at an empty chair in the offices of Wellness Networks, which has an AIDS hot line. "He died in the spring," Walton, the executive director, is saying. "I sang at his memorial service."

The phones are ringing and lights are blinking on buttons. Volunteers jab the buttons and listen to voices:

A woman is crying. She was in a department store dressing room and noticed a spot of blood on a chair. She isn't

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In his Tulsa kitchen, Dave makes AIDS drugs not yet federally approved. "This is war," he says. "I'm a general in the trenches."

sure she touched the blood but she is terrified she will get AIDS. A volunteer tells her, over and over, that that is virtually impossible. Finally the woman seems persuaded, somewhat.

"No, mosquitoes do not transmit AIDS," another volunteer says.

A man has shown positive on the HIV-antibody test. He wants to know whether he will get AIDS; he may. He wants to know whether he can have sex without communicating the virus; there will always be risk. The volunteer, sneaker-clad feet crossed on his desk, gently recommends a support group.

A woman's husband has forbidden the family to use the public swimming pool because of AIDS. The pool is safe, she is told.

A woman is worried because she washes out communion chalices at her church. That is safe, she is told.

A regular: He has been in a peep show booth that was unclean and is scared. Last week he had been to a topless bar, touched a dancing woman and was scared. A volunteer, familiar with the voice, tells him to go see his therapist.

Scott Walton, elegant in gray suit and shiny black cowboy boots, hits another button and asks a caller how he's feeling today.

Walton's face becomes anguished.

He names a doctor. "Call us back if you have any problems," he says.

And the phones keep ringing.

10:15 a.m. A Kitchen Lab, Tulsa

An angry young man, looking like a left-over '60s hippie in ponytail, T-shirt and jeans, works at a wooden picnic table in the kitchen of his small, cramped apartment. He wishes to be known only as Dave, since what he is doing is extra-legal. On a gauze strip stretched between two bricks, he lines up a dozen capsules of Imuthiol, a compound used to treat metal poisoning. In a shot glass atop a digital scale, he carefully mixes nine grams of acetone, a prime ingredient of nail polish remover, and a gram of white powder called CAP, for cellulose acetate hydrogen phalate. He stirs with a swizzle stick, then, using tweezers, dips in the capsules, coating them, he believes, against stomach acids which would make them inactive and toxic. "We've had to become our own physicians," he says bitterly, "because the medical establishment is letting us die."

Dave's kitchen is one of 65 guerrilla labs that have sprung up across the country since the fall of 1985, all desperately turning out "work-alike" versions of remedies that may or may not be effective in retarding the progress of AIDS and that lack the approval of the Food and Drug Administration. Dave, 31, is a former commercial artist, and he got into this field in April 1986, when his lover, Jay, developed AIDS and was told he had only two months to live. Dave refused to accept the prognosis. "The doctors gave up

on him," he says. "In fact, they probably made his condition worse by bombarding him with last-resort drugs as if he were Hiroshima." He put Jay on nutritional supplements and a high-carbohydrate diet. He went to Mexico to procure ribavirin and isoprinosine, neither approved for AIDS treatment by the FDA. He haunted medical libraries and steeped himself in scientific journals to the point where government researchers would chat on the phone with him about unreleased drugs, never guessing he was not one of their own. He set up a nationwide PWA (People With AIDS) co-op to get discounts on nutritional supplies and offers printed handouts with the latest "recipes." "I can't recommend anything," he says, "but I can tell people what's out there based on the scientific data and my own experiences."

The phone rings. A man is calling from New York about ribavirin; then a researcher in Texas who wants Dave's view on a substance made from aloe vera. "Drugs are sitting out there that could save our lives," Dave says. "It's genocide. I kept Jay alive a year longer than the doctors expected."

He dips the Imuthiol capsules as he talks. Precisely. Bitterly. Jay died three weeks ago.

10:20 a.m. Providence House, Long Beach, Calif.—Part 1

"Jim!" comes a cry from the porch of the

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Nurse Melinda McDonald lays a soothing hand on Saturnino Morales at St. Clare's, a Manhattan hospital devoted to PWAs.

big, weathered post-Victorian house. "It's the hospital. Frank's taken a turn!"

Jim Johnson bounds up the steps from the sidewalk. Johnson, who looks a bit like Tom Selleck—big, fit, muscular, mustachioed—is the head of an interdenominational AIDS support group called Beyond Rejection, and he runs Providence House, Lily House and the San Juan Hotel, three boarding facilities for PWAs. By local ordinance, the houses can hold only six patients each, the hotel 20. In their 11 months the three shelters have handled 43 PWAs. Six of them got well enough to leave; six are now hospitalized; 15 are now residents; 16 have died.

Frank. A week ago Frank seemed almost healthy. He had gone out to dinner and a movie with his family, in a limo, had laughed and enjoyed himself. Several days later pneumocystis hit and he was rushed to the hospital. Johnson races to go see him.

He gets to the hospital in less than 10 minutes. "Frank was my pet," he says in the elevator. "I try not to single anyone out, to treat everyone equally, but..."

At the second-floor ICU, Frank's family and friends are huddled in the waiting room, somber. A young man is slumped in a plastic chair. "It's so unfair," he says.

Johnson is too late. He leans weakly against a mustard-colored wall. "This is a hard one," he says.

The Morning Paper, New York City
Legal cases focusing on people accused of knowingly exposing others to the AIDS virus are cropping up around the country, raising troubling issues for the courts, public health officials and the law-enforcement authorities....

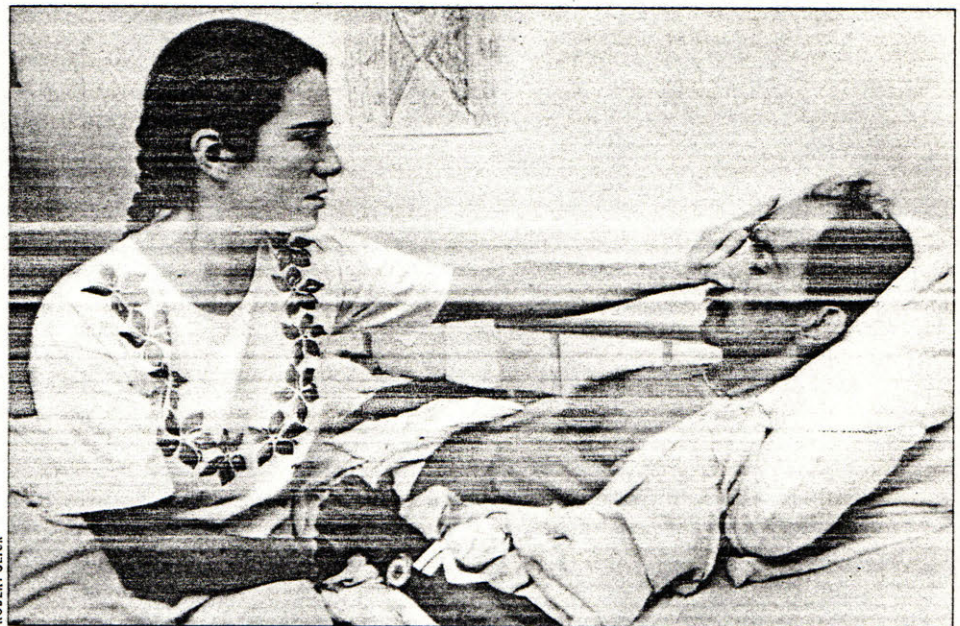
"We've got a classic case of hard cases making bad law," said Lawrence O. Gostin, executive director of the Boston-based American Society of Law and Medicine. "It's totally a symptom of the hysteria surrounding AIDS."

—The New York Times

11:45 a.m. The Louisiana House of Representatives, Baton Rouge

The honorable members of Louisiana's lower chamber are engaging in catcalls and also dogcalls, meowing and barking to greet a bill on pet-food taxes. This may be a form of release; on Wednesday, by a margin of 62-27, the representatives passed a bill permitting the arrest and quarantine of any person with AIDS.

Alphonse Jackson Jr., a 59-year-old who came up through the civil rights movement, was the quarantine bill's sponsor, and right now he has more to worry about than pet food. The Louisiana ACLU has already denounced the bill, the Governor is talking veto, and gay people



on the street fear concentration camps. Jackson is worried. "This measure isn't intended to round up AIDS patients," he protests, putting a starched white handkerchief in his breast pocket. "We don't round up people with tuberculosis, but we have a law to deal with them if they endanger public health. What if someone broke into this chamber and started kissing and sticking people, infecting others simply to take their lives?"

There seems to be some miscommunication here. "We don't need this bill to deal with AIDS," says Louise McFarland, the epidemiological section chief of the State Health Department. "We need it for tuberculosis patients, who can spread their disease without actual physical contact." Health Department and ACLU lawyers are already working together on amendments to soften the bill.

Jackson sighs. He is tired. He admits the bill as written could be abused. "Suppose we did get a tyrannical health inspector who did want to round up these patients?" he worries. "I would rather take the quarantine section out than encroach on anyone's civil liberties." On the other hand, "This disease is a modern-day plague," Representative Jackson says. "It could immobilize this country." And, "AIDS is behaviorally driven and we have to have mechanisms to control it, if necessary."

The pet-food bill is defeated. The AIDS bill will be withdrawn next week.

Noon. A Fireman, Finksburg, Md.

This was supposed to be Gary Brewer's first full day back at the firehouse. Instead, he is sitting on the deck of his blue ranch house, his wife having gone to her job as a legal secretary, watching their son, Eric, 17, mow the lawn. Eighteen days ago, Brewer and a medic responded to a call about a pregnant woman who had been shot in the abdomen by an arrow meant for somebody else in a quarrel.

She was bleeding profusely and the men stanching the flow as best they could. When it was over, Brewer's arms and hands were covered with her blood. The woman and her baby died anyway. She was later found to have tested positive for the AIDS virus.

Normally easygoing, Brewer started yelling at his wife, washed his hands compulsively all day long, couldn't sleep. His first AIDS test was negative but two more tests remain, in September and December. He is on sick leave, seeing a psychologist, and angry because he feels the department has been nonsupportive. Yesterday he reported back to the department's doctor, who could certify him for duty, but they agreed he wasn't ready yet. So today Brewer, 40 years old and a 17-year veteran, sits on the deck. In two days he will start a week's vacation in Daytona Beach, Fla., with his family. "I'm just going to lie on the beach," he says firmly. "I want to put this behind me."

But he can't. He thinks about quitting the department. It's the nonsupport, the risk of more calls that might endanger everything, the strain. "I'm in limbo," Gary Brewer says, and looks out at Eric, mowing the grass.

12:30 p.m. A Woman in a Certain Town, Northern California

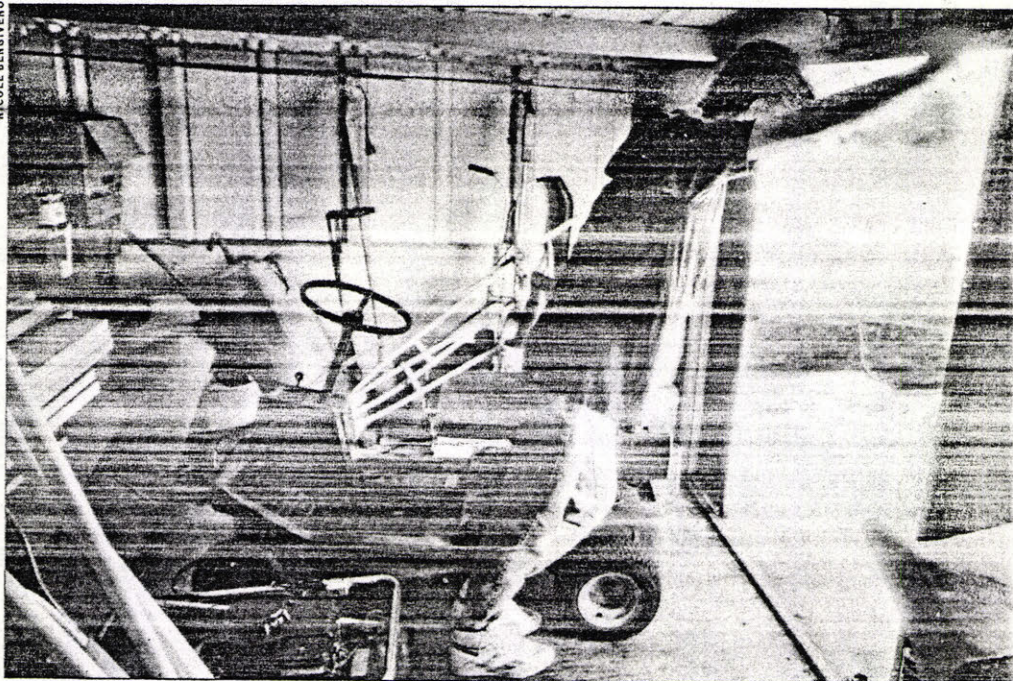
It was six years ago, Ann thinks, that she contracted the AIDS virus from a bisexual lover, but almost nobody in town knows that she has it. She's almost certainly the only such person there, and revealing that wouldn't do her any good. By the time she learned she had the virus, she'd had four kids. Now the two youngest test positive for exposure to AIDS. Although she and her husband of five years started to practice safe sex, they sometimes slip up. "He thinks I'm silly for insisting on condoms," she says. "He doesn't feel he will catch it at all."

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At noon in Pittsburgh, Bill, a PWA, and Chet, HIV-positive, move out because their two roommates are nervous. They will live temporarily with Chet's parents.



NICOLE BENVENUTO



In New Orleans, a 16-year-old boy grieves for his father, who is down to 100 lbs. "They told me in November," he says. "My mom was devastated. It doesn't hurt me that he has AIDS. It hurts that he's dying. They sent him home to die."

ANDY LEVIN

Yvette Townsend, an accountant, arrived yesterday at Bailey House, a Manhattan residence for homeless PWAs. That's why she's singing in her afternoon tub. "This is a sick person's dream of comfort," she says. "To know that you are being taken care of."



DONNA FERRATO



At 5 p.m. in San Francisco, widow Ruth Brinker nears the end of a 12-hour day for Open Hand, the program she founded, which brings free meals to 165 PWAs daily. Ruth works seven days a week. "She is the heart of God," says one grateful client.

In northern California this afternoon, the face of Ann's son Casey, 2, shows his fears during IV hemoglobin treatment. He, Ann and his younger sister have AIDS antibodies. "He has sores in his mouth," says Ann, "but overall he's doing real well."

That's how Ann, 32, got pregnant again last January.

She cried for a couple of days after that because the doctors told her there was a 60 to 75 percent chance this child would get AIDS too. They offered to do an abortion for free. Ann was ready. "But then I looked at my other children playing around my feet. I just couldn't do it. I love my kids." Then there was her husband, the one who doesn't think condoms are important. "He's really an optimist," she says. "He's convinced this child has a really good chance. I don't know if he's superpositive or just in a state of denial." As she dishes out franks and beans for lunch, Ann shares that incorrigibly sunny view. "I consider myself perfectly healthy," she says. "Maybe I was just exposed a teeny, tiny bit to AIDS. I mean just enough to give my body some resistance."

So how does she justify bringing a baby into the world knowing the odds are high that its life will be short and full of pain? "I would rather see a child be loved for two years than be on earth for 50 years without love and affection," she says. Even if the child suffers? "I would hate to see it happen," says Ann.

1 p.m. David Chickadel's Day, Philadelphia—Part 1

The picture in the silver and brass frame on the dresser of David Chickadel's apartment was taken in the summer of '83, and it shows two handsome young men: David and his lover of seven years, Thomas. They are vacationing on Fire Island, N.Y., and smiling. That was just before David was diagnosed as having AIDS in the fall; Thomas received the same diagnosis in October '85. He died in January, and David, 34, is fighting for his life. In the pic-

CONTINUED



ture, he weighed 210. Now he's 120 and looks gaunt, ascetic, like an Indian holy man.

The phone rings and David picks it up. No one there. He's used to that by now. "Two friends came right out and told me they didn't want to have any direct contact with me because I'm sick," he explains. "But they'd call to make sure I was still alive."

He shrugs, having a lot to do today, starting with a doctor's appointment. He locks the front door, begins to walk the five blocks. Then halfway to the hospital he can't remember if he locked the front door or not. Memory lapses are common in PWAs. "My, we're looking a little petite today," the doctor at the Graduate Hospital tells him. David laughs. "You're not doing so bad," says the doctor, after reviewing his tests, "but I want you to gain some weight." David vows he will. The doctor asks how his support group is working. "I'm not going anymore," David says. "There's just too much talk about death and dying. It's ridiculous. You've got to put some humor in it."

On the way home David stops at the pharmacy and buys \$954 worth of medicines. They will last him about 24 days.

When he gets back to his one-bedroom, top-floor apartment, beautifully decorated in soft blue and rose, David is met by his "buddy" Anne Greenberg, a volunteer. Two years ago Anne, 44, survived a bout with lung cancer and decided to help those people "who are not getting any

support." She cooks for David, she cleans for him, but mostly she serves as a friend, one of his best friends now.

"How are you doing?" Anne asks cheerily.

"I don't know," David says. "This past day I've been bursting into tears for no reason... no reason at all."

She puts an arm around his shoulder.

1:10 p.m. Providence House, Long Beach—Part 2

Jim Johnson gets back from the hospital and finds one of his residents, James, sitting on the porch next door at Lily House, changing the batteries in his beat box. James is 46, and music goes wherever he goes. "How's Frank?" he asks.

"We just lost Frank," Johnson says. "He's with the Lord."

Surprise, frustration, resignation wash across James's face. Blindly, he pushes a pack of Marlboros toward Johnson. The two smoke in silence, heads bowed. Before, James was a cook in the merchant marine; bedridden in January, he has revived enough to take up the culinary duties for the house.

"Frank was my roommate when he first came in here," James says. "I liked him."

Johnson pats him on the knee. "Get your music going," he says. As he crosses the yard toward Providence House, Luther Vandross' voice wafts through the warm California air: *Give Me a Reason*.

Five minutes later Officer John Griffith

pulls up in his official white car with the city seal on the sides. The neighbors have called again, this time to complain that there are more than the allowed six people per house in the complex, so Code Enforcement Officer Griffith has come to investigate. After Johnson demonstrates that the charge is wrong, he and Griffith discuss the importance of death with dignity. "Ten out of 16 died here at home," says Johnson.

He pauses, then corrects himself: "Out of 17."

"Don't try setting people up in the garages," Griffith advises in a friendly way as he leaves. "People would call in on that, you can count on it."

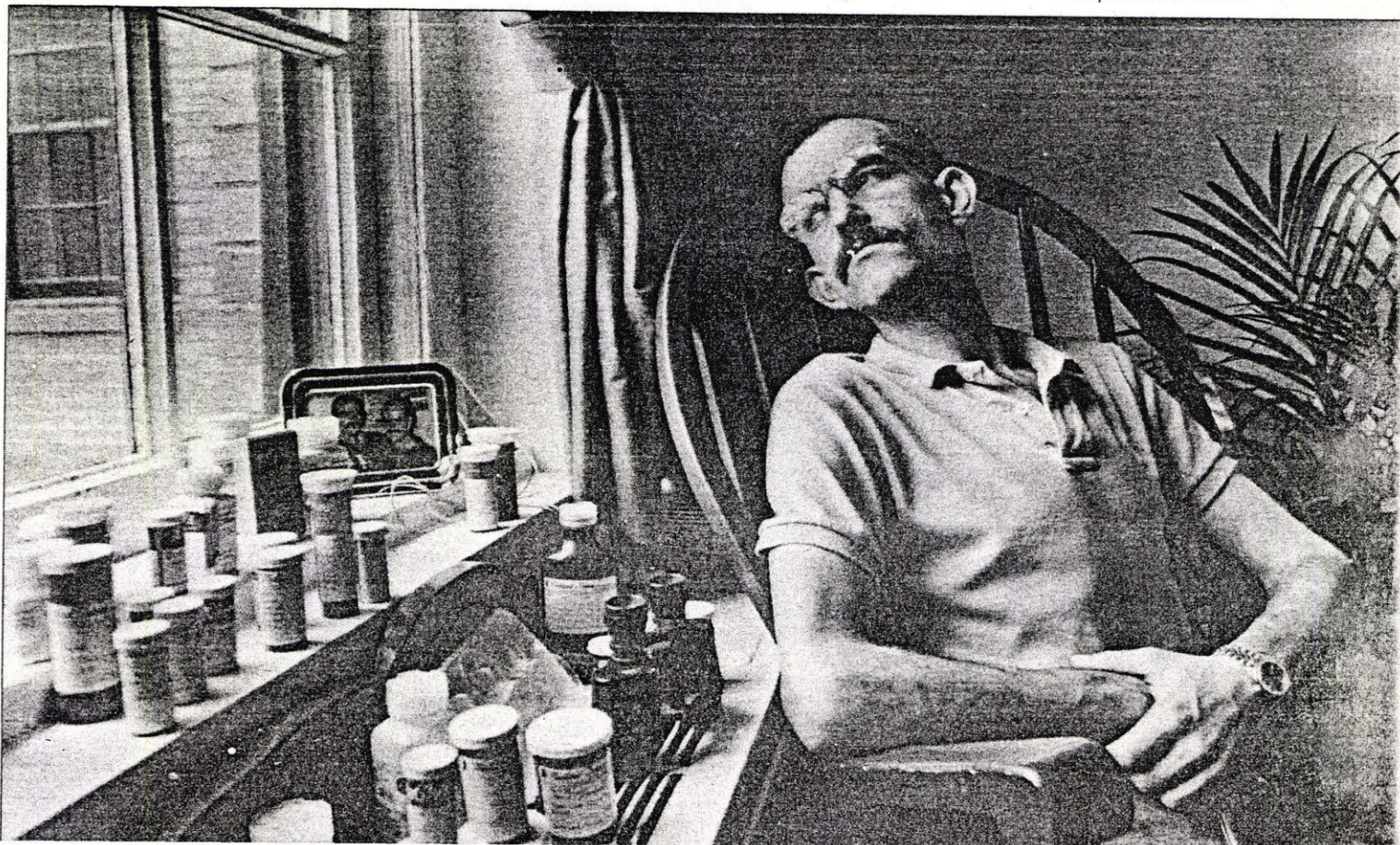
2 p.m. Fred, a PWA, Philadelphia

I'm not an IV drug user and I'm not homosexual or bisexual, so after the first two tests I didn't believe it. But if enough people tell you you look like a horse, you'd better start buying hay. Finally I went into an AIDS shelter. There were 13 of us there at the start and to my knowledge, I'm it—the only survivor. But depression will kill you faster than anything. I went through my suicide period like everyone else, but then it occurred to me that the way my luck had been running, I'd probably jump out of a window, land on some cop and have to serve time. I don't think those kind of thoughts anymore.

3:35 p.m. Providence House, Long Beach—Part 3

Jim Johnson, on the phone, accepts a new
CONTINUED

Philadelphia's David Chickadel contemplates today's medicines and a photo from a happier time: The lover in the picture is dead.





JILL FREEDMAN

In a Washington, D.C., suburb late in the day, Michelle Valentine, a 25-year-old single woman, hugs her foster baby, 6-month-old Christina, who has AIDS. "I don't think I can cry anymore," Michelle says. "I've got to be strong because she needs me. Nobody else wanted her."



JOY WOLF/PICTURE GROUP

resident. His name is Tim, he is 31, and he's been living in Hollywood with his friend Larry. He is about to become homeless. Larry's landlady said Tim can no longer sleep on his couch.

3:45 p.m. Ralph, a PWA, Atlanta

I found out I had AIDS in October 1985. My parents had shunned me since 1983, when I told them I was gay. But deep down I thought it would make a difference if they knew I was terminally ill. I thought they'd get over the gay issue and come around. The doctor kept pressuring me to tell someone. I finally called them. It didn't make them change at all. My mother said, 'Oh, my God, we can't handle the other thing, how can we handle this?' They let me know they thought I had shoved this gay thing down their throats. If I die, they will not be at the funeral.

My grandmother and I have always been unusually close. When I told her I was gay, she said, 'I'd love you if you had carrots growing out of your ears.' She went to the family. She said, 'He's sick, you've got to help him.' They ran her out of the house.

Ralph's Grandmother, in a Small Southern Town

Ralph's a fine young man. You're not supposed to have special grandchildren. I've

tried not to, but Ralph is special. I did not know about AIDS. I did not realize it is so serious, and spreading so. I worry. I don't know if he's getting all the rest and the good food he needs. I've got this big ole house. I'd like for him to come here and let me take care of him. But my children won't let me. I grieve since all this started. I want to help Ralph, but I can't risk losing my daughter. I may need her help some day. I think about him all the time. I look down the road and wonder what will be and how it will be. I wish there were something I could do about it. I pray about this, I sure do.

4 p.m. A Meeting of Mothers of PWAs, Los Angeles

Greg was a well-known theatrical lighting director in New York, and he really couldn't face the fact that he was dying of AIDS until maybe a month or so before he died. He was always so bright and alert and affectionate. He always loved cats, and as he was dying, a yellow cat walked in the door and lay down on his bed. The day Greg died, the cat left. I don't know what it means, but it stays with me. Many of the mothers report certain spiritual developments or strange things at such times.

—Mary Jane Edwards
I'm just not the same person I was before my son died. In his dying, he taught me living, though he could never speak freely about his feelings to us. There was a dove that kept flying to his window as he was dying. We have never had a dove come to our house before or since.

—Connie Searcy

As the afternoon shadows lengthen in Los Angeles, Connie Searcy, in a mothers' group, remembers her son and mourns.

4 p.m. A Dumpster, Indianapolis

Two 11-year-old boys, just wandering around, find a baby bird in some bushes behind the MetroHealth clinic on the west side of town. Looking for a box to put it in, they spot a banged-up Dumpster containing a cardboard box. They take out its contents—20 vials of blood and 125 syringes—put the bird in the box and hide the vials and syringes in the bushes. At least one of the vials is contaminated with AIDS.

The next day the boys will come back here with 10 or so pals. They will mess around with their find, heaving vials at a brick wall, getting blood all over themselves. If any of the kids has an open wound, as boys do, and the AIDS blood gets on it, he will be in danger of infection. Of course, the kids don't know any of that yet. Neither do their parents. They will all find out Sunday.

Several days later the kids will be tested for AIDS. All will be found safe, for now. There will have to be more tests over the next few weeks and probably more after that. The incubation period for AIDS may be five years or more.

4 p.m. A Woman in Kansas City

"I'm not thin," says Marie, a 34-year-old office worker. "I'm not pale. I'm middle class. I'm heterosexual. I live in Kansas City. And I have AIDS."

She is sitting in the living room of her comfortable suburban-housing complex with another woman, an AIDS counselor. "You're not supposed to have AIDS in Kansas City," agrees the other woman.

Marie's got two teenage kids, and she's been divorced for 15 years. During that time she's had just four sexual encounters. "I have not been a loose woman," Marie says, blushing. "I'm not a bar person and I haven't done drugs. I'm somebody's mother. Somebody's sister. Somebody's daughter. They say I'm in a low-risk group, so if I can get AIDS, anyone can."

4:15 p.m. David Chickadel's Day, Philadelphia—Part 2

David and his buddy, Anne, are making dinner plans. She is suggesting Fratelli's, a good, trendy Italian restaurant downtown. David seems oddly reluctant, but finally he makes the reservation. "Be absolutely sure you seat us on the first floor, not the second," he tells the maître d'. "The first, please be sure of that." He is adamant.

Then it's 4:20, time for another trip to another doctor. A pathologist, this time. David has found a spot on his wrist, and he's terrified it might be Kaposi's sarcoma, a cancer which has stricken 40 percent of all PWAs.

Walking to the pathologist, he again

tells Anne, "It's strange, the past day I've been bursting into tears for no reason." Then he adds, "Maybe it's the roses."

The day before, a friend in San Francisco had sent David a dozen yellow roses. He put them in a vase on his dresser, near the picture of him and Thomas.

"Were yellow roses important to you and Thomas?" Anne asks quietly. David just nods slowly.

At the pathologist's, David's jaw is clenched with dread, but the spot on his wrist turns out to be nothing more serious than a mole he'd never noticed before. They head for Fratelli's and as they get near, David begins to get excited: "Everything's good there," he says. "But the seafood pescatore, well, it's just fabulous." As he insisted, they are seated on the ground floor. But when it comes time to order, David's eyes grow sad.

"The pescatore may be fabulous," he says, "but I'll have the lasagna. It's more fattening."

4:58 p.m. Providence House, Long Beach—Part 4

Tim, the newest resident, is driven up to

Providence House by his friend, Larry. He is given a room, on the ground floor. Larry carries him in and puts him straight to bed. Tim is too weak to walk, talk or eat.

5 p.m. A Wake Near Chicago

Julio was "macho," says his brother. "He liked to work and watch sports," says his mother, who is crying. "He rode a motorcycle. He traveled." The brother remembers he was a pretty good pickup outfielder, liked to party, had his share of girlfriends. At the moment, only his relatives from Cleveland are here at his wake in Aurora's Healy chapel, which is small and discreet; his aunts and cousins from Puerto Rico will be arriving soon.

Julio was 40. Last year he started to lose weight and got stomach cramps, but a series of neighborhood doctors told him he had a virus, forget about it. In May, worse, Julio went to the hospital and tested positive for AIDS. He broke it to his family over Memorial Day weekend. Then he went back to the hospital for good.

CONTINUED



An emaciated PWA at St. Clare's Hospital in Manhattan reads—and rereads—a father's day card from his daughter.

At 5:15 p.m. in Seattle, a therapist's massage turns into a game of peekaboo. The mother (lying down) has AIDS; her baby may develop it. They are at the home of an AIDS volunteer with the "Chicken Soup Brigade" who wants to be the baby's foster mom.



Leonard Matlovich, a Vietnam vet with two Bronze Stars, applies medication to a friend's lesions in San Francisco. Matlovich, discharged 12 years ago from the Air Force for being gay, is a PWA, AIDS activist and, still, a political conservative.

In his last month Julio, a Catholic-turned-Pentecostal-turned-agnostic, started looking for the Lord again. He asked his family to read from the Bible, especially Psalms 88 and 52:

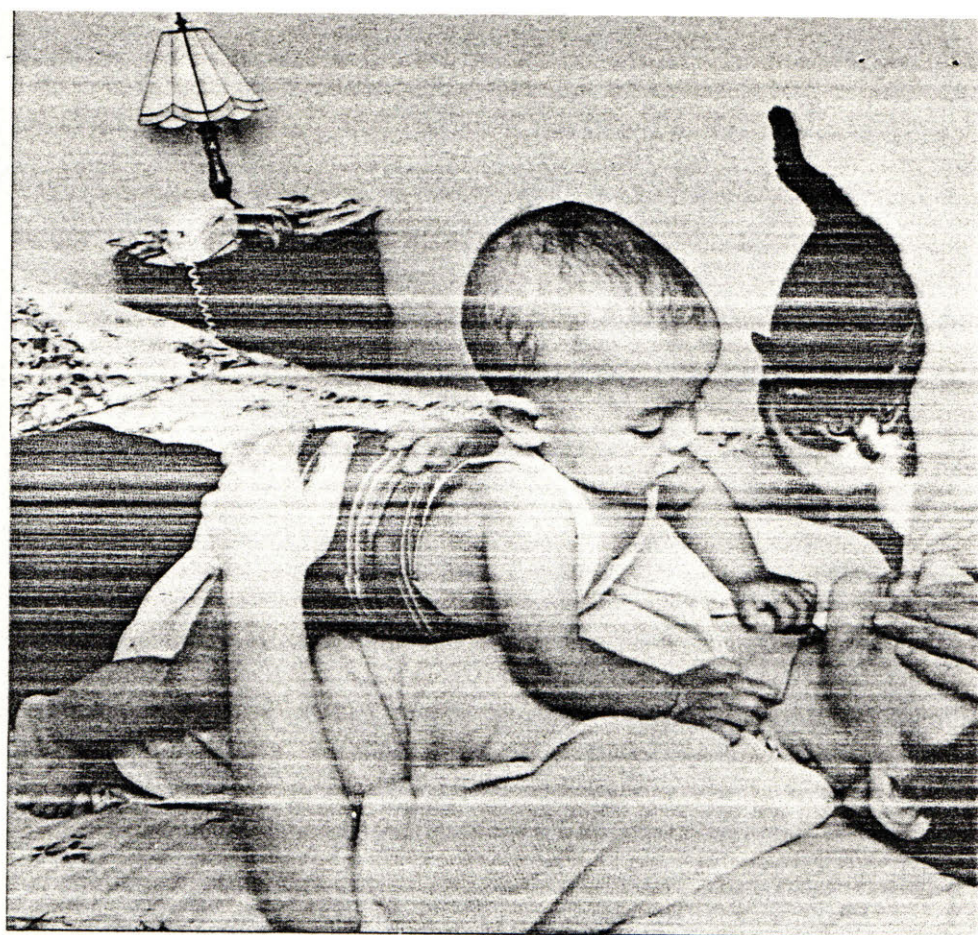
*Yo soy afligido y menesteroso...
Has alejado de mí el amigo y el
compañero,
Y mis conocidos se esconden en la
tiniebla...
Mas yo estoy como oliva verde en la
casa de Dios.
En la misericordia de Dios confío per-
petua y eternamente.**

5:30 p.m. The Hemlock Society, Chicago

Michael is sitting in the small apartment, full of literature and mismatched furniture, of the director of the local chapter of the Hemlock Society, which helps people learn how to commit suicide. This time Michael is getting material for a friend. He already knows how he is going to kill himself.

Michael, a 49-year-old theatrical designer, is urbane. Sophisticated. He has an eye for what is beautiful and what is not. A few years back he watched his mother

**I am afflicted and ready to die...
Lover and friend hast thou put far
from me, and
mine acquaintance into darkness...
But I am like a green olive tree in the
house of God.
I trust in the mercy of God for ever
and ever.*



die after an eight-year struggle with muscular dystrophy. At the end, she was a vegetable. So when his AIDS was diagnosed in June 1986, he immediately contacted the Hemlock Society and worked up a blueprint for himself.

"I will wake up that morning," says Michael, "and I will tell my lover of 26 years to stay away from home for at least 24 hours. I don't want him legally implicated in my death. Then, at 10:30 a.m. I will take 30 mgs. of Compazine, a stomach muscle relaxant that keeps you from vomiting. I will eat some toast or crackers, drink some vodka with apple juice and then I will take 600 mgs. of Seconal. I plan on sitting in my favorite Miës van der Rohe chair and reading until I fall asleep. In 15 minutes, I will doze off." His tombstone is already picked out, the funeral arrangements all made.

"Don't you see?" Michael says. "I want to die as well as I've lived."

6:15 p.m. Providence House, Long Beach—Part 5

Jim Johnson is changing Buddy, all 85 lbs. of him. Buddy is a 41-year-old in the final stages, near comatose and incontinent. Afterward, worn out, the house director joins Ken, 36, who has been taking AZT for two weeks and feels better already. "I can't wait to see my blood tests next week," Ken says hopefully. "I'm convinced they'll show improvement." Then, cautiously: "But maybe it's psychosomatic."

Ken asks how Frank is doing.

"Frank didn't make it," says Johnson.

Ken grimaces, and his grimace looks odd. He wears glasses but can't afford to replace a missing left lens. "It happened so fast," he whispers. "It's really not fair. That's so hard to handle, to see your friends go, one after the other. I'm going to lock myself in my room and not make any more friends."

Then he looks up at Johnson, smiles weakly and says, "That's the wrong attitude, isn't it?"

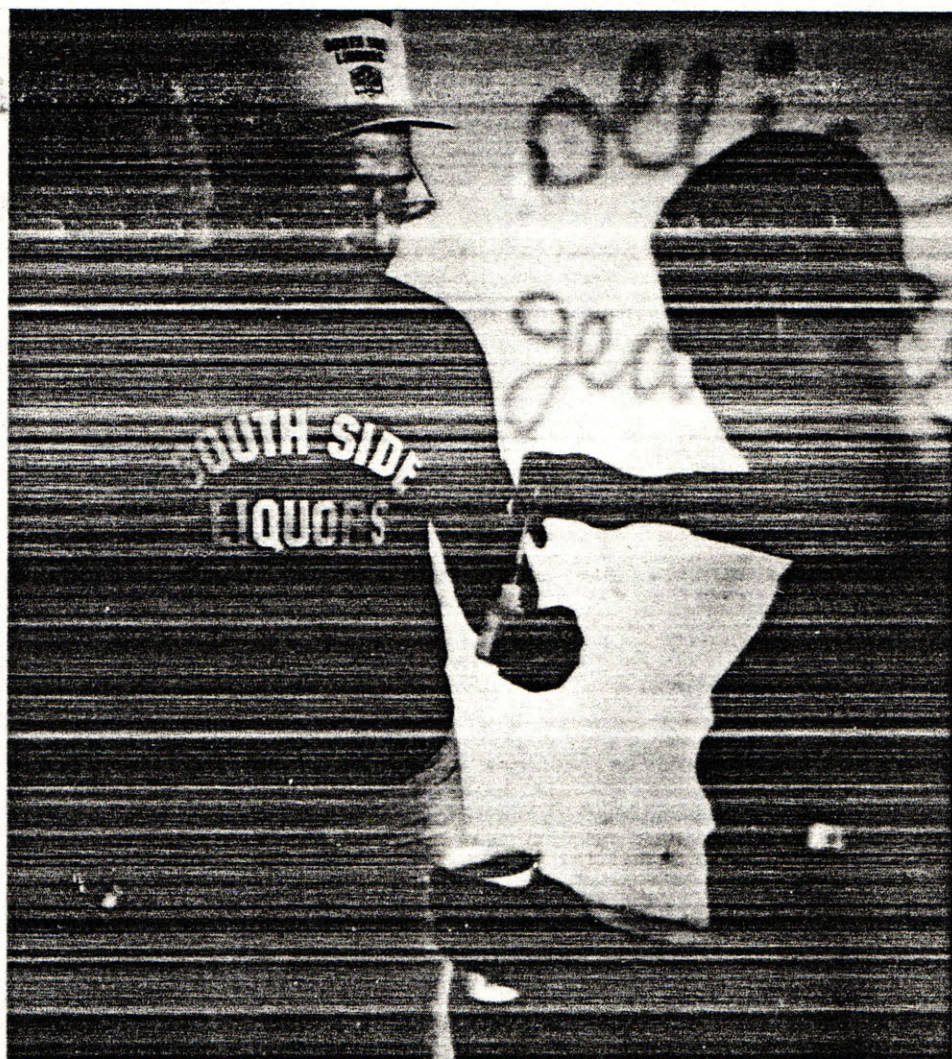
6:45 p.m. A Single Woman, New York City

Sarah, a 25-year-old buyer for a gourmet food store, wriggles into a black '50s-style one-piece bathing suit. At her feet, on the floor, are two mattresses swathed in beige sheets. She pulls on a short black skirt, then slips into a green vintage man's jacket. She's on her way to a party and she'd love to meet "someone special." In fact, she's prepared for that eventuality. "I'd been telling all my gay male friends to be careful," she says. "Then suddenly I realized—the same applies to me. I was devastated." Too embarrassed to buy condoms herself, she had a gay friend lay in a supply. "In college you met someone at a party, you went home with him," she says wistfully. "Not anymore." Condom etiquette, however, is a real problem. "There's no good time to bring it up," she says. "It's a weird thing. Uncomfortable." She finishes her makeup. "I know myself," she says. "Stuff happens, and I'm not that strict with myself. I'm easily tempted. I know I'm not going to stop having sex



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In Chicago's South Side at 9 p.m., Claude Rhodes, an AIDS field-worker, shows an addict how to sterilize his needle using common laundry bleach. An ex-addict himself, Rhodes takes his lecture to the city's shooting galleries most nights.



STEVE KOGAN

till they find a cure for AIDS. I'm just trying to be realistic."

Sarah checks her purse. Lipstick, blush, mascara, condoms are in place. She will use them all.

7:05 p.m. A Transmission From the Associated Press, Washington, D.C. Three American condom manufacturers have issued recalls of several lots of their contraceptive, antidisease rubber products because they failed leak tests, the Food and Drug Administration announced Friday. . . .

Bill Grigg, an FDA spokesman, said about 100,000 condoms are involved in the domestic recall and that most of them have been recovered in transit or at distributors before they reached the public.

7:15 p.m. Mark, Joe and Christine, Cape Cod

Mark is waiting. Time, he knows, is short. Whenever a car door slams outside, he looks up hoping to see Joe, his lover of three years, come through the breezeway. "Where are they?" Mark wonders aloud. Earlier, Joe and his sister Christine, who's visiting from Houston, went to the hospital, and the waiting is making Mark edgy. He starts to set the dinner table. "I want to be with Joey when he dies," he says. "Nobody should have to die alone.

I'd rather grow old with him. But. . ."

Finally, in come Christine and Joe. Both men light up when they see each other. "They offered me morphine for pain," says Joe, who walks gingerly, in obvious pain. "I said, 'Not yet.'" Nodding, Mark goes off to the kitchen to prepare the pasta.

"He's so good to me," Joe says when he is gone. "I wish I could be braver. I give in to my feelings too much. But Mark never gets depressed. Sometimes I feel guilty."

Christine interrupts sternly. "You're too hard on yourself, Joey."

Well, he wanted to do great things with his life. He wanted to complete his doctoral dissertation. And now he won't. "I probably won't be here by the fall," says Joe. "But in a way I'm dying happy. I've got Mark. I've got my family. I just don't have much time to enjoy it all."

Mark calls them in to dinner at 7:45. On the table is a spray of red and white carnations. Mark has prepared pasta primavera, one of Joe's favorites. But Joe can barely eat. From time to time Mark pats his arm. Afterward, on the way to the den, he supports Joe with an arm around his shoulders. "Want anything else, hon?" he asks. "Ice cream?"

Christine volunteers for the dishes. Although she's supposed to go back to Houston in three days, she's not sure she

will. "I feel so awful, so helpless," she says. "Joe was always my guiding light. He was the one I turned to for advice when I was getting married. We'd always go for long walks and talk and talk."

"I don't want him to die," she adds suddenly, with vehemence. "I know it's selfish, but I don't want that void in my life." Christine's voice quivers, which is bad: Joe hates when his sister cries, always has. It makes him cry too. "It's easier knowing Mark is here," says Christine when she gets control of herself. "I think God sent Mark to Joe."

In the den Joe is slumped on the couch, his dog's head on his lap, Mark next to him, waiting for the fall.

11 p.m. to 1 a.m. Joplin, Mo.

If you're looking for excitement, it looks like you've come to the wrong place, podner. The sidewalks here were rolled up hours ago. You can't get much more Bible Belt than Joplin: It has 113 churches.

But wait. A pickup truck takes a left on Main. It pulls into a parking lot behind a brick building. Out steps a lithe young man wearing a cowboy hat, muscle shirt and skintight jeans. Welcome to the parking lot that serves C.G.'s Lounge and Billy Jack's—among the biggest, best bars in Joplin, and both catering to local gays.

CONTINUED



At Providence House, Buddy has weakened and, clutching his teddy bear, is rushed to the hospital by Jim Johnson.

The scene is Fellini-esque. A motorcycle with a white, five-foot teddy bear in the passenger seat circles the lot where 100 or so people—cowboys, preppies, rockers—laugh, drink and dance. Inside C.G.'s, a guy in a golf shirt takes a sip of his bourbon. "In this town we're not gay," he says. "We're queers. But as long as we pretend we're straight, they leave us alone." At a table, a bronzed, whippet-thin cowpoke signals for another tequila sunrise. "AIDS don't much touch us here," he says. "One guy had it, but he got it after messing around in California. Hell, he didn't get it here in Joplin."

Next door at Billy Jack's, Tom drains the last of his beer. He's about to check out the parking-lot action. "It isn't that we don't care here," he says. "It's more like we don't know. AIDS is like being gay in Joplin. It ain't exactly real." Yet.

2 a.m. David Chickadel's Day—Part 3 David Chickadel is staring at the silver- and brass-framed picture on the dresser.

"It's so hard to lose someone you love," he says. "On New Year's Eve, we went to Fratelli's and had pescatore, our favorite. Thomas was pretty sick by then, but we were happy. Six days later, he was dead."

David shakes his head slowly. He looks exhausted. "It's been a long day," he says. "And, you know, lately I just burst into tears for no reason. Did I tell you that? Maybe it's the yellow roses."

3 a.m. King's County Hospital, N.Y.C. A baby has just been born who is at risk for AIDS, the last of eight such babies born at King's County tonight. In a little

while this infant, like the other seven, will test free of AIDS—the first of many tests.

5 a.m. Providence House—Part 6

Jim Johnson is asleep. Like David Chickadel's, his day had been long. At 9:10 p.m., as he was settling down for a quiet evening, Buddy came near to death. He was pale, coughing hard and moaning when Johnson rushed out the door with him in his arms at 9:18. By 9:22 Johnson was carrying Buddy into the hospital. Buddy's blood pressure was perilously low, but he was placed on an IV and stabilized. Shortly after midnight, Johnson returned to his own lodging, a room next to the Providence House chapel. In the chapel, a small mahogany-colored box holds the ashes of a resident who died a week before Frank. When he finds time, Johnson knows he must scatter the ashes at sea as the dead man's family requested.

Now, not quite five hours later, Jim Johnson awakens from a restless sleep. He is surprised to find that he is crying.

Dawn, Saturday. New Orleans

In the backyard of Lazarus House, about seven miles from Bourbon Street, the first

birds of day have begun to stir. It is still dark, and inside the house, a church-sponsored residence for PWAs, all is silent except for the low murmur of a television set on the second floor. In front of the set, on a couch, lies a tall, bearded young man, staring listlessly at the screen or exchanging a few labored words with his mother, who sits on another sofa a few feet away. He asks her something; she quickly brings him a glass of liquid with a straw in it. She lifts his head; he drinks.

The sun rises quickly in New Orleans, skimming over the swamps and lowlands that surround the city, brushing the low, shotgun houses and pastel-painted Creole cottages. It bathes the trees, whose branches reach almost to Lazarus' second floor. It streams through the wide window and paints bright streaks through the room with the television set...

... where, only a few seconds after swallowing, the young man has gagged on his drink and spit it up. His mother, startled, grabs some tissues and wipes his bearded face and neck. She leans over him to comfort him; and they are framed in a ray of light. They might be a *pietà*, except that her face is too tightly drawn, has no serenity, as though it might at any second splinter into a dozen pieces.

This is the new day, and it is broken. □

A Postscript

Several people in this story have died: among them, two of Jim Johnson's Providence House charges, Buddy and Ken, and Ralph of Atlanta. Ralph survived longest—until July 16. His grandmother was beside him at the end. As he predicted, his parents did not attend his funeral.

On July 2, two of Ken's hospice-mates found him in his usual place—in front of the TV, remote control in hand, still wearing the glasses with only one lens. His eyes were wide open; they thought he was watching TV. He had been dead for several hours.

Buddy, pictured on this page as Johnson was taking him to the hospital Friday night, was released that Sunday. "He was obviously terminal," says his sister Jenny, but because he lacked insurance, "nobody wanted him." On Monday, Buddy's screams kept the people of Providence House awake all night. Through heavy sedation, he was pleading with Jenny to kill him. He died on Thursday night, June 25.

Jenny went back to Providence House to collect his things the next morning. On his bureau she found a letter, unmailed, to their mother. It read: "Dear Mom, I suppose you've been hearing that I'm not doing very well. But don't give my last shirt away. I'm not through yet."

This story was written by Jack Friedman and David Van Biema from reports by Jennifer Ash, Marilyn Balamaci, Angela Blessing, S. Avery Brown, Linda Easterlin, Andrea Fine, Johnny Greene, Eleanor Hoover, Mary Huzinec, Tina Johnson, Jack Kelley, Maria Leonhauser, Joyce Leviton, Doug Lindeman, Benilde Little, Denise Lynch, Alexandra Mezey, Andrea Pawlyna, Bill Shaw, Civia Tamarkin, Diana Waggoner and others.



Another day breaks over Bourbon Street in New Orleans, where fear and hope walk arm in arm.



100 YEARS LATER, THE GRAND HOTEL STILL BOASTS THE BIGGEST FRONT PORCH IN AMERICA

Mackinac (pronounced Mack-i-naw) Island is a 20-minute ride by ferry across Lake Huron from the Michigan mainland. At every landing the boat is met, as it has been for the past century, by a red-liveried bellman who calls out, "The Grand Hotel. All guests for the Grand Hotel!" And that's when the real trip begins—back to an America of lazy summer days, endless green lawns and folks fanning themselves on front porches.

Back, in short, to the Grand. A beautiful 286-room Victorian wedding cake of a hotel, the Grand sports a front porch

that lives up to its name—at 682 feet it's the world's longest and one of the reasons the hotel has survived to celebrate its 100th anniversary this summer. The Grand is the largest and oldest summer hotel in America. Celebrations, pyrotechnics and special events will mark its centennial, including the Democratic Governors' conference this week, for which the party's presidential contenders will be carried up the hill to that famous front porch in a horse-drawn surrey (no cars being allowed on the island even now, not even for them).

They'll find a Grand made grander by a recent renovation—and no doubt bump into the man responsible, owner R.D. "Dan" Musser Jr., 55, who presides over the hotel's 500 acres as his late uncle, W. Stewart Woodfill, did before him. Musser, notepad in hand throughout his 14-hour days (his scribbles are typed into an average 50 memos daily), oversees every detail at

the hotel, checking the golf course, noting dusty light bulbs, supervising the 1,200 dinners that are served in the hotel's six dining rooms. He does it all with the same sense of awe he felt when he first came to the hotel as a 7-year-old. "I had come off the farm and I had no sophistication," he recalls. "It was incredible to me to see a whole dining room full of men in ties."

Musser started out as a cashier in the hotel when he was a teenager, then worked his way through the kitchen and laundry to the registration desk. After he graduated from Dartmouth, Musser and his wife, Amelia, settled into a cottage near the grounds and raised their three children, who worked at the pool or the front desk or in the shops, in the Grand tradition. (Mimi, 27, now runs the hotel's ten shops. Danny, 24, is reservations manager. Only Robin, 29, moved away; married, she works at