

COMMUNICATION #3-4

To: ALL MEMBERS of the ACHA Task Force on AIDS
 Bill Christmas, Steve Blom, and Maggi Bridwell

From: Rich Keeling

Date: July 13, 1987

Method: First Class Mail

Subject: Updates

I apologize for my relative invisibility to the past few weeks. I have been working very number of Task Force projects, all of which deadlines at about the same time. As this mail, I am leaving for a 10 day vacation in family; fortunately, this departure coincides date for the various grant proposals that I you below.

*Send letter
 re of task
 force
 trans. from
 for us*

CENTERS FOR DISEASE CONTROL COOPERATIVE AGRE

I enclose an **Outline** of the CDC Cooperative proposal, which reflects much of the structure and content I discussed with many of you at our Task Force meeting in Chicago and at subsequent meetings with small groups of you there and in Washington. I won't repeat the whole structure of it here; please read through the summary outline for that. What I do want to do is tell you where we stand with it.

The proposal is due in Atlanta on Wednesday, July 15. As I mail this to you, the final draft is in the hands of our consultants, Johnson/Bassin/Shaw, in Silver Spring. Gail Bassin and Jeri Shaw have been wonderful this past two weeks in helping to get this thing put together and ready to send out. I've been to Washington twice to meet with them, and they've given up all kinds of personal time to spend hours at a word processor reworking the draft, the budget, and the goals and objectives as required by the CDC. I've done the same, and I think the result will be worth it all: it's an excellent proposal.

A few points about the proposal: we would hire a National Workshop Coordinator, to be placed in Rockville at the ACHA central office; this will be a full-time, intensive position. The Coordinator will supervise the development of the modules for the Regional Workshops, the organization of the workshops themselves, and the sorting and writing of new materials. There will be half-time clerical support in

COMMUNICATION #3-4

To: ALL MEMBERS of the ACHA Task Force on AIDS
Bill Christmas, Steve Blom, and Maggi Bridwell

From: Rich Keeling

Date: July 13, 1987

Method: First Class Mail

Subject: Updates

I apologize for my relative invisibility to many of you over the past few weeks. I have been working very hard on a number of Task Force projects, all of which seem to have deadlines at about the same time. As this piece goes in the mail, I am leaving for a 10 day vacation in Florida with my family; fortunately, this departure coincides with the due date for the various grant proposals that I will describe to you below.

CENTERS FOR DISEASE CONTROL COOPERATIVE AGREEMENT

I enclose an **Outline** of the CDC Cooperative Agreement proposal, which reflects much of the structure and content I discussed with many of you at our Task Force meeting in Chicago and at subsequent meetings with small groups of you there and in Washington. I won't repeat the whole structure of it here; please read through the summary outline for that. What I do want to do is tell you where we stand with it.

The proposal is due in Atlanta on Wednesday, July 15. As I mail this to you, the final draft is in the hands of our consultants, Johnson/Bassin/Shaw, in Silver Spring. Gail Bassin and Jeri Shaw have been wonderful this past two weeks in helping to get this thing put together and ready to send out. I've been to Washington twice to meet with them, and they've given up all kinds of personal time to spend hours at a word processor reworking the draft, the budget, and the goals and objectives as required by the CDC. I've done the same, and I think the result will be worth it all: it's an excellent proposal.

A few points about the proposal: we would hire a National Workshop Coordinator, to be placed in Rockville at the ACHA central office; this will be a full-time, intensive position. The Coordinator will supervise the development of the modules for the Regional Workshops, the organization of the workshops themselves, and the sorting and writing of new materials. There will be half-time clerical support in

Rockville, as well. I envision that the Coordinator will have some time to work with us on Task Force matters, as well.

The Role of the Task Force: is great. All of us are the "supervisors" for the Coordinator, though he/she will report directly to me and to Steve Blom. Several members of the Task Force will be asked specifically to be on a Technical Panel in the proposal, that panel charged with developing the curriculum for workshops and overseeing the process, approving the materials, etc. Enclosed in this mailing is a Special Communication (#3-6) for the seven or eight we are allowed to have on this panel. The rest of us are going to contribute a lot to the overall project and to the individual regional workshops; the Task Force people in each area will be asked to work with the ACHA Regional REpresentative in organizing, planning, and carrying off the regional effort.

Our chances: seem pretty good. As you will recall, \$100,000 is earmarked for an organization representing college and university health services, which sounds pretty much like us. We had several competitors early on, but most have turned into cooperators instead. And, we have made some good friends for future work and have gotten important endorsements from some major groups. For example:

1. **The Red Cross:** a powerful opponent or ally, they have fortunately chosen to be ally. I had several meetings and discussions with representatives of the National RED Cross. They originally had decided to apply for the college educational money from the CDC; after initial discussions, they were going to go for other grants within this RFP, and eventually they decided not to bid at all. HOWEVER: our relationship worked out so well that they have endorsed our proposal, and I have committed that we will assist them in some future college educational effort next year.

2. **National YWCA:** The National YWCA went through a similar evolution. I went to New York and met with their representatives, had several phone conversations, and exchanged a lot of letters. In the end, they have decided not to apply for CDC money either, but, also, have agreed to endorse our proposal and to help us.

3. **National Rural and Small Schools Consortium:** represents rural secondary and primary school districts, and is not applying for the college grants. However, they sought the endorsement of ACHA for their proposal to educate in that population, which I agreed to, and have in turn agreed to endorse our proposal.

4. National Council of Churches: I've had a wonderful relationship with Mr. Earl Lowell of the NCC. He and I had some great discussions. They plan to apply for one of the other cooperative agreements, which will involve using the network of campus ministers to work with community churches and provide AIDS education both on and off campus. We will cooperate and endorse them, and they have endorsed us as well.

5. National AIDS Network: through my connection by being on the Board of NAN, we have the endorsement of NAN for our proposal, as well.

6. American Council on Education/NASPA: Jo Ann Ciperson of the Central Office and I met in Washington this past Thursday with Elizabeth Nuss, the new Executive Director of NASPA, and with Donna Shavlik, in the Office of Women of the ACE. Both have agreed to endorse our proposal as well. We have enjoyed a superb working relationship with both of these organizations; ACE was good enough to let us use their conference rooms and space all day this past Thursday.

Cross your fingers; I can't send you the whole CDC proposal yet because it's still being typed and readied to go to Atlanta. The outline you have is the best I can do for now, but more will be coming.

Special thanks to Bill Bolding for his help with this one. Bill spent two days in DC at the CDC Grants Application Meeting, taking copious notes while I was in Chicago at the ACHA meeting. As I write this, I think Bill is on a much-deserved vacation in California with his kids. By now he may have made contact with Lee Wessel, as I suggested he do.

Status: The final drafts of this will be circulated to me in the first day or so of my vacation in Florida. It will then make it into the CDC by the deadline of July 15.

AMERICAN FOUNDATION FOR AIDS RESEARCH: PROPOSAL #1 - COMPUTER ASSISTED EDUCATIONAL INFORMATION

We discussed reopening our AMFAR grant from last summer and reapplying this year. I have done this. I got some good feedback from several of you about the old proposal and have made a few changes recognizing that assistance in the new one. All we have to do at this point is send in the two page cover letter, 200 word abstract, and a CV. **I enclose copies of the Cover Letter and the Abstract from this proposal for your information.**

You will note that it is structurally the same as last year. We would still use a word processor, a quarterly

distribution scheme for updates, and a user-updatable three ring book for the system. I have made the plan a little less compartmentalized (clinicians, mental health, educators) than last year to account for the interest and needs of people in other areas; thanks especially to Lee Wessel for pointing out the need to do that. Thanks also to Paul Grossberg, Cathy Kodama, and Jeff Gould -- your comments and notes were valuable, and will be even more so when we get to the point of submitting an actual complete proposal with a budget. We don't do that unless and until they approve the intent.

Status: this proposal was sent by Federal Express to the AMFAR Grants Office late last week. It therefore more than met the deadline.

AMERICAN FOUNDATION FOR AIDS RESEARCH PROPOSAL #2 -- INNER CITY COLLEGE AIDS EDUCATION PROJECT

As a consequence of the Montefiore conference on "AIDS and the University" organized by Dr. Phyllis Vine, I got interested in the subject of AIDS education for urban schools, with commuter/non-resident populations, lots of non-traditional students, minorities, etc. We met in New York right after the Montefiore conference and decided to apply for AMFAR money to sponsor another conference particularly relevant to those issues; it would result in the publication and distribution of a resource guide/program manual for inner city schools.

I enclose the letter of intent and abstract for this second AMFAR proposal. Phyllis and her colleagues at Montefiore would actually do most of the work, and we would contribute our expertise and experience.

Status: this proposal has been sent Federal Express this morning to California; it is due in the AMFAR Grants Office on July 14.

COLLEGE SATELLITE NETWORK PROGRAM

The CSN program on AIDS on the campus is set for Wednesday, September 30. After our discussions in Chicago and several subsequent ones, Bill Bolding and I met in Washington with Shelly Weinstein of CSN. Several subsequent meetings and calls resulted in my consulting with Jo Ann Ciperson and Steve Blom, after which we gave our endorsement to the CSN program. ACHA will be listed in the credits and on the program guide. I enclose a letter from Shelly Weinstein referring to these arrangements for your information.

We have substantial input into content, as well. Shelly has sent me the draft of the viewers' guide, which I have reviewed and commented on. She made a presentation at our meeting with NASPA and ACE this past Thursday, and brought along their moderator, Hodding Carter. I think both ACE and NASPA will endorse them as well. All three organizations will be involved in two meetings in Washington in August for the purpose of evaluating and commenting on content, format, script, and personality appearances.

The plan is for me to appear on the show. Others to be on may include Ron Reagan, Patti Labelle, General Koop. I don't know that they have commitments from any of those people yet, though. I'm impressed that they are a responsible organization and that the program will be helpful. It comes, accidentally, on the Eve of AIDS Awareness Month...

ANOTHER NEW PROJECT: AIDS EDUCATION THROUGH RESIDENCE LIFE PROGRAMS

I heard from a colleague in New York about a proposal from the premier AIDS education agency there, the Gay Men's Health Crisis, to do AIDS education on college and university campuses in New York City through the residence life programs -- by educating the RA's. I thought this was the kind of thing we should know about and be involved in, so I wrote to the GMHC people and asked if we could work with them somehow. They were delighted, and have been very gracious in including me in their planning.

They are looking to do four or five seminars for RA's, one in each of the boroughs of New York City, in September and October of this year. They, again, are doing most of the work; they are using us as consultants to their program. I've been to New York twice to talk with them, and have been impressed with the innovative thinking they do. An old friend of our Task Force, Mark Ostfield, is now working for GMHC and will be involved in this; Mark has just graduated from the University of Pennsylvania where he worked with Chris Lyman a lot. He was out in Berkeley at the January meeting, as well.

I don't have anything in writing to send you yet about this program, because it is all very new; suffice to say it is an exciting opportunity for us to be involved in the important business of AIDS education in urban areas of the East, where we have not had as much contact thus far. I am very pleased by this initiative and by the one with Phyllis Vine for the AmFAR grant.

Status: the GMHC people (Raymond Jacobs, Mark Ostfield, John Flinn, Chuck McKinney there) are working on format,

curriculum, arrangements; we will meet in New York again shortly after my vacation to consult further.

AND ANOTHER GRANT APPLICATION, THIS ONE NOT DUE UNTIL SEPTEMBER, THANKFULLY: THE METROPOLITAN LIFE FOUNDATION

I also received an invitation to apply for funding under the MLF's "Project REACH" program. Details are in a self-explanatory letter and attachment which are with this mailing. This is particularly interesting and important to us because it would provide funding for existing programs without our having to develop a new offering...which we could certainly use. If the CDC and Both AmFAR grants were to come through (unlikely), we would be involved in a lot of new initiatives as it is.

MEMBERS OLD AND NEW

I am happy to say that we have two new members in the group:

Richard Wolitski (Rich) is a graduate student in Long Beach at California State. He has been an incredible burst of energy for their AIDS education program, has a lot of wonderful ideas, and has agreed to share them with us as a new student member of the Task Force.

David Kersey (David) is a resident in psychiatry in the Yale University training program in Connecticut; he's doing this first year in medicine at Greenwich Hospital. David was a medical student here at Virginia, and has done a lot of work with me in researching the neurological and psychosocial aspects of AIDS. As Lee Wessel graduates to faculty status, David will become our Task Force resident.

Good news for Bob Wirag! I've just heard that Bob has taken the Directorship at Texas. Hearty, hearty congratulations, Bob -- we assume that you'll be busy but that you'll stay connected with us in your new job.

OTHER MATTERS

1. Jeff Gould has done a wonderful resource guide and directory, intended for use in the revision of our report on educational methods and resources. It is so excellent that I have reproduced it and included it in this mailing for all of you. Thanks, Jeff!

2. Terry Weisser shares the wonderfully ridiculous flyer from "Ampersand," a dating service for the HIV-negative in New York City. I saw Terry while in New

York in June and again last week; he sends love and best to everyone.

3. Jo Ann Ciperson and I have been working on the need to diversify the illustrations in the "Making Sex Safer" brochure. The all-white couples pictured are obviously a bad message for a thousand reasons, and we all have 20/20 hindsight enough to see that. Having recognized the error, however, we are trying to deal with it forthrightly. The improved graphics should be ready to go soon and a better brochure will be the result.

4. I have sent Chris Lyman and Harriett Mogul some material about Women and AIDS for their use in preparing the material for their Working Group. I must say that the whole topic of women's issues in AIDS has captured the attention and imagination of a lot of groups. NASPA and ACE in particular are awaiting the results of this work with great anticipation.

5. Work on the Sexual Decision Making brochure is proceeding, I hear, through Annie Lomax and Jeff Gould. I know that Cathy Kodama, Lee Wessel, and Doug Conaway are also ready to help as that goes along.

6. I am the holdup in the production of the new version of our educational piece. Jeff has worked very hard and has developed some excellent materials, which I have thus far not had time to work on much. But after vacation, watch out. The resource guide I enclose is but one small example of his great work.

7. Paul Grossberg and I are still working now and then on the clinical evaluation material. Paul has been busy with fatherhood and with a grant application to the Apple Corporation for AIDS Education using computers in Wisconsin. However: he and I will be meeting in Madison in a couple of weeks (on my way back from a meeting in South Dakota, of all places) and we may make some progress.

ENOUGH FOR NOW...PAGES AND PAGES. JUST WANTED TO LET YOU KNOW WHAT I'VE BEEN DOING. THANKS FOR THE NOTES AND CALLS; PLEASE DON'T STOP. I'LL BE SENDING COPIES OF THE FINAL CDC PROPOSAL SOON. IN THE MEANTIME, I'M GOING TO FLORIDA WITH MY FAMILY...DISNEYWORLD. I'LL BE IN TOUCH SOON AFTER I GET BACK.

Please send any comments, suggestions, etc...I need to hear from all of you. Hope all are having a wonderful summer. Keep in touch!

Oh -- the weather -- hot, humid, sticky. Thunderstorms every afternoon.



COLLEGE SATELLITE NETWORK, INC.

June 30, 1987

Dr. Richard P. Keeling
Director
Department of Student Health
University of Virginia
1400 West Main Street
Entrance Building, Room 6
Charlottesville, VA 22908

Dear Rich:

Thank you for your thoughtful note of June 8, 1987. CSN is very pleased to have the endorsement of the American College Health Association and your participation on CSN's September 30th program will give you and other academic and elected officials, as well as some well known personalities an opportunity to engage hundreds of thousands of college students in a dialogue about AIDS and its related public policy issues. The goal is to use the "Sex on Campus" telecast as a catalyst for college activities and programs which will provide clear and accurate information about AIDS and other sexually transmitted diseases and to increased the numbers of students educated about behavior that puts them at risk of infection.

As we have discussed the outreach activities include viewers' guides, mass mailings, training and promotional materials, local ad campaigns, PSA's and local fundraising events. Following the program, edited video tapes will be prepared for wide distribution by schools, libraries and educational organizations. We would also like to discuss with you efforts to encourage PBS and cable stations to broadcast the edited tapes.

I look forward to our meeting on July 9 with American Council on Education and National Association for Student Personnel Administrators at ACE headquarters. Your active involvement and guidance in planning will contribute greatly to the success of CSN's program.

Sincerely,

Shelly Weinstein
Shelly Weinstein
Vice President, Communications

SW/lb

AMERICAN COLLEGE HEALTH ASSOCIATION
TASK FORCE ON AIDS
RICHARD P. KEELING, M.D., CHAIRMAN

OUTLINE OF PROPOSAL TO
CENTERS FOR DISEASE CONTROL

\$100,000 COOPERATIVE AGREEMENT FOR A NATIONAL ORGANIZATION
REPRESENTING COLLEGE AND UNIVERSITY HEALTH SERVICES FOR AIDS
EDUCATION PROGRAMS

JUNE 25, 1987

The American College Health Association (ACHA) is applying for a cooperative agreement with the Centers for Disease Control for the purpose of increasing the number of institutions providing AIDS education to college and university students and the number of students educated about AIDS.

Key Program Elements

1. Regional Workshops. The ACHA proposes to develop and implement a series of regional workshops to which individual institutions of higher education would send faculty/student teams. These workshops will be held on college campuses. The workshops, which would be 1 1/2 to 2 days in length, would include training in needs assessment; methodologies for initiating AIDS education programs; current information about AIDS itself; strategies for recruiting and training campus peer AIDS educators; guidelines for educational sessions; strategies for promoting and preserving behavior change; values clarification sessions; guidelines for evaluating programs; and practical suggestions concerning funding, trouble-shooting, and public relations.

Workshop Curriculum. ACHA will develop a curriculum for the workshops which will be modular in nature, allowing for the emphasis of different topics and programs in different areas, depending on needs, attitudes, and community values. Both written and audiovisual materials will be used in the workshops and in follow-up mailings to participants. The resources of the ACHA and its Task Force on AIDS will be available to assist participants when they return to their institutions to begin programs. In addition, participants will be exposed to the work and programming of other organizations and agencies doing AIDS education, and will be encouraged to develop cooperative programs.

2. Peer Education Model. The workshops will train participants to use a peer education model in implementing AIDS education activities with the support of institutional

faculty and staff. The combination of faculty and student participation in the workshops promotes cooperation in programming and may facilitate acceptance of AIDS education programs on the campus. Peer education programs have strong support in the individual institutions which make up ACHA, and the peer education model has been utilized effectively in extending health education programs concerned with alcohol and drugs, sexuality, stress management, and first aid, among others. Participants will learn how to conduct a local needs assessment, how to design programs responsive to those needs and local values, how to utilize educational materials effectively, and how to promote, diversify, and evaluate programs. Sessions will emphasize recruiting, training, evaluating, and continuing education of student peer educators. Students who have been involved in campus AIDS education will be members of the "faculty" in each workshop; they will provide practical training based on experience. The emphasis in structuring peer education programs will be on integrating AIDS education into other health education efforts, which already exist on many campuses.

Program Implementation

1. Development and Implementation. ACHA will develop the curriculum; assess, produce, and distribute materials; and organize the structure and format of the workshops during the Fall Semester, 1987. Implementation of the workshops themselves will begin in early 1988; ACHA plans to complete at least six workshops during the Spring Semester, 1988. When possible, workshops will be held in conjunction with meetings of ACHA affiliate organizations in each region. Other workshops will be scheduled continuing into the Fall and Spring semesters of 1988-89. The initial workshops will be carefully evaluated and the results used to improve the subsequent efforts. ACHA intends to build on the experience of the first year to develop specific cooperative programs with other organizations (see below) in the subsequent budget years.

2. Staff Required. ACHA proposes to use part of the funds made available through the cooperative agreement to support an AIDS Workshop Coordinator, who will be based in the ACHA national office in Rockville, MD, and to provide part-time secretarial support for this individual. The Coordinator will report to the Executive Director of ACHA in Rockville and to the Chairman of its Task Force on AIDS. The Chairman and members of the Task Force on AIDS will work extensively with the Coordinator to develop and implement the curriculum of the workshops and will participate actively in teaching during the workshops themselves. Thus, ACHA will bring to bear the considerable existing AIDS education resources of its members in extending the impact of the cooperative agreement. The Coordinator will have major responsibility

for researching, evaluating, and selecting materials for inclusion in the workshops and will be responsible for managing the cooperative agreement itself. The Coordinator will schedule and supervise the organization of the regional workshops; identify local and regional speakers and resources; work with representatives of other organizations and agencies doing AIDS education in each area; and oversee the evaluation of the program.

3. Curriculum Development. The Workshop Coordinator and members of the ACHA Task Force on AIDS will work together to develop curriculum and materials for the workshop in consultation and cooperation with the Centers for Disease Control. In doing so, they will consult leaders in educational program design, evaluation, needs assessment, and social marketing, including individuals with specific experience in AIDS education programs. Some of these consultants will teach in workshops on a limited basis, as well, as needed to satisfy local needs.

4. Regional structure. ACHA will use its existing regional affiliate structure and its Task Force on AIDS as a framework for the implementation of the program. The ACHA divides its affiliate organizations into six regions: New York/New England, Mid-Atlantic, South/Southwest, Mid-America, Rocky Mountain, and Pacific Coast. Within each region, two or more workshops will be held. Each region has a Regional Representative who sits on the Executive Board of ACHA; the Regional Representative will share responsibility for publicizing, promoting, and organizing the workshops in the region. Members of the ACHA Task Force on AIDS also work in each region; they will be involved in workshop planning and will present and facilitate sessions during the workshops. The utilization of these regionally placed people will reduce travel costs.

5. Addressing Local Needs and Values. Each workshop will be designed individually to suit local needs and values by a Workshop Planning Team which will include the national Workshop Coordinator, the Regional Representative, the regional members of the ACHA Task Force on AIDS, and delegates from the health service on the host campus and several other health services in the area. The Workshop Planning Team will conduct a regional needs assessment to determine what curriculum components are most appropriate for the area, to identify institutions needing assistance in developing AIDS education programs, and to discover the kinds of human, print, and audiovisual resources already in place. A "menu" of curriculum components and of print and audiovisual materials developed by ACHA and other organizations will be available for inclusion in the workshop. A Review Panel as required by the Centers for Disease Control will approve all materials prior to their utilization.

6. Cooperation with other Organizations. The Workshop Planning Team will consult with representatives of the American Red Cross, the National Council of Churches, and the National YWCA, which organizations are proposing AIDS education programs involving college students as well, to guarantee the best use of resources, the avoidance of overlapping or competitive activities, and the widest possible audience. ACHA hopes that representatives of those organizations will be available to assist in promoting and presenting at workshops, as well.

7. Post-Workshop. ACHA will have a follow-up curriculum for participants after the workshop. Depending on local resources and needs, this follow-up material may be in print or audiovisual format, or both. ACHA will also make available resource lists for individual participants to call for further assistance from health service AIDS educators in their region.

Special Features

1. Multiplier Effect. The program proposed by ACHA will multiply the effect of the \$100,000 cooperative agreement several times through the availability of:

1. Existing ACHA Task Force on AIDS professional resources, supervision, and materials
2. Existing ACHA regional/affiliate networks, newsletters, and meetings
3. ACHA regional representatives to promote, publicize, and organize workshops
4. Members of ACHA Task Force on AIDS and other health service AIDS educators to participate in workshops and develop materials
5. Commitment to program by individual schools which fund their student/faculty team's travel expenses

2. Existing Resources. ACHA will carry out the cooperative agreement using existing space in the central office in Rockville, MD; existing computer and office equipment; and existing personnel other than the national Workshop Coordinator and secretarial support mentioned earlier.



UNIVERSITY OF VIRGINIA
DEPARTMENT OF STUDENT HEALTH

Medical Center Box 378

Charlottesville, Virginia 22908

Telephone: 804-924-5362

6 July 1987

Mr. Jay Theodore, AmFAR Grants Officer
American Foundation for AIDS Research
Grants Department
9601 Wilshire Boulevard
Mezzanine Level
Beverly Hills, CA 90210-5294

RE: RFP: AmFAR 587.4

Dear Mr. Theodore:

The American College Health Association (ACHA) submits this letter of intent in response to RFP: AmFAR 587.4. We propose to use a grant from the American Foundation for AIDS Research to develop an innovative system of producing and distributing educational materials relevant to HIV infection. The beneficiaries of this project will be the students, faculty, and staff in institutions of higher education. Recognizing the unique risks of HIV infection that exist among students in college and university environments, the ACHA proposes to improve the quality and availability of information about the specific clinical, psychosocial, and educational issues of HIV infection that affect young people and campus communities. ACHA would distribute the materials developed to health care providers, mental health professionals, health educators, student affairs administrators, personnel officers, and communications offices in higher education.

Our objectives are: (1) to improve the quality and availability of information about HIV infection for communities in higher education; (2) to develop effective ways of teaching risk reduction in a college context, taking into account the developmental challenges of young adults; (3) to provide a variety of educational models and strategies from which individual educators can select programs most consistent with local needs and values; (4) to assure the competent medical and psychological evaluation of people concerned about HIV infection through health services and counseling centers; (5) to disseminate realistic and compassionate guidelines for the provision of psychological and social services for those in the campus community who are concerned, asymptotically infected, or ill; and (6) to implement a system for keeping the information and materials distributed current, accurate, and complete. We foresee that the model system we propose could be utilized effectively in other contexts as well; in that sense, it is a demonstration project.

The ACHA is a multidisciplinary, not for profit organization (501 (c) (3)) established in 1920; it represents and assists professionals and students who provide health care in colleges and universities. The Association appointed a Task Force on AIDS in September, 1985. Dr. Richard P. Keeling, Associate Professor of Internal Medicine and Director of the Student Health Service at the University of Virginia, chairs the Task Force and is the Principal Investigator for the current proposed project. In less than two years, the Task Force has produced an important group of informational brochures about HIV infection and risk reduction, videotapes for students and administrators, a set of guidelines for policy development, and a Special Report composed of discussion papers dealing with the most

Mr. Jay Theodore, AmFAR Grants Officer
6 July 1987
Page 2

pressing issues AIDS poses for higher education. By working with other organizations in higher education, ACHA has assumed a leadership role in dealing with the issues of AIDS on our campuses. It has sponsored three national conferences on the subject, and members of the Task Force have consulted and presented at more than 150 colleges and universities. Copies of some of our materials are enclosed.

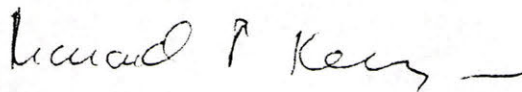
ACHA has a unique familiarity with the target population, with effective and practical methods in AIDS education, and with the concerns of students and administrators in higher education. We propose now to use those strengths in addressing clinical, psychosocial, and educational issues in a systematic way which will provide current and relevant guidance for individual institutions.

A critical feature of our proposal is the implementation of a novel updating system. We would develop a body of information and materials using word processor/desktop publishing technology, allowing for ready alterations and inexpensive production. When updates are required in any area, they can be issued easily and entered by the user in the text in the appropriate position. A three-ring binder format will allow easy access to the materials for insertion of updates and removal of outdated information.

During the one-year period of the grant requested, ACHA would do a needs assessment of member institutions; research the information and format best suited to each topic area and target population; draft documents and select appropriate materials; publish and distribute an initial compendium; and set up the updating system. Grant monies would be expended in professional salaries, clerical and computer assistance, supplies, travel costs, and the publication and distribution of the initial compendium.

College students are an important target group for AIDS education because of the developmental vulnerabilities that create special risk for them, the factors in "campus ecology" that promote risk behaviors, their openness to educational strategies, and their childbearing potential. Many students have not yet received adequate education about HIV infection because of limited budgets for health promotion, timidity about the subject matter, or a misguided conviction that AIDS is "somebody else's problem." Students or employees with concerns or symptoms may not get appropriate and complete evaluation under these circumstances. Few institutions of higher education have developed adequate psychological and support services. Improved services and education on the campus will have beneficial impact in the college community, as well. We believe that the ACHA can materially improve educational, clinical, and psychosocial programming in higher education through this proposal, and we ask your support.

Very truly yours,



Richard P. Keeling, M.D.
Principal Investigator
Chairman, Task Force on AIDS
Director, Student Health
Service
University of Virginia

RPK:pmh
Enclosure

ABSTRACT

Title: AIDS Education Compendium for Colleges (RFP: 587.4)

Proposed Grantee: American College Health Association

Principal Investigator: Richard P. Keeling, M.D.

In order to improve AIDS education and promote risk-reducing behaviors in college communities, and to make medical, psychological, and support services for people with HIV infection more complete, sensitive, and widely available on campuses, the ACHA proposes to develop an innovative system of continuing education materials for health care workers, mental health professionals, health educators, and certain administrators in higher education. A computer-assisted updating system and three-ring binder format will assure the currency of the compendium.

The specific content and nature of the materials distributed will be determined by a needs assessment of each professional group. Clinical sections will include guidelines for the medical, serologic, and immunologic evaluation of people with suspected or proved HIV infection, emphasizing the presentation of HIV-associated disorders among young people. The psychosocial section will deal practically with management strategies for psychological, social, and support services. Educational sections will include guidelines and resources for program management and execution, emphasizing promotion of risk-reducing behaviors in a way that fits the developmental context of students. During the grant year, ACHA will produce and distribute an initial compendium, develop methodologies for recognizing and incorporating new information, and establish the computer-based updating system.

UNIVERSITY OF VIRGINIA
DEPARTMENT OF STUDENT HEALTH
BOX 378, MEDICAL CENTER
CHARLOTTESVILLE, VIRGINIA 22908

July 11, 1987

Mr. Jay Theodore
AmFAR Grants Officer
American Foundation for AIDS Research
9601 Wilshire Boulevard, Mezzanine Level
Beverly Hills, CA 90210-5294

Re: RFP AmFAR 587.4

Dear Mr. Theodore:

The American College Health Association (ACHA) and the Department of Epidemiology and Social Medicine of Montefiore Medical Center submit this letter of intent in response to RFP: AmFAR 587.4. We propose to work jointly using a grant from the American Foundation for AIDS Research to promote more effective AIDS education, counseling, and service programs in institutions of higher education in inner cities in the United States.

AIDS prevention and service programs designed for most residential colleges do not entirely satisfy the needs of students in inner cities. We cannot approach a predominantly commuter population having large representations of students from racial and cultural minority groups and large numbers of older, part-time, or returning students with the same program elements as are used in full-time, residential settings. The epidemiology of HIV infection in urban areas more commonly involves both needle sharing and heterosexual transmission to the sex partners of drug users, factors which increase the concerns of women. Older students and those with children have distinct needs in education. Cultural issues in AIDS education for Blacks and Hispanics have not been adequately addressed in the college setting. Providing clinical and support services to this diverse urban population will be challenging; there is currently little understanding of the potential impact and cost of these services nor of the most effective ways to implement programs.

We plan to develop and produce a conference for key faculty and staff of publicly-funded inner city junior and community colleges, four-year colleges, technical schools, and universities. We will invite representatives of schools from New York City to Baltimore to this model conference. The attendees will work toward designing effective AIDS intervention, prevention, and support programs for inner city schools through integrating the important ethnic, cultural, and gender issues described earlier and by identifying methods of educating and serving commuter and non-traditional students. We will assemble the major findings and recommendations of the conference in a report and program manual. The American College Health Association will distribute this manual widely to other colleges and universities outside the geographic area of the proposed project. The conference thus will evolve strategies and guidelines that will be used in other sites and settings. Invited attendees will include "gatekeepers" who provide students access to helping resources; health service staff; counselors; deans in housing and residence life programs; job and career counselors; and faculty in

women's studies and Black studies. Presenters and facilitators will include not only physicians, mental health professionals, and health educators, but also epidemiologists, urban anthropologists, sociologists, and leaders in minority and gender study programs.

We will hold the meeting on the campus of a college in the New York area in the spring of 1988. The conference will last about two days; participants will pay no fees. We hope to house attendees in institutional facilities at low or no cost. Within 4 months of the conference, the American College Health Association will distribute the conference report and program manual to all urban colleges and universities. We would use grant funds to produce the conference and distribute materials; to pay for the directly applied time of the primary organizer, Dr. Phyllis Vine; to support modest secretarial assistance; to pay for materials and supplies for the conference itself; and to pay expenses for presenters. The ACHA will contribute the expertise of its Task Force on AIDS and copies of its AIDS education materials.

The two co-principals in this project bring together considerable experience in health advocacy, women's issues, medicine, health promotion, and AIDS programming in higher education. Dr. Keeling, a physician, is Director of the Student Health Service and Associate Professor of Internal Medicine at the University of Virginia; he chairs the Task Force on AIDS of the ACHA and is President-Elect of that organization. He has extensive experience in AIDS prevention programs and has written widely about the clinical, educational, and administrative issues of HIV infection for higher education. Dr. Vine's MPH and Ph.D. in History, combined with her experience in health advocacy, mental health issues, women's concerns, and social medicine, provided the basis for her organizing an important conference on "AIDS and the University" at Montefiore in June, 1987. She is currently on leave from Sarah Lawrence College and is working in Epidemiology and Social Medicine at Montefiore, which is a recognized center for the evaluation and treatment of AIDS and the study of the epidemiology of HIV infection.

The American College Health Association applies for this grant as a multidisciplinary, not-for-profit organization (501 (c)(3)). Its Task Force on AIDS, appointed in 1985, has produced educational materials, workshops, seminars, national conferences, videotapes, and a comprehensive special report dealing with AIDS on the campus. ACHA has a unique familiarity with the target population; we propose now to use our skill and experience to collaborate with Dr. Vine in identifying and addressing the specific concerns of inner city students.

Very truly yours,

Richard P. Keeling, M.D.
Principal Investigator
Chairman, Task Force on AIDS
American College Health Assoc.
Director, Student Health Service
University of Virginia

Phyllis Vine, M.P.H., Ph.D.
Co-Principal Investigator
Department of Epidemiology and
Social Medicine
Montefiore Medical Center
Bronx, New York

ABSTRACT

Title: AIDS Education in Inner City Colleges

Proposed Grantee: American College Health Association and Department of Epidemiology and Social Medicine, Montefiore Medical Center

Principal Investigators: Richard P. Keeling, M.D. (AHCA), and Phyllis Vine, M.P.H., Ph.D. (Montefiore).

We propose to promote more effective and accessible AIDS education, counseling, and service programs for students at inner city institutions of higher education through the development and implementation of a model conference on the design, content, format, and impact of these programs. Issues in AIDS programming for students in these primarily non-residential schools include women's concerns, racial and cultural minority education and services, the impact of intravenous drug abuse, and the challenge of educating a commuter population with many part-time and non-traditional students.

The conference, to be held on a college campus near New York, would address these issues with the contributions of presenters from the fields of medicine, mental health, health education, epidemiology, sociology, and anthropology. The seminars and workshops would strive to assess the impact of AIDS-related services on inner-city schools, to determine the best strategies for addressing the special needs of students in these schools, and to prepare a report and program manual which would guide other inner city colleges and universities in their program design, production, and evaluation. This document would then be widely distributed by the American College Health Association.

SELECTED RESOURCES AND BIBLIOGRAPHY

GENERAL INFORMATION AND RESOURCES

American College Health Association
15879 Crabbs Branch Way
Rockville, Maryland 20855
(301) 963-1100

ACHA is a national organization comprised of health care professionals working with college populations, including administrators, physicians, nurses, dentists, mental health care workers, health educators, and students.

ACHA publishes many pamphlets on important health topics, including: AIDS...What Everyone Should Know, Safe Sex, Making Sex Safer, and Acquaintance Rape. ACHA also has several educational videotapes available on AIDS. For complete information, send for ACHA's catalogue.

HIV AND AIDS

National Hotlines

Many local and state governments sponsor phone hotlines staffed by volunteers and professionals who are able to provide up-to-date information on AIDS. Many students feel comfortable using hotlines because of the assurance of anonymity. Check your phone book or state department of health and human services for information on local hotlines. Some national toll-free hotlines are:

Centers for Disease Control
HOTLINE 1 (800) 342-AIDS
(In Atlanta, GA: (404) 329-3534

National Gay Task Force
AIDS Crisis Hotline
(800) 221-7044
(212) 807-6016 (NY state)

National Sexually Transmitted Diseases Hotline
American Social Health Association
(800) 227-8922

Public Health Service AIDS Hotline
(800) 342-AIDS

Information and Referral

Other groups exist which can provide useful information on statistics, research updates, and marketing AIDS education for various populations. Some also offer prepackaged literature or posters for sale which can be used on any campus. Several follow:

AIDS Action Council
729 Eighth Street, S.E.
Washington, D.C. 20003

This organization, providing lobbying in Washington, D.C. for AIDS education and research, represents 270 AIDS service providers across the country.

Gay Men's Health Crisis
Box 274
132 West 24th Street
New York, NY 10011
(212) 807-6655

This organization has developed many brochures on AIDS applicable to several special populations including women, Blacks, and Hispanics.

Health Education Resource Organization (HERO)
101 W. Read Street, Suite 819
Baltimore, MD 20022

This organization has developed brochures on AIDS for IV drug users, pregnant mothers, and others. The organization also prints posters about AIDS, which although they list HERO as a resource, can be used anywhere with some adaptation.

Hispanic AIDS Forum
c/o APRED
853 Broadway, Suite 2007
New York, NY 10003
(212) 870-1902 or
870-1864

Los Angeles AIDS Project
1362 Santa Monica Boulevard
Los Angeles, CA 90046
(213) 871-AIDS

Minority Task Force on AIDS
c/o New York City Council of Churches
475 Riverside Drive, Room 456
New York, NY 10115
(212) 749-1214

National AIDS Network
1012 14th Street, N.W.
Suite 601
Washington, D.C. 20005
(202) 347-0390

National Coalition of Gay Sexually Transmitted Disease Services
c/o Mark Behar
P.O. Box 239
Milwaukee, WI 53201
(414) 277-7671

San Francisco AIDS Foundation
333 Valencia Street, 4th floor
San Francisco, California 94103
(415) 863-2437

Whitman-Walker Clinic
AIDS Education Services
2335 18th Street, N.W.
Washington, D.C. 20009
(202) 332-7095

Posters and Brochures

AIDS

Suite 700
1555 Wilson Boulevard
Rosslyn, VA 22209

This organization provides materials produced by a joint effort of the Public Health Service and the American Red Cross. Available are: A poster featuring Patti LaBelle with the message "Don't listen to rumors about AIDS. Get the Facts!" and which lists the PHS AIDS hotline; leaflets on various topics including AIDS, caring for people with AIDS, antibody testing, and facts about drug abuse and AIDS.

Medical and Ethical Literature

Researchers and scientists are generating numerous studies and articles on AIDS: etiology, epidemiology, psychological and psychosocial issues, etc. Although it becomes increasingly more impossible to stay up to date on the literature, the following references can prove particularly useful.

Koop, C. E. (1986). Surgeon general's report on acquired immune deficiency syndrome. Washington, DC: U.S. Department of Health and Human Services.

For up to 50 free copies of the Surgeon General's report,
write to:

AIDS

P.O. Box 14252
Washington, DC 20044

National Academy of Sciences. (1986). Confronting AIDS.
Washington, DC: National Academy Press.

National Academy of Sciences. (1986). Mobilizing against
AIDS. Cambridge, MA: Harvard University Press.

Task Force on AIDS, Keeling, R. P. (Ed.). (1986). AIDS on
campus. Rockville, MD: American College Health
Association.

See ACHA listing above. This brochure is available from ACHA
for \$5.00 for ACHA members and \$7.50 for all others.

This brochure provides recommendations and guidelines for
administrative and health professional response to AIDS on
college campuses. At the writing of this paper, many
colleges and implemented many of the recommendations made by
the brochure. The brochure includes recommended statements
on: Institutional Response to AIDS, Institutional Policies
and Administrative Liaison, Housing Policies, Educational
Priorities and Methods, Statement on HTLV-III Antibody
Testing, and Confidentiality of Information.

Literature on Responding to People with AIDS

Support Groups for People with AIDS and the Worried Well

Mothers of AIDS Patients (MAP)
c/o Barbara Peabody
3403 E Street
San Diego, CA 92102
(619) 234-3432

National Association of People with AIDS
P.O. Box 65472
Washington, D.C. 20035
(202) 483-7979

SEXUALITY

Communication Between Sexual Partners

Branden, N. (1983). "If you could hear what I cannot say."
New York: Bantam.

Support Groups for the Sexually Compulsive

Sexaholics Anonymous

A 12 step support group for sexually compulsive individuals

LESBIAN, GAY, AND BISEXUAL ISSUES

Professional and Social Support Organizations

American Counseling and Personnel Association Standing Committee
for Lesbian, Gay, and Bisexual Awareness

American Psychological Association Committee on Lesbian and Gay
Concerns
1200 Seventeenth Street, N.W.
Washington, D.C. 20036
(202) 955-7600

This committee "[represents] the concerns of gay male and
lesbian psychologists and gay male and lesbian consumers of
psychology."

National Federation of Parents and Friends of Lesbians and Gays
Box 24565
Los Angeles, CA 90024
(213) 472-8952

After 10/27/87
P.O. Box 20308
Denver, CO 80220

Regional Contacts:

Buffalo, NY (716) 827-8833	New York, NY (914) 793-5198
Denver, CO (303) 333-0286	Philadelphia, PA (215) 572-1833
Detroit, MI (313) 478-8408	Portland, OR (503) 244-3225
Sacramento, CA (916) 444-9510	Washington, DC (301) 439-3524
New Orleans, LA (504) 891-3866	
Ft. Lauderdale, FL (305) 741-3648	

This organization provides support, information, and social
space for parents whose children are lesbian, gay, or

bisexual and friends of lesbians, gays, and bisexuals. Members of the organization are often available to lecture and the organization publishes numerous pamphlets and brochures aimed at helping lesbians, gays, and bisexuals share information about their sexual orientation with parents and at helping parents in the process of accepting their children despite their sexual orientation.

Theories of Sexuality

Bell, & Weinberg . (19). Homosexualities.

Journal of Homosexuality. Binghamton, NY: Haworth Press.

This journal "is devoted to theoretical, empirical, and historical research on homosexuality, heterosexuality, sexual identity, social sex roles, and the sexual relationships of both men and women. It was created to serve the allied disciplinary and professional groups represented by psychology, sociology, history, anthropology, biology, medicine, the humanities, and law.

Kinsey, A. C. & Martin, C. E. (Eds.). (1953). Sexual behavior in the human female. Philadelphia: W. B. Saunders.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). Sexual behavior in the human male. Philadelphia: W. B. Saunders.

Marmon, J. (Ed.). (1980). Homosexual behavior. New York: Basic Books.

Masters, W. H. & Johnson, V. E. (1979). Homosexuality in perspective. Boston: Little, Brown.

Rofes, E. E. (1983). "I thought people like that killed themselves": Lesbians, gay men and suicide. San Francisco: Grey Fox Press.

Counseling Lesbians, Gays, and Bisexuals

Gochros, H. L., Gochros, J. S., & Fischer, J. (Eds.). (1986). Helping the sexually oppressed. Englewood Cliffs, NJ: Prentice-Hall.

Gonsiorek, J. C. (Ed.) (1985). A guide to psychotherapy with gay and lesbian clients. New York: Harrington Park Press.

Green, F. (Ed.). (1987). Gayellow Pages 1987, 15, New York: Renaissance House.

This book is a national listing of political, social, and religious groups in the lesbian, gay, and bisexual

community. It also lists lesbian, gay, and bisexual owned and run businesses across the country and is a valuable referral source.

Moses, A. E. & Hawkins, Jr., R. O. (1982). Counseling lesbian women and gay men. St. Louis: C. V. Mosby.

Literature on Coming Out

Legal Issues for Lesbians, Gays, and Bisexuals

CHEMICAL DEPENDENCY

Self Help Groups For Chemical Dependents and Their Families

Listed below are national offices for several self help groups. Almost all of these groups hold meetings in every major city in the country. Often, area offices are listed in phone books, and one can get information on the times and locations of nearby meetings. If you find no listing in your area, contact the national office for further information.

Many of the self help groups offer meetings for special populations including lesbians, gays, and bisexuals; non-smokers; women; etc.

Most of the groups follow adaptations of the 12 steps and 12 traditions established by Alcoholics Anonymous (see description of AA below). The 12 steps provide a structure and process whereby individuals can actively move toward recovery from their chemical dependence.

Adult Children Anonymous (ACA)

World Service Office for Anonymous Programs for Adult Children
P.O. Box 35623
Los Angeles, CA 90035
(213) 464-4423

A support group for adult children of alcoholic parents

Al-Anon

Al-Anon Family Group Headquarters, Inc.
P.O. Box 182
Madison Square Station
New York, NY 10159-0182
(212) 683-1771

A 12 step support group for families and friends of alcoholics

Ala-Teen

A 12 step support group for teenagers with alcoholic friends or family members. The group is run by and for teenagers, although there is usually an adult sponsor involved in helping to organize the group. This group is sponsored by Al-Anon and information on the group can often be found by contacting Al-Anon if there is no separate phone listing in your area.

Alcoholics Anonymous (AA)
World Services, Inc.
P.O. Box 459
Grand Central Station
New York, NY 10163

AA "is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism."

"The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions."

"A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes."

"Our primary purpose is to stay sober and help other alcoholics achieve sobriety." - From The A.A. Grapevine, Inc.

Families Anonymous
P.O. Box 344
Torrance, CA 90501
(213) 775-3211

Nar-Anon

P.O. Box 2562
Palos Verdes Peninsula, CA 90274
(213) 547-5800

A 12 step support group for families and friends of the chemically dependent

Narcotics Anonymous (NA)
World Services, Inc.
P.O. Box 622
Sun Valley, CA 91352
(213) 768-6203

A 12 step support group for the chemically dependent in recovery

National Association for Children of Alcoholics (NACoA)
31706 Coast Highway, Suite 201
South Laguna, CA 92677
(714) 499-3889

A support group for children whose parents are alcoholic

Information and Referral

National Association of Lesbian and Gay Alcoholism Professionals
204 West 20th Street, New York, NY 10011
(212) 807-0634

National Clearinghouse for Alcohol Information (NCALI)
1776 E. Jefferson Street, 4th floor
P.O. Box 2435
Rockville, MD 20852
(301) 468-2600

National Clearinghouse For Drug Abuse Information (NCDAI)
P.O. Box 416
Kensington, MD 20795
(301) 443-6500

Pride Institute, a rehabilitation program for alcoholic and drug dependent gay and lesbian patients

Literature

National Association of State Alcohol and Drug Abuse Directors, Inc. (1985). Resource directory of national alcohol-related associations, agencies and organizations. Washington, DC: U.S. Department of Health and Human Services.

This is a report for the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse.

Contact: U.S. Department of Health and Human Services
Public Health Service
Alcohol, Drug Abuse and Mental Health
Administration
5600 Fishers Lane
Rockville, Maryland 20857

Finnegan, D. G. & McNally, E. B. (1987). Dual identities.
United States: Hazelden.

This is a book written for lesbians, gays, and bisexuals who not only have to deal with daily pressures resulting from their sexual orientation, but who also are chemically dependent.

National Association of Lesbian and Gay Alcoholism Professionals. (1987). National directory of facilities and services for lesbian and gay alcoholics. New York: New York City Department of Health.

Copies available for \$5.00, from NALGAP, see address above.

National Clearinghouse for Drug Abuse Information. (1985). National directory of drug abuse and alcoholism treatment programs. [Publications No. (ADM) 85-321 (1985)]. Washington, DC: U.S. Department of Health and Human Services.

Contact: NCDAI
Box 1908
Rockville, MD 20850

DEVELOPMENTAL ISSUES

The following book and chapter summarize the five major families of theories of the student personnel profession. All of the families of theories can be used to provide structure and process to educational programming, but the cognitive developmental and psychosocial families are of particular use, no matter what the content of the programming. These are two sources for developing a better understanding of cognitive and psychosocial issues faced by traditional college age students.

Knefelkamp, L. L., Widick, C., and Parker, C. A., Eds. (1978). Applying new developmental findings. San Francisco: Jossey-Bass.

Widick, C., Knefelkamp, L., and Parker, C. A. Student development. In U. Delworth and G. R. Hanson (Eds.). Student services (pp. 75-116). San Francisco: Jossey-Bass.

The following books are original sources for many of the theories summarized in the sources above. For indepth understanding and a historical sense of the development of certain theories, these are important books to read.

Chickering, A. W. (1972). Education and identity. San Francisco: Jossey-Bass.

Utilizing psychosocial theory established by Erikson and elaborated upon by Keniston to describe development in stages throughout the lifetime, Chickering elaborates on stage development that commonly occurs in traditional college age students.

Chickering, A. W. (1981). The modern American college. San Francisco: Jossey-Bass.

This book includes writings by several developmental theorists on many aspects of changes occurring among college students, both traditional age and returning adults.

Gilligan, C. (1982). In a different voice. Cambridge, Massachusetts: Harvard University.

In this work, Gilligan questions the assumption that men and women develop morally in the same fashion. She argues that because of gender differences in socialization and differences in gender expectations, women follow a different moral developmental path than men.

Keniston, K. (1979). Youth and dissent. New York: Harcourt Brace Jovanovich.

Keniston takes Erikson's theory of psychosocial development during life stages and develops a new one experienced only by traditional college age students.

Non Traditional Age Students

Schlossberg, N. (19). Adults in transition.

Grief, Death, and Dying

HOLISM AND STRESS REDUCTION

Jacobson, E. (1976). You must relax. New York: McGraw Hill.

Ryan, R. S. & Travis, J. W. (1981). Wellness workbook. Berkeley, CA: Ten Speed Press.

RACIAL AND ETHNIC ISSUES

WOMEN'S ISSUES

National Women's Studies Association
University of Maryland
College Park, Maryland 20742
(301) 454-3757

This organization was "founded to promote the educational, political and professional development of Women's Studies...NWSA works to eliminate sexism...anti-Semitism, heterosexism and oppression based on age, class, religion, ethnicity, disability and national origin, as well as other barriers to liberation in our social structure." - from the NWSA membership brochure

Literature

Cox, S. (Ed.). (1981). Female psychology. New York: St. Martin's.

Freeman, J. (Ed.). (198).

Rich, A. (1979). On lies, secrets, and silence. New York: W. W. Norton.

This is a collection of essays on sexism, sexual assault, lesbianism, and other women's issues. Rich, a noted poet and essayist is must reading for individuals interested in women's issues.

Richardson, L. & Taylor, V. (Eds.). (1983). Feminist frontiers. Menlo Park, CA: Addison-Wesley.

SEXUAL ASSAULT

Information and Referrals

National Center for the Prevention and Control of Rape
Room 15-99, Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
(301) 443-1910

National Coalition Against Sexual Assault (NCASA)
P.O. Box 7156
Austin, TX 78712
(512) 472-7273

Many cities also provide hotlines, counseling services, and legal advice for survivors of sexual assault. For more information on services available in your area, check the phone book under rape or sexual assault.

Literature

Brownmiller, S. (1975). Against our will. New York: Bantam.

McEvoy, A. W. & Brookings, J. (1984). If she is raped.
Holmes Beach, FL: Learning Publications.

This book offers suggestions to husbands, fathers, and male friends for responding to survivors of rape.

This book offers a definitive analysis of rape and sexual assault historically, cross-culturally, and sociologically.

HANDICAPPING CONDITIONS

American Psychological Association Committee on Disabilities and Handicaps

PUBLISHERS AND MAIL ORDER BOOK STORES

Hazelden

(800) 328-9000

(800) 257-0070 (in Minnesota)

This publisher offers a free catalogue of the literature they print dealing primarily with chemical dependence.

Lambda Rising

This alternative bookstore offers mail order services on all the titles they carry. The store carries books on homosexuality, AIDS, chemical dependence among lesbians and gays, coming out to parents and loved ones, healthy sexuality, and mental health and counseling lesbian and gay clients.

Sibyl Jacobson
President



One Madison Avenue, New York, NY 10010-3690

RECEIVED

JUN 29 1987

AMERICAN COLLEGE
HEALTH ASS'N

June 25, 1987

Dr. Richard Keeling
Director AIDS Task Force
American College Health Association
15879 Crabbs Branch Way
Rockville, MD 20855

Dear Dr. Keeling

I am pleased to invite you to submit a proposal under our Foundation's Project Reach: An Aids Education Program. Under this program, we anticipate awarding a total of \$150,000 in 1987. Grants of up to \$25,000 each will be made for AIDS education efforts judged to be the most effective.

Through Project Reach, we hope to encourage national organizations as well as community groups to mobilize resources in the area of AIDS education. Project Reach seeks to help disseminate information about the disease of AIDS by supporting quality programs which have the potential to reach significant numbers of people, especially populations at risk. We believe your organization could be effective in these efforts and wish to give you the opportunity to participate in the grant request process.

Guidelines for Project Reach and a cover sheet to apply for a grant are enclosed. Please note in the attached guidelines that while we encourage collaboration among organizations, the submitting organization must have tax exemption under Section 501(c)(3) of the Internal Revenue Code. The deadline for submissions is September 30, 1987.

Sincerely

SJ/hf

Enclosures

REQUEST FOR PROPOSALS
METROPOLITAN LIFE FOUNDATION
Project Reach: An AIDS Education Program
Submission Deadline: September 30, 1987

The Need

The Acquired Immune Deficiency Syndrome (AIDS) is an infectious disease which has already taken the lives of thousands of people across the country. Continuing Metropolitan's longstanding commitment to helping people become more aware of serious public health issues, Metropolitan Life Foundation has developed Project Reach: An AIDS Education Program. Through this program, the Foundation hopes to bring quality information and materials to the public about the life-threatening disease of AIDS.

The Program

Metropolitan Life Foundation is pleased to invite a number of selected organizations to participate in **Project Reach**. In 1987 the Foundation expects to award a total of \$150,000 for AIDS education programs. Grants up to \$25,000 will be given for the expansion of existing educational programs and materials and the development of new educational programs and materials on the prevention of AIDS. The purpose of this project is to reach varied groups with prevention information and education through collaboration and outreach efforts.

The primary objectives of **Project Reach** are:

- ° To expand dissemination of existing educational approaches and programs
- ° To develop and disseminate new educational approaches and programs
- ° To encourage networks of national organizations, chapters of organizations and/or local community groups

The **Project Reach** audience may be:

- ° Hard-to-reach and high-risk populations
- ° Junior high school and/or high school students
- ° Parents
- ° Teachers
- ° Health care professionals
- ° People who work with and/or who can reach target populations

Applications may be submitted under the following separate categories, or a combination of both.

Category 1. Expansion and dissemination of existing educational approaches which can include programs and materials.

Category 2. Development and dissemination of new educational approaches which can include programs and materials.

Under each category special consideration should be given to: bilingual materials; collaboration to bring existing materials to a variety of people within a community; and the means to reach significant numbers both nationally and locally. Emphasis must be placed on one or all of the following:

- ° Ability to reach public at large and/or target populations
- ° Ability to coordinate and disseminate educational programs and materials which would reach targeted groups
- ° Methods of dissemination which have proven effective in the past
- ° Involvement and support of other organizations and/or community groups, in addition to the submitting organization, is encouraged

Eligibility

National organization with local chapters - the national organization will be the submitting organization and the recipient of the grant. The submitting organization must have tax exemption status from the Internal Revenue Service under Section 501(c)(3) of the IRS code.

Consortium of national organizations and community groups - the submitting organization will be the recipient of the grant and must have tax exemption status from the Internal Revenue Service under Section 501(c)(3) of the IRS code.

Criteria for Selection and Judging

- ° Ability to coordinate programs through chapters or networks.
- ° Involvement of professionals with expertise and knowledge of AIDS and experience with the target population.

Application Requirements

NOTE: Only one proposal can be submitted from an organization.

Application for grants must adhere to the following format:

1. Complete the enclosed **Cover Sheet** indicating:

- a. Name, address, and phone number of the submitting organization.
- b. Name of the president of the submitting organization.
- c. Names, addresses, and phone numbers of all other participating organizations.
- d. Description of educational approaches. If the project is for expansion, indicate how it has been disseminated and attach copies of any applicable materials.
- e. Whether the project is to expand existing educational approaches or to develop new ones.
- f. Target audience.
- g. Total budget.
- h. Source of current financial support for the project.
- i. Amount of grant request.
- j. An abstract of the project, not to exceed 200 words.
- k. A letter of commitment to the project from each participating organization, signed by the president of each organization.
- l. Name/title, address and phone number of the project coordinator/director.
- m. Signature of project coordinator/director.
- n. Signature of the president of submitting organization.

2. A general description of the project, not to exceed four pages (single spaced) including the following:

- a. Proposed activity.
- b. Description of project plans. Specific plans for distribution and time schedules from all participating organizations must be submitted. Details must include the target group, how distribution will be accomplished, and how many people will be reached.
- c. Staff

3. Project budget, fully defined.

NOTE: The budget should not include indirect costs.

4. Vitae of project coordinator/director and any other staff professionals involved in a major portion of the project.
5. Describe methods used that ensure information provided is accurate and timely. A list of members on a quality review committee or medical consultants should be furnished.

Submission Procedures

1. Ten copies of each application must be submitted. Photo reduction copies will not be accepted.
2. Each copy must be stapled together, and should not be placed in binders or covers. The attached Cover Sheet must be the top page of each copy.
3. A self-addressed adhesive label must be enclosed for acknowledgment of application receipt.
4. Send submissions to:

Metropolitan Life Foundation
Project Reach
One Madison Avenue, Area 12H
New York, NY 10010-3690

5. Submissions must be received by September 30, 1987.
6. Shipping expenses are the responsibility of the applicant.
7. No submission accepted for consideration will be returned.
8. No application will be considered without proof of the submitting organization's tax exemption status.
9. Announcement of winners will be made in November 1987.

Submissions must contain all necessary information in the format prescribed in the application requirements for each category.

Metropolitan Life Foundation reserves the right to discontinue or amend the provisions of this program at any time. The interpretation, application, and administration of the program will be determined by the Foundation and its decisions will be final. The Foundation also reserves the right to publish descriptions or other reports regarding this program.

COVER SHEET

Metropolitan Life Foundation
Project Reach: An Aids Education Program

A. Name of the Submitting Organization _____

Address _____

Phone Number Area Code () _____

B. Name of the President of Submitting Organization _____

C. Names, Addresses and Phone Numbers of All Other Participating Organizations

D. Description of Educational Approaches _____

E. Expand Existing Educational Approaches and Programs

Develop New Educational Approaches and Programs

Check one

F. Target Audience _____

G. Total Amount of Budget \$ _____

H. Source of Current Financial Support for the Project

I. Amount of Grant Request \$

J. Abstract of the Project (200 words)

K. Attach to this cover sheet letters of commitment to the project from each participating organization, signed by the president of each organization.

L. Name/Title of the Project Coordinator/Director

Address

Phone Number Area Code ()

M. Signature of Project Coordinator/Director

N. Signature of President of Submitting Organization

Note: Enclose copy of Internal Revenue Service letter to submitting organization acknowledging tax exemption status under Section 501(C)(3) of the IRS code.

THINK ABOUT AMPERSAND.

THE FIRST SINGLES CLUB IN NEW YORK FOR THOSE WHO TEST AIDS-NEGATIVE.

Great Idea—But Not For Me

Ampersand is the singles dating service for those who don't really need one. It's for those who want the confidence and security that comes only from knowledge. And who want to meet people with the same level of commitment.

Popping The Question

Yes, *that* question. "Have you ever been exposed to someone who might have been exposed to someone . . . ?" They may not know. And if they know, they may not tell the truth.

Members of Ampersand don't have to ask.

The Negative That's All Positive

All our members have been verified as AIDS-negative based on results of tests taken at independent medical centers. All are re-tested at six-month intervals. We can provide a list of those places prospective members can be tested.

Now That That's Out Of The Way

It's all chemistry — the chemistry you create. You'll meet eligible professional people who are educated, interesting, and would rather be safe now than sorry later.

Not A Computer In Sight

So how do we get you two together?

We ask provocative questions. We develop an individual program just for you. If there's something you want us to keep confidential, we do. Nothing is standardized, because there are no standard formulas for connecting with the right person.

We'll coach you through a video about you. We'll produce it as many times as it takes until you're happy with it. If you prefer not to have one, that's okay, too.

We'll enter your personal description and photograph into our membership library, and we'll keep your video on file, too.

When You're Ready

We're open late, so you can come in, have a glass of wine or beer, relax, look through the books in our library and view other members' videos at your leisure.

Not Everyone Goes By The Book

So we also arrange parties, brunches, lectures, sporting events, trips and other great ways to meet Ampersand people.

Let Us Introduce Ourselves

To you. So you can introduce yourself to others who share the same interests and concerns.





AMPERSAND
SINGLES
CLUBS, INC

41 EAST 60TH STREET

NEW YORK, NY 10022

TELEPHONE: 212 644-5050

When to Test for AIDS

Why not compel everyone to be tested for AIDS as the basis for halting further spread of the virus? That's a natural first thought to anyone who ponders the deadly epidemic. But it's only a first thought. That some senior Administration officials argue for mandatory AIDS testing shows how late in the day they have arrived at step one.

William Bennett, the Secretary of Education, wants AIDS tests to be given to everyone admitted to the hospital or applying for a marriage license. Gary Bauer, a senior White House aide, says opponents of such tests are promoting "a bizarre type of enforced ignorance." The Public Health Service now says that all immigrants will be screened for AIDS virus.

There are at least six reasons for believing that advocates of general forced testing are opinionated, hasty or poorly informed.

Lesson One: Don't drive victims underground. Homosexuals and intravenous drug abusers, the principal victims, are not mainstream America. Living at the edge of social tolerance in many states, they face plenty of discrimination already. Their cooperation in changing their own behavior is crucial in slowing the disease's spread to other groups. Mandatory testing is the surest way to discourage them from contact with health authorities.

Lesson Two: A consensus is not a conspiracy. No one should lightly deny public health officials the tools they need to combat AIDS, including use of the AIDS antibody tests. What public officials want — for the reason cited above — is more voluntary testing, not mandatory testing. Mr. Bennett seems to believe that the Federal public health agency has fallen under the influence of homosexuals who oppose mandatory testing for self-interested reasons. But the reason for agreement is not conspiracy. Both groups believe voluntary testing is the better way of halting AIDS.

Lesson Three: Why in hospitals? Hospital patients are predominantly the elderly and the very young, two categories least likely to have AIDS. Why does Mr. Bennett propose to look there for the virus instead of among high-risk groups? Because hospitals are where testing is easiest. So too argued the drunkard who lost his keys in the dark and explained he was searching for them under the lamp-post because the light was better.

Lesson Four: Like it or not, morals have changed. Many states require a syphilis test for those seeking a marriage license. Mr. Bennett can't understand why an AIDS test isn't given too. The

reason is that a minute proportion of known syphilis cases are detected this way. New York recently dropped the syphilis test because the results were not worth the cost, and because of suspicion that some couples nowadays have sex before marriage. The same logic applies to AIDS, but there's another, far more cogent reason.

Lesson Five: False alarms have grim consequences. The two present tests for AIDS virus are highly specific but even in conjunction are not totally accurate. The danger of "false positives" — diagnosing individuals as exposed to AIDS when they are not — is probably minuscule with high-risk populations. But the danger grows rapidly when screening large populations at low risk.

According to a paper to be published shortly by Michael J. Barry and colleagues at the Harvard School of Public Health, the two standard AIDS tests would identify 28 true positives, 2 false negatives and 11 false positives when applied to a low-risk population, defined as 30 AIDS cases per 100,000 people. What those figures say is that, for every 28 cases correctly diagnosed, the tests risk falsely informing 11 individuals that they carry the virus of a deadly disease and should never have children. Without guarantees of confidentiality, the insurers, employers, landlords and classmates of these 11 individuals may also learn, and act, on the false information. What a burden for mandatory testers to bear.

Lesson Six: AIDS makes a poor political football. Mr. Bauer believes that public health officials have few qualms in urging explicit sex education for young children, offensive as that may be to conservatives. But when it comes to testing, "the left's political agenda takes over." He says, "Either this is potentially the Black Death or it isn't." In fact, no one knows how widely AIDS will spread, but it's prudent to take precautions. Teaching teen-agers safe sex is an effective precaution — and mandatory testing is not.

AIDS is a medical issue. Those who politicize it, or see political motives where none exist, are seriously delaying national policy on AIDS and measures to save lives. The only known way to curb AIDS is to persuade people to change behavior. The Administration still has not mounted a massive public education program of the sort already under way in several European countries. The Secretary of Education should be leading the charge for education about AIDS and voluntary testing. Mandatory testing should be his last thought, not his first.

FOCUS A GUIDE TO AIDS RESEARCH

Volume 2, Number 5

April 1987

Whether To Take the Test: Counseling Guidelines

Peter Goldblum, PhD, MPH
Neil Seymour, MA, MFCC

As the availability and use of the AIDS antibody test become more widespread, many more individuals are evaluating the benefits and risks of learning their antibody status. Some of these individuals will seek counsel from mental health professionals to help them decide whether to take the test. Clients already involved in counseling may wish to discuss these issues as part of their ongoing work. In addition, clients whose physicians have recommended the test for medical reasons may want to discuss their concerns about the possible negative psychological and social effects of taking the test. We outline here guidelines to help mental health practitioners in their work with clients concerned about taking the test and coping with the results.

Background and History

In early 1983 researchers identified the virus (now named the Human Immunodeficiency Virus, HIV) believed to cause AIDS. Shortly thereafter, private companies developed a sophisticated laboratory test called ELISA (enzyme-linked immunosorbent assay) to detect antibodies to the virus. The primary purpose of the test was to screen blood and blood products for HIV contamination. The test in and of itself is not a test for AIDS and the test result does not reveal whether a person will develop AIDS.

Infection by the AIDS virus causes a response by the body's immune system. Part of this response is the production of antibodies which recognize and attach to specific proteins on the virus, called antigens. Since the antibodies are tailor-made for particular antigens, tests can be designed to detect these specific antibodies. Tests for antibodies include the ELISA, the IFA (immunofluorescence assay), and the Western Blot. Each of these tests is based on the same principle, and each uses different methods to detect the same antibodies. Thus, the IFA or the Western Blot can be used as a way to support results obtained by the less-expensive ELISA.

The antibody tests are all very sensitive, which means that they detect almost all of the positive sera. They are also very specific, seldom indicating negative sera as positive. While testing procedures may vary, the required repeat testing of positive tests increases the accuracy of the test. False reactions do occur for reasons that are not completely understood. A false negative result may occur because an individual has not yet

developed antibodies to the virus. Most people produce antibodies within 2 to 8 weeks after exposure; some, however, will take up to 6 months.

Conversely, a false positive reaction may occur if the antibodies have developed in response to other similar proteins in the blood. Also, antibodies may have developed in reaction to another part of the test system, such as the cells in which the virus is grown. This would be called a non-specific reaction.

For individuals with little risk, the probability that a positive result is a "false positive" is greater only because there seems little chance that such individuals would have been exposed to HIV. Especially in these cases, testing by another method or repeat testing in a few months should be encouraged. The recommended procedure for all positive results is to be tested by another method such as IFA or Western Blot. While false positive and false negative reactions may occur, accumulating evidence shows that the ELISA test is very accurate, especially for individuals at high risk.

Mental health professionals must examine their own bias about the test before they counsel persons about it . . . It is important to understand fully the limits of the test and to appreciate the real risks that the test presents to clients.

Concerned that people at high risk might donate blood to learn their antibody status, public health officials developed an alternative test site program providing either anonymity or at least strict confidentiality to participants. Over time other purposes of the test have emerged. These include diagnostic and epidemiological applications as well as use in family planning settings to help clients make informed choices about pregnancy, parenthood, and birth control. Many see the test as an important preventive education tool for use in helping people understand their risk of contracting and transmitting the AIDS virus.

Ever since the antibody tests were developed, confusion and conflict about individual civil rights and public health interests have prevailed. Several public health officials and medical investigators wanted to use the test to help track and control the spread of the disease and to study the effects of infection. Advocates for people at high risk for HIV infection emphasized that many of these individuals are already socially stigmatized and that further use of the test might foster discrimination against those with positive results. Others, such as employers and insurance companies, showed an interest in the test for their own purposes.

Fears of discrimination have a realistic basis. Individuals in high-risk groups, regardless of their medical status, have lost

continued on page 2

A Publication of the AIDS Health Project University of California San Francisco

FOCUS is a monthly publication of the AIDS Health Project, an organization concerned with AIDS Prevention and Health Promotion. Funded by a grant from the state Department of Health Services to the San Francisco Department of Public Health, FOCUS presents AIDS research information relevant to health care and service providers. The AIDS Health Project is affiliated with the University of California San Francisco and the Department of Public Health. © 1987 UC Regents. All rights reserved.

Executive Editor and Director, AIDS Health Project: James W. Dilley, MD; Editor: Michael Helquist;
Medical Adviser: Stephen Follansbee, MD; Administrative Assistant: Joseph Wilson.

THE
**AIDS
HEALTH
PROJECT**

Guidelines . . .

continued from cover

jobs, have been denied housing and insurance, and have suffered from disruptions in relationships with families, partners, and friends. Homophobia, racism, and dislike or fear of drug addicts have been exacerbated by the hysteria and panic that have accompanied the AIDS epidemic. It is no wonder then that individuals in high-risk groups have been distrustful and suspicious in regard to the use of the antibody test. Given these facts, mental health professionals who counsel clients about the antibody test should provide information about possible consequences of taking the test and ways of managing the test information to prevent later difficulties.

Preparation for Counseling

To prepare for counseling, mental health professionals should first become familiar with the test, what it means and does not mean, its level of accuracy, and the potential benefits and risks of knowing one's antibody status. It is helpful to have ready access to community resources that can provide updated information relative to the test. Government-sponsored test sites have been established in several communities to offer information about the test and to provide anonymous testing free of charge. Clients can receive basic information at these sites and then return to their primary mental health counselors to review the information and weigh the personal benefits and risks prior to making a final decision.

Mental health professionals must examine their own bias toward the AIDS antibody test before they counsel clients about it. Counselors should understand fully the limits of the test and the real risks that the test can present. Clients must understand that the test alone will not indicate if they have AIDS or ARC, and that it will not predict who will develop these diseases.

In some cases antibody testing has resulted in a positive psychological and behavioral adaptation to the threat of AIDS. For those who prove to be antibody negative, knowledge of their test results usually reduces unneeded anxiety, although some recipients may face problems with "survivor guilt" and extra stress about remaining negative. Many individuals who receive a positive result have been motivated to take their health more seriously and to improve their health behaviors. Since research has shown that most people with AIDS antibodies have active virus in their bodies, a positive result strongly implies that an individual is able to pass the virus to another. Knowledge of a positive status has motivated many individuals to be more judicious in following safer sex guidelines and in no longer sharing I.V. needles. However, for many individuals troubling psychological reactions to test results frequently accompany the news of seropositivity. These responses range from mild to moderate anxiety to full-blown anxiety and depressive disorders. Although adequate pre-counseling can lessen the likelihood of these reactions, it is no guarantee that these will not happen.

Outline of Benefits and Risks

The benefits of antibody testing include:

- (1) to protect the blood supply by testing individuals who are considering donating blood;
- (2) to ensure that organ donations are safe from HIV contamination;
- (3) to help support a medical diagnosis in individuals who exhibit unexplained symptoms that their doctors think might be related to a HIV infection;
- (4) to help women at high risk decide whether to become pregnant or give birth;
- (5) to help women with a history of risk behavior decide whether to breastfeed an infant or have an infant inoculated with vaccine produced from live virus;
- (6) to reduce anxiety in individuals who are at low risk for HIV infection yet who have extremely high anxiety about it;

- (7) to motivate individuals who continue to practice high-risk behavior and who feel that a positive test result may help them reduce these behaviors;
- (8) to help researchers design experimental treatment protocols and to help potential subjects determine whether or not to participate in the drug trials;
- (9) to help scientists determine the extent of HIV infection in the population at large and, by following seropositive individuals, to understand the natural history of HIV infection.

The risks of antibody testing include:

- (1) severe psychological reactions, including anxiety, nightmares, sleep disturbance, depression, and suicidal behavior;
- (2) disrupted interpersonal relations, including potential for rage reactions and their extreme manifestations, such as homicidal behavior;
- (3) social ostracism and self-imposed social withdrawal;
- (4) relationship problems (blaming partners, sexual dysfunction, disrupted ability to make plans as a couple);
- (5) stigmatization and discrimination if a positive antibody status is made known to others outside of guarantees of confidentiality;
- (6) problems with employment or insurance;
- (7) preoccupations with bodily symptoms; and
- (8) a false sense of security and denial if the test proves negative (for example, believing one is immune to infection and thus continuing with risk behavior).

The Counseling Process

The process for helping clients decide whether to take the antibody test should be based on three important elements: (1) accurate information about the test, (2) a systematic decision-making process, and (3) an action plan that will maximize benefits and minimize risk.

Although the availability of information about the antibody test varies from one location to another, basic information and the location of the nearest test site should be available at any Public Health Department office. Some clinicians feel that clients should take responsibility for locating and obtaining information; others feel more comfortable providing information directly. In any case, clinicians should emphasize the importance of not proceeding with the test without proper background knowledge.

Clinicians should take responsibility for providing a structure for facilitating the decision-making process. This may be a process that has been used already with ongoing clients or one which is geared specifically for the immediate purpose. One process that has been used successfully is based on a "benefit-risk analysis." The client is asked to list the potential benefits that might be involved with taking the test. Subsequently, the client lists the potential risks. For the benefits list, the counselor encourages the client to consider each item and determine whether the benefit can be received by some means (other than the antibody test) that does not have concomitant risk. For example, if an individual is taking the test to lower the risk of contracting the disease through sexual contact, understanding that the same guidelines hold true for those who test positive as those who test negative may obviate the need to take the test.

If a greater overall benefit has been established to proceed with the test, a careful review of risks must be undertaken. In some cases perceived risks are in fact groundless, such as the fear that someone could obtain an individual's name from an anonymous test site. (A participant's anonymity is protected at these test sites; the individual's name is never recorded). Other risks can be reduced somewhat by careful planning; for example, discussions by couples prior to testing about how they will cope with the test results.

After a careful examination of the benefits and risks, the final choice — an educated decision — is the client's own to make.

An Action Plan

If a client chooses to take the test, additional attention should focus on how to minimize risks once the results are known. Clients may begin to process their feelings and thoughts by imagining their reactions to receiving a positive result and developing strategies to cope with these reactions. This process may take several sessions before the client is psychologically prepared to take the test. Even this preparation is no guarantee that unexpected reactions may not overwhelm the client.

Clients can be encouraged to arrange for additional emotional support during the testing process, including the period of waiting for the results. A counseling session should be scheduled shortly after clients receive the test results so they have the opportunity to discuss their reactions. Additional resources may be needed in order to assist adaptation to the test results. Clients should also think beforehand about disclosure of information about being tested, and they should consider how to protect their civil liberties. For example, when possible, clients should be encouraged to use anonymous testing sites. In some cases negative psychological reactions have emerged some time after receiving a positive test result. Clients should be assured of continued availability of assistance if this should occur.

Follow-up counseling may also be required to help clients incorporate test results into a plan of action that will produce the anticipated benefit. For example, the person who feels that it is necessary to take the test in order to be shocked into compliance with risk guidelines may need to continue seeing a counselor to accomplish this goal realistically. Shock value is only effective in the short-term, and long-term strategies are essential with AIDS risk prevention. Such a counseling plan may be established prior to taking the test.

Peter Goldblum, PhD, MPH is the Education Development Specialist for the AIDS Health Project. Neil Seymour, MA, MFCC, is the Coordinator for the AIDS Antibody Counseling Program for the AIDS Health Project.

Diagnosis/Treatment/Prevention

Heterosexuals and AIDS: Report from Atlanta

Michael Helquist

"AIDS has always been transmitted heterosexually; only our denial has kept this fact from us," asserted James Curran, MD of the U.S. Centers for Disease Control (CDC) during a recent presentation. The steady increase in media coverage of the threat of AIDS to heterosexuals has begun to challenge that denial. In February a major conference in Atlanta took that interest one step further and focused on the prevalence and prevention of AIDS in children, adolescents, and heterosexual adults.

Apparent among the nearly 800 conference participants was a consensus about how our understanding of the AIDS epidemic and our efforts to control it should be framed. Researchers and health officials appear to have adopted the notion that we should move away from the epidemiology of AIDS to an epidemiology of the HIV infection. Robert Redfield, MD of Walter Reed Medical Center advised his colleagues at the conference that "to focus on the number of AIDS cases today is to be five years out of date; the cases we record today tell us where HIV infection was five years ago."

General agreement has also developed about the need to emphasize high-risk behaviors rather than high-risk groups. Redfield suggested that the only realistic risk group is that one

comprised of humans with potential sexual, parenteral, or perinatal exposure to HIV. Even with this broader understanding of HIV transmission, the CDC monitors the spread of AIDS by looking at rates of increase among different population groups. Curran of the CDC explained that these rates have shifted during the period from 1985 to 1986. Among gay men there has been a 50% increase in the number of cases. That number corresponds with an 82% increase among bisexual men, a 63% rise for heterosexual men, and a 77% increase among women.

Although the current statistics clearly show the rise in overall numbers of AIDS cases among heterosexuals, researchers have yet to agree on the efficiency of the bidirectional transmission (from men to women and from women to men) of the virus. One recent study conducted at Walter Reed Medical Center showed that 44% of spouses of infected husbands became infected themselves as a result of unprotected sexual activity. While several researchers at the Atlanta conference asserted that HIV can be efficiently transmitted bidirectionally, other scientists regard male to female transmission as the more efficient route. One researcher noted that with many sexually transmitted diseases (STDs) there is a greater efficiency from men to women even though in every society STD prevalence is always greater in men.

Constance Wofsy, MD of San Francisco General Hospital suggested that the discussion of HIV transmission often reveals a bias that places major responsibility on women to control the spread of the AIDS virus. She cited the emphasis placed on prostitutes as supposed "reservoirs of infection," the expectation that women will adopt condom use in their sexual activities, and women's role in perinatal transmission. James Oleske, MD of the New Jersey College of Medicine in Newark called for men to share the responsibility of halting the spread of HIV. "Men are the major propagators of this disease," he said. Wofsy added that society must come to terms with its attitudes about prostitution. She posed the question, "Can we alter the existence of prostitution or can we make it safe?"

Pediatric AIDS

Oleske, who has worked with infants and children with AIDS for several years, estimated that by 1991 there will be 10,000 to 20,000 children with AIDS in the United States. In Newark alone Oleske and his staff are caring for 100 children now; by 1991 he expects that number to increase to 600. Oleske added, "Most pediatric cases are asymptomatic, and the latency period is relatively brief for infants."

Other differences between manifestations of AIDS in children and in adults are the less common appearances of Kaposi's sarcoma (KS), B-cell lymphoma, and Hepatitis B in children. Oleske also reported that children frequently have severe lung involvement, that they may have normal T-cell ratios, and that neurological disease is secondary to primary HIV infection. Curran of the CDC announced during the conference that that agency is currently devising a classification system for pediatric symptoms.

Gwendolyn Scott, MD from the University of Miami noted that there appears to be a 30 to 50% chance that the fetus of an HIV-infected mother will also be infected. Sheldon Landesman, MD of the Downstate Medical Center in New York City said he believes there is no method at this time to determine readily the status of an infant whose mother is seropositive. "You will not be able to tell until the baby develops disease," he said. Landesman added that a foster care mother cannot be told whether a baby from an infected mother is itself infected since that baby is carrying the mother's antibodies. Scott of Miami mentioned that her studies showed that mothers do not follow predictable patterns: sometimes an infected mother will give birth to a well infant following the births of two infected infants.

Several researchers indicated that pediatric AIDS cases can be seen as the index of infection in the family, and they emphasized the importance of surveying the risk factors of the infant's mother and also those for the other family members.

continued on page 4

Report . . .

continued from page 3

Prevention Among Adolescents

Richard Keeling, MD, chair of the AIDS Task Force for the American College Health Association, suggested that when planning AIDS education for adolescents, "We need to know who we are talking to and we must recognize that dealing with the problems of AIDS will involve not just education but also social justice."

Keeling advised his colleagues to consider three guidelines for their education efforts: (1) that adults cannot change the behavior of adolescents; only the adolescents themselves can change their behavior; (2) that community-based AIDS organizations, many comprised of gay men, have already dealt effectively with many questions about AIDS education and have much to teach those more recently involved in AIDS prevention; and (3) that while there is nothing wrong with choosing abstinence, there is nothing wrong with healthy sex.

Having worked mostly with college-age youth, Keeling concluded that what may work better than simple AIDS information campaigns is a comprehensive, multi-faceted education effort that emphasizes the development of self-esteem, self-respect, and accountability. "We will be more successful marketing AIDS education in the context of qualities important to the developing adolescent: winning, achieving, competing, succeeding, and fitting in," Keeling explained. "This kind of approach will allow for messages of choice, morality, and safety — rather than instruction, moralism, and warning."

The three-day conference was sponsored by the International Interdisciplinary AIDS Foundation, based in Atlanta.

Michael Helquist is the editor of FOCUS.

BRIEFS

Recent Reports

Women At Risk: Effect of HIV Antibody Testing and Notification. A San Francisco study has found that HIV Antibody Testing can be particularly problematic for women. As a result of structured, open-ended interviews with 37 women at risk for HIV exposure, researchers Jane Zones and Diane Beeson identified five specific areas of difficulty: (1) social isolation — women confront the risk of AIDS in a context of less social and personal support; (2) absence of formal support — difficulty in obtaining adequate medical care and social services, especially outside urban areas; (3) the stress of media reports — news related to AIDS is perceived as increasingly grim and is a constant source of stress; (4) safer sex — antibody testing itself does not ensure safer sexual practices among women who are positive or in relationships with seropositive men; and (5) worry about children — children are the focus of tremendous anxiety with particular worry centered on reproductive risk, infection of their children, leaving children motherless, having them taken away, and exposing them to social stigma. This study was supported by UC San Francisco, the San Francisco Department of Public

Health, and California State University at Hayward; current data was presented at the Bay Area Researchers' Conference on Women, Children, and AIDS, sponsored by the San Francisco AIDS Foundation.

AIDS Awareness and Risk Behavior: Discrepancy Among Heterosexual I.V. Drug Users. Members of the Sacramento, California AIDS-I.V. Drug Abuse Task Force found that local I.V. drug users (IVDU) were aware of HIV transmission via shared needles and unprotected sexual intercourse, but significant numbers did not translate that knowledge into behavior change. By means of two questionnaires and personal interviews, the researchers determined the knowledge and risk behaviors of 150 IVDUs attending local IV drug abuse programs. Some of the findings from the study included the following: 93% believed that HIV was present in some IVDUs in Sacramento; 93% believed they would eventually acquire HIV and AIDS through needle-sharing; 95% said they wanted to avoid acquiring HIV; 91% believed HIV could be spread heterosexually; and 64% believed that condoms could prevent the transmission of HIV. However, a review of the IVDU's behavior revealed that 77% of the time they shared their needle (rig) with someone else either before or after they shot up. Although 87% of the time, IVDUs said they cleaned their rigs between users, 87% of the time the cleaning only involved water. Of the 150 IVDUs 67% shared a rig 1-10 times in the last month, 13% approximately 30 times, and 7% approximately 50 times.

Reasons given for rig-sharing included general sociability, the criminal offense status of possessing a rig, and the cost of the equipment. The respondents said cleaning of their rigs between uses was complicated by perceived lack of disinfectant in immediate environment, compulsion to inject as quickly as possible, and a belief that the person with whom they were sharing wasn't infected with HIV.

Next Month

The higher profile in the scientific race against AIDS is given to experimental drugs and the development of a vaccine. At the same time, however, other scientists study the interrelationships among the immune system, the nervous system, and psychological stress for clues about vulnerability to the AIDS virus and the body's means to combat HIV infection. Current studies looking at how AIDS relates to a mind-body connection are part of a larger and established field of inquiry called psychoneuroimmunology.

In the May issue of FOCUS, George F. Solomon, MD, a pioneer in the field of psychoneuroimmunology, will consider questions relevant to HIV infection. These include whether an "immunosuppression-prone" personality can predispose one to HIV infection, whether stress can trigger HIV infection from a latent to an active state, and whether psychosocial factors are related to progression of disease. Solomon is a professor of psychiatry in residence at UCLA and an adjunct professor of psychiatry at UC San Francisco, where he has been a member of the Biopsychosocial AIDS Project since 1983.

FOCUS A GUIDE TO AIDS RESEARCH

SUBSCRIPTIONS/CORRESPONDENCE

The amount of research information now appearing in the medical and lay press staggers most AIDS health care and service providers. The goal of FOCUS is to place the data and medical reports in a context that is meaningful and useful to its readers.

Subscriptions for 12 monthly issues of FOCUS are \$24 for California residents outside the San Francisco Bay Area, \$36 for other U.S. residents, and \$48 for individuals and organizations in other countries. Make checks payable to "U.C. Regents"; address subscription requests and correspondence to FOCUS, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884. Also available are back issues of FOCUS, for a description of these, contact the office at the above address or call (415) 476-6430. © 1987 UC Regents.

MOVING? To ensure uninterrupted delivery of FOCUS, send your new address four weeks before the change becomes effective.

FOCUS A GUIDE TO AIDS RESEARCH

Volume 2, Number 7

June 1987

Learning to Care: Health Care Workers Respond to AIDS

Molly Cooke, MD

The emergence of AIDS has stimulated enormous amounts of research since its first description in 1981. The majority of investigative efforts have been directed toward identifying the cause, describing the natural history, and managing the clinical complications of HIV infection. However, AIDS has other important effects that have been recognized, if not extensively studied, since the beginning of the epidemic.

Care of people with AIDS elicits in health care professionals strong responses which affect the experience of both health care workers and their patients. If current projections of the prevalence of AIDS in the year 1991 are correct, 1500 physicians delivering full-time AIDS care will be required to meet the needs of the patient population in the United States. It seems both unrealistic and undesirable to expect that this care will be provided entirely by AIDS specialists and referral centers. To the extent that people with AIDS are cared for in nonspecialty centers, correspondingly larger numbers of physicians, nurses, and supporting health care workers will be involved. As the demands on the health care system intensify, it will become increasingly important that we understand how medical professionals feel about this challenge.

Early Problems with Provider Response

At the onset of AIDS, patients were few and their unusual opportunistic infections provoked intellectual curiosity in physicians. However, as the pattern of the epidemic became clear and health care professionals became aware that the opportunistic infections reflected an underlying immunodeficiency transmitted as an infectious disease, fear replaced curiosity. Failure of professional responsibility with significant clinical consequences was not uncommon. One patient was sent 400 miles by private automobile to a public hospital with a dangerously low arterial oxygen content because the emergency physician in the referring hospital felt the patient was "unsuitable" for his facility. In one hospital an indicated autopsy was left undone because the pathologist refused to perform the examination and explained, "I have four children." Several AIDS patients missed their meals because meal trays were left outside the doors of the patients' rooms. These fairly egregious problems and others like them produced hurt and anger as well as physical discomfort for people with AIDS. This lack of adequate care also engendered indignation among those health care workers who were meeting their responsibility. Sometimes media coverage of these events generated a public outcry.

Health care workers who refuse to care for patients with AIDS are not the only ones to experience strong emotional and psychological responses. People who have worked extensively with AIDS patients — in research studies and compassionate clinical care — describe their own strong feelings about their work. Their responses are likely to be even more important than the reactions of the occasional providers who find themselves absolutely unable to confront AIDS.

A Medical Housestaff Study

Recognizing the distress among physicians who were providing substantial amounts of AIDS care, Barbara Koenig of the Division of Medical Ethics at the University of California San Francisco (UCSF) and I undertook in late 1983 a study of housestaff attitudes toward AIDS. We surveyed the entire medical housestaff with a questionnaire which addressed the estimation of risk of infection to health care workers and the anxiety and

As health care workers prepare to meet the technical challenges of AIDS, it is important to also address the psychological and emotional responses provoked by AIDS care.

satisfaction elicited in the care of AIDS patients. It is important to remember that although the AIDS virus had already been isolated, the etiology of AIDS was still uncertain in the minds of health care workers and the HIV antibody test was still unavailable. Because of this uncertainty and since experience with HIV-related disease was relatively brief, it was unclear to what extent the work of health care professionals put them at real risk of acquiring AIDS.

Sixty-eight percent of the 56 respondents felt that health care workers were at risk of acquiring AIDS by virtue of their occupation. Men and women differed significantly in their estimation of risk; 84% of men compared to 48% of women who agreed that health care workers were at risk. This sense of risk affected the degree of precautions felt necessary for work with AIDS patients. Men reported significantly more frequent use of a mask and gloves and admitted to avoiding unnecessary entry into the patient's room. Anxiety was very common; respondents estimated that more than 80% of the housestaff were at least "mildly anxious" and that 20% were "very anxious." Only two respondents denied ever worrying about getting AIDS.

The survey revealed several other indications of worry about AIDS among respondents. Thirty-five percent reported being preoccupied about giving AIDS to a family member; 20% reported dreams or nightmares about AIDS; and 18% reported symptoms which they thought were suspicious of AIDS. Men were more likely than women to report preoccupation, dreams, and nightmares. They also rated their anxiety significantly higher than did the women respondents.

continued on page 2

A Publication of the AIDS Health Project University of California San Francisco

FOCUS is a monthly publication of the AIDS Health Project, an organization concerned with AIDS Prevention and Health Promotion. Funded by a grant from the state Department of Health Services to the San Francisco Department of Public Health, FOCUS presents AIDS research information relevant to health care and service providers. The AIDS Health Project is affiliated with the University of California San Francisco and the Department of Public Health. © 1987 UC Regents. All rights reserved.

Executive Editor and Director, AIDS Health Project: James W. Dilley, MD; Editor: Michael Helquist; Medical Adviser: Stephen Follansbee, MD; Administrative Assistant: Joseph Wilson.

THE
**AIDS
HEALTH
PROJECT**

Learning to Care . . .

continued from cover

As a group, the housestaff expressed neither satisfaction nor dissatisfaction with AIDS care. Greater satisfaction in AIDS care was correlated with increased contact with AIDS patients and increased levels of training. Sixty-eight percent of house officers who have cared for 10 or fewer AIDS patients reported disliking AIDS care compared to 35% who have cared for more than 10 AIDS patients.

We concluded that medical housestaff were responding to AIDS with expertise and compassion. At the same time care of a large number of people with AIDS produced consternation relating to questions of risk, the moral values of the provider, educational balance and training, and physician satisfaction with the doctor-patient relationship.

Provider Response — The Current Situation

It might be argued that the reproducible information on the seronegativity of health care workers involved in AIDS care and the extremely low risk of seroconversion after needlesticks would decrease the importance of fear about occupational risk as a significant early response among providers. However, this does not appear to be the case. Contact with physicians, nurses, hospital staff, hospice volunteers, and other groups leads me to believe that fear remains the overwhelming early response. In like manner, the earliest expressed worry involves concern about risk.

Sophistication does not appear to be an antidote to fear. Recently I was asked by a well-informed member of a medical audience if the antigenic instability of HIV and the recent isolation of a second AIDS virus in West Africa did not call into question our assertions about the low risk of occupational transmission. In time, however, people who are motivated or obligated to work with AIDS patients master their anxiety about their risk as providers. At that point, other issues surface which tend to be formulated as triage concerns. Medical educators and trainees worry about the impact of a high volume of AIDS care and educational balance at training institutions. Hospitals and planners wonder how much medical care is appropriate in the face of a poor prognosis in the era of cost containment.

Talking to people who are confronting their responses to AIDS care has made me question whether the articulated concerns about the work are the real impediments to a satisfying and caring professional relationship. Recently I listened to a nurse present for an hour and a half the data on occupational transmission and needlesticks. She concluded, "I guess I believe it's safe, but I still don't want to do it." We must address these underlying issues — as well as the ostensible ones — if AIDS care is to be gratifying for both the patient and the health care worker.

AIDS care raises issues of morality, impotence, and mortality — all difficult for health care providers. It is clear that health care providers have strong negative feelings about diseases which they perceive to be self-inflicted. These feelings are intensified further if the associated behaviors are stigmatized (intravenous drug use and sexual activity among men) rather than accepted or partially accepted (alcohol or cigarette use; sexual activity between men and women). Despite our societal preoccupation with all things sexual, a broad Puritanical streak of shame and embarrassment persists. In addition, many health care workers are deeply uncomfortable with homosexuality. This discomfort with homosexuality may account in part for the differences in the response of men and women medical students in the UCSF study. On the other hand, AIDS care may have been more difficult for some of the men in the study due to the particularly intense empathy that some male physicians feel for their patients who often are so similar in age and circumstances to themselves.

The sensitivity of healthcare workers may cause problems in other ways as well. Health care professionals like to cure patients, and yet AIDS forces us to confront our own impotence

at a time when recent advances in medicine and science suggested that disease could be totally mastered. The frustration and despair we feel are often profound when we confront the limitations of our own capabilities. Finally, AIDS presents all of us with images of our own mortality. The skin lesions, the emaciation, and the dementia overtaking robust and productive people in the prime of their lives are truly and deeply horrifying. Health care workers are, if anything *more uncomfortable* with the transience of the flesh than lay people. As a result, we are particularly horrified by AIDS.

Helping Providers to Care

This study of medical house officers demonstrated that, although they often found it difficult, the medical house staff wanted to take good care of people with AIDS. This desire is expressed by many health care workers: doctors, nurses, hospital support staff, and volunteers. However, many providers worry that they will not be able to meet the needs of their patients. As health care workers prepare to meet the technical challenges of AIDS, it is important to also address the psychological and emotional responses provoked by AIDS care. To some extent this is an educational issue. Health care workers must be confident in their clinical abilities to assess and manage the complications of AIDS. They require accurate and up-to-date information about the risks of occupational transmission.

Experience with providing counseling to health care workers involved in AIDS work demonstrates that education alone is not a sufficient intervention. A broad range of interventions including stress reduction, counseling about countertransference, information about homophobia and negative reactions to intravenous drug use, grief counseling, and burnout may alleviate the discomfort and distress experienced by these medical professionals.

Conclusion

Care of people with AIDS is difficult. There is far too little that we can do in the face of what often seems a relentless destruction of mind and body. Despite the difficulties of the work, many doctors, nurses, technicians, and volunteers are delivering AIDS care with grace, compassion, and strength. If we are to meet the needs of our patients, we must understand better the skills that those providers are using. With this knowledge we can help increasing numbers of people find gratification and hope in this work.

Molly Cooke, MD is Assistant Clinical Professor of Medicine at the University of California San Francisco and San Francisco General Hospital. Dr. Cooke presented the findings from this study at the Third International Conference on AIDS held in Washington, D.C. earlier this month.

Editor's note: Future issues of **FOCUS** will address in greater detail concerns raised in this article; specifically, countertransference, understanding homophobia, and coping with grief.

A PERSONAL VIEW: The following reflections are excerpted from a commentary (JAMA, December 12, 1986) written by Steven D. Pearson, a medical resident at San Francisco General Hospital:

"AIDS, without doubt, will be the most profound teacher in our emotional education as physicians. . . . Both the worst and the best of our experiences in medicine, usually told only to colleagues in the dark of a late night, are experiences with AIDS patients. Love, hope, and humanity can be found in their stories. To keep them in view, however, is not easy — a goal to which more explicit thought must be applied. . . . Residents need structural changes in their training to keep from being inundated with AIDS patients. Residents and students need more emotional support and guidance to survive the burden that continues to grow. AIDS is here to stay. As we continue to care for its victims, it is time we turn to help the healers as well."

INFECTIOUS DISEASE ALERT

A semi-monthly update of current developments
in infectious disease and immunology

ISSN 0739-7348

Volume 6 Number 19

July 1, 1987

AIDS EPIDEMIC: NEGLECTED ISSUES

The emergence of AIDS as an epidemic has profoundly affected the practice of clinical medicine in this country and the world. In its beginnings, AIDS was a novelty. It represented a model of immune deficiency which could be used to mold a better understanding of how cells of the immune system functioned. Now the epidemic has grown to such proportions that many institutions and practitioners are less anxious to assume primary responsibility for caring for this illness. Farber and Kaplan outlined a more comprehensive multidisciplinary approach for caring for AIDS patients and addressing the disease.

Educational programs must be created or expanded; schools must openly develop preventive programs on this subject. Local communities must find new ways and resources to incorporate educational elements into their constituents. Long-term and home care programs must be developed. AIDS is a chronic illness; longitudinal or intermediate care is needed. Economic incentives should be developed which will allow hospitals to convert empty wards into long-term care or hospice facilities. Some hospitals may require new freestanding structures; others may be added to existing institutions. Better reimbursement is required in order to provide the care required for these patients. Outpatient economic support must be developed to lessen the enormous financial burden now relegated to unnecessary inpatient management.

Federal funding of full-time physicians, social workers, and others are necessary incentives for providing a better quality of care. Facilities carrying large numbers of AIDS patients need appropriate compensation for their burden. Patients who lack financial support need better government support for their illness. AIDS remains a large social problem. Hospital-based social workers and case managers need to be developed expressly for caring for the unique problems of the AIDS patient. Social support groups are also needed outside the hospital. The government must develop regional clearinghouses for AIDS information. Screening for AIDS must be advocated. This screening, however, also requires aggressive counseling. Emphasis should be placed on preventing vertical transmission of this illness.

EDITOR: Jeffrey E. Galpin, M.D. **MANAGING EDITOR:** Lawrence A. May, M.D. **ASSOCIATE EDITOR:** Marvin Turck, M.D. **EDITORIAL ADVISORY BOARD:** James D. Cherry, M.D., Professor of Pediatrics, Chief, Pediatric Infectious Disease, UCLA School of Medicine. **Anthony C. W. Chow, M.D.,** Professor of Medicine, Chairman, Division of Infectious Disease, University of British Columbia. **Sydney M. Finegold, M.D.,** Professor of Medicine in Residence and Professor of Microbiology and Immunology, UCLA School of Medicine; Associate Chief of Staff for Research and Development, Wadsworth VA Medical Center. **Lawrence Freedman, M.D.,** Professor of Medicine, UCLA School of Medicine; Associate Chief of Staff for Education, Wadsworth VA Medical Center. **Sherwood L. Gorbach, M.D.,** Professor of Community Health and Medicine, Tufts University School of Medicine. **Benjamin M. Kagan, M.D.,** Professor Emeritus of Pediatrics, Cedars-Sinai Medical Center, UCLA School of Medicine. **David T. Kingsbury, Ph.D.,** Associate Director, Biological, Behavioral and Social Sciences, National Science Foundation; Professor of Medical Microbiology and Virology, University of California, Berkeley. **A. Martin Lerner, M.D.,** Clinical Professor of Medicine, Division of Infectious Diseases, Wayne State University, School of Medicine. **Stuart Levin, M.D.,** Professor and Associate Chairman, Department of Medicine; Director of Infectious Disease, Rush Medical College/Presbyterian-St. Luke's Medical Center. **Robert C. Moellering Jr., M.D.,** Shields-Warren Mallinckrodt Professor of Medicine, Harvard Medical School; Physician-in-Chief, New England Deaconess Hospital. **Stephan Targan, M.D.,** Professor of Medicine, Director of UCLA Inflammatory Bowel Disease Research and Clinical Center. **Samuel Eric Wilson, M.D.,** Chairman, Department of Surgery, Harbor-UCLA Medical Center; Professor of Surgery, UCLA School of Medicine.

This is an educational publication designed to present scientific information and opinion to health professionals to stimulate thought and further investigation. It does not provide advice regarding medical diagnosis or treatment for any individual case. It is not intended for use by the layman.

Address all editorial and subscription correspondence to American Health Consultants, 67 Peachtree Park Drive, NE, Atlanta, GA 30309. (404) 351-4523. Customer Service Number: 1-800-221-3908.

Copyright © 1987 by American Health Consultants, 67 Peachtree Park Drive, NE, Atlanta, GA 30309. All rights reserved. No part of this newsletter may be reproduced in any form — by microfilm, xerography, or otherwise — or incorporated into any information-retrieval system, without the written permission of the copyright owner. Published semi-monthly. Subscription price - USA, US possessions, and Canada: \$70 per year. Student/Resident rate: \$35. Elsewhere: \$80 (Student/Resident: \$45) per year. For 25 Category 1 CME credits add \$75. American Health Consultants is accredited by the Accreditation Council for Continuing Medical Education to sponsor CME for physicians.

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.

AMERICAN COLLEGE HEALTH ASSOCIATION
TASK FORCE ON AIDS

REPORT FOR 1986-87

December 15, 1986

Richard P. Keeling, M.D., Chairman

The Task Force on AIDS is working on six major new projects this year, several of which were identified as important needs during the evaluation process we completed last summer. They include:

1. The Working Group on Psychosocial Issues and Support Services of the Task Force is writing a report on the psychosocial issues of AIDS as they apply specifically to students in higher education. This document will be published as a supplement to "Coping With AIDS," a booklet produced by the National Institute of Mental Health. Our work on the supplement is commissioned by the National Institutes of Mental Health under a federal contract, which we acquired in a competitive bidding process last summer. Our associates in the project are Johnson, Bassin, and Shaw, Inc., a Washington-area consulting firm, and the National AIDS Network. It is important to note that this is the first federal grant or contract ever received by the ACHA. The Working Group met with representatives of the NIMH, the National AIDS Network, and our consulting firm in Washington in early December, and submitted a detailed outline of the text for approval in mid-December; our first text draft is due in January, with completion of the work scheduled for March.

2. The Working Group on Psychosocial Issues and Support Services is also working on a more detailed, practical, "hands-on" document which will function as a workbook for college and university health services to use in developing, identifying, and structuring support services for people with concerns about AIDS. During an initial meeting in Philadelphia in August, we developed a rough sketch; a subsequent meeting in Washington just prior to the NIMH meeting in December allowed us to refine a second draft and to define the final direction of the document. We will meet again in Berkeley in late January just after the AIDS Conference there, and we anticipate completing the workbook by the end of the second semester.

3. The Working Group on Clinical Issues has the ambitious goal of preparing a useful guide for clinicians in college and university health services to use in responding to students with concerns or

symptoms. Time and travel constraints have forced the Group to meet in small sets in Charlottesville, Richmond, and Washington, but from those meetings have emerged the general design and structure of what should be an excellent and helpful document; it also should be complete by late Spring. We had hoped to receive a grant from the American Foundation for AIDS Research to assist in the development of these materials, but our good fortune in the case of the NIMH contract was not repeated.

4. The Working Group on Educational Programs is reviewing the educational guidelines and content suggestions made in the Special Report last spring and is revising those to take into account new epidemiologic data and new clinical information (for example, about neuropsychiatric complications and presentations of AIDS). This material should be ready for distribution by the end of the second semester, as well.

5. Several members of the Task Force are participating in an important meeting on AIDS on the college campus in January. Sponsored by the University of California at Berkeley and the State of California, this conference will provide good opportunities for education and discussion.

6. The Task Force is arranging a three hour update workshop on AIDS for the ACHA Annual Meeting in Chicago. To be presented on Wednesday, May 27, this session will use a multiplicity of presentation formats and styles and will emphasize the important issues and questions facing those in our field.

In addition to these projects, the Task Force continues to provide information, speakers, and answers for our colleagues and to work with individual institutions in doing workshops and programs. We re-evaluate our educational materials periodically, and have revised "What Everyone Should Know," the basic AIDS information pamphlet, this year. We are working now on a revision of the old ACHA "Sexually Transmitted Diseases" brochure, which will involve collapsing some of the risk reduction information from the current illustrated "Safe Sex" brochure into text about other sexually transmitted diseases. We are responding to the wishes and needs of many who have asked for a shorter videotape on AIDS for use in 20-30 minute programs; we hope to have this ready shortly after the first of the year.

COMMUNICATION #2-19

To: ALL MEMBERS of the ACHA Task Force on AIDS

From: Rich Keeling *R*

Date: May 6, 1987

Method: Overnight express mail

Annual Meeting Plans: After a multitude of phone conversations and discussions, the following has emerged as our plan for the AIDS Colloquium on Wednesday afternoon, May 27. Finishing touches still are needed and many details remain to be worked out, but this is at least the general format and pattern.

1:00-2:20 PM: General Session

Introduction - *Rich Keeling*

Update on AIDS - *Rich Keeling*

Multiple format short highlights dealing with major issues

Antibody testing, confidentiality, record-keeping, women's issues, psychosocial/support issues, risk assessment, educational resistance, developmental issues in AIDS education -- *Annie Lomax, Jeff Gould, Paul Grossberg, Lee Wessel, Doug Conaway, Cathy Kodama, Bob Mirag, Chris Lyman, Rich Keeling*

[some of these will be quick role plays; others short discussions; some will use planted questions in the audience; some will involve hypothetical scenarios acted and discussed, etc etc]

AIDS: Personal Perspective, a Year Later -- *Terry Weisser*

2:30-3:45 PM: Breakout Sessions (Workshops)

Session 1: Risk Assessment and Antibody Testing
Paul Grossberg and Lee Wessel

Session 2: Educational Strategies and Developmental Issues in Education
Annie Lomax and Jeff Gould

Session 3: Women's Issues in AIDS
Chris Lyman and Harriet Mogul

**Session 4: Use and Development of Audiovisual
Materials in AIDS Education**

Dominic Cappello and Cathy Kodama

**Session 5: Student and Community Groups in AIDS
Education and Services: Urban and Rural Experience**

Doug Conaway, Joel Gray, and Leah Ingram

[Joel Gray and Leah Ingram are from the University of Iowa in Iowa City. Joel has been involved in an effective grassroots effort to provide AIDS education and services in rural Iowa and is a member of a task force dealing with rural issues. Joel and Leah will present special considerations of the rural focus and Doug will discuss the organization of programs and services in areas with more resources]

**Session 6: Psychosocial Issues and Support
Services**

Terry Weisser and Rich Keeling

As I said a little earlier, we still have lots of details to work out, especially about the multiformat section of the big general presentation. Some of that we will accomplish by phone in the next week; other details will wait for Chicago. Please remember our Task Force meeting on Tuesday night in Chicago.

Major Issue for Consideration Before and During Chicago Meeting: The CDC/Public Health Service have sent out RFP's for \$6 million total awards for AIDS education programs on a national scale. One of the major foci of their interest is in college/university populations, and they specifically have indicated that an award will be made for educational programs involving college health centers. Right up our alley. After reading the grant information and discussing this with Steve Blom, I think that we should go for this money. Somebody is going to get it. If we don't, we will be in the bizarre position of having another organization or firm come in and structure AIDS education on college campuses. I will need all of your help, obviously, both in preparing the proposal and in administering and doing the work if we get it. But it presents a wonderful opportunity to do some great stuff with real money. The deadline for the grant proposal is in the middle of July, so we have a little time to get ready for it. Please be thinking about ways to structure AIDS education programs on a national scale. Included in this mailing is a copy of the preliminary information from the CDC.

A particular complication: the CDC is having a meeting in DC to discuss the grant and its implications. When

is the meeting? You guessed it. Right in the middle of the Chicago sessions, probably on the same day as our AIDS Colloquium...

Included in this mailing are a lot of other things:

1. **the NIMH Report.** This final document is the supplement to "Coping with AIDS" produced by the Working Group on Psychosocial Issues. Special thanks to Chris Lyman, Annie Lomax, Terry Weisser, Cathy Kodama, and Lee Wessel for an extraordinary amount of time and effort in writing, reviewing, rewriting, critiquing, and editing. I think the final product is excellent and is a real credit to the ACHA. I plan to have a bunch of copies of this made and shipped to Chicago so that it can be handed out in the AIDS Colloquium to all the audience.
2. An important article on **Condom Sense** from the JAMA last week.
3. A brochure describing an interesting if completely misguided and probably immoral program called "**Safe Love International.**" Read for yourself.
4. A copy of the new, printed, nicer version of "**What Everyone Should Know.**" This will also be available at the Chicago meeting.
5. An unsettling paper called "**Do Something**" being distributed in airports and other places by certain groups.
6. A "**Consumer Guide to Testing**" printed in a recent issue of *US News and World Report*.
7. "**A Time of Testing,**" a longer article about testing from the same issue of USNWR.
8. A copy of an article on application of section 504 to college and university situations, from the Journal of College and University Law.
9. A copy of my **Annual Report** for the Task Force.
10. An article on Section 504/AIDS/higher education by Laura Rothstein.

I will likely be communicating with some or all of you again before we go to Chicago. I very much look forward to the good times and good work of being together there, and I hope for the same wonderful spirit we enjoyed together last year. I want to acknowledge, by the way, all of the birthday greetings I got...especially, perhaps, the helium-filled

balloons delivered by a large, grunting, chest-beating gorilla. They arrived right in the middle of one of my medical student teaching sessions, much to the delight of the students...courtesy of Annie Lomax and Chris Lyman. All I can say is: just wait. 😊

Take good care, travel safely, and be ready for Chicago.

Lia

SCHOOL HEALTH EDUCATION TO PREVENT THE SPREAD OF AIDS

CDC's initiative to help schools nationwide provide effective education to prevent the spread of AIDS will incorporate five broad strategies.

1. Cooperative agreements will be awarded to national organizations that have the organizational capacity, experience, and constituencies to help schools in communities across the Nation provide effective education about AIDS. Illustratively, cooperative agreements will be awarded to national organizations that respectively can: represent the interest of parents, school boards, school administrators, and teachers; assist all State departments of education to help schools in their State provide effective education about AIDS; help colleges and universities nationwide provide effective education about AIDS for their students; help colleges of education provide effective inservice and preservice teacher training about AIDS for current and prospective teachers; assure that effective education about AIDS is provided for Black youth; assure that effective education about AIDS is provided for Hispanic youth; etc. A national coalition of these and other private- and public-sector organizations will convene periodically to plan complementary activities, avoid duplication, and implement a national (instead of Federal) program.
2. Cooperative agreements will be awarded to assist about 10 State and about 12 local education departments that serve jurisdictions with the highest cumulative incidence of AIDS to provide intensive education for school-age populations in these high risk areas. Each education department will be required to work with its corresponding health department; and will be required to help provide education for school-age populations that may not be attending schools.
3. Additional support will be provided to each of three local and one State department of education that are funded to implement AIDS education programs, to also establish training and demonstration centers. Support consequently will be provided to at least 300 local and State education department personnel from other cities and States to attend these centers and receive assistance for implementing effective school health education about AIDS in their own jurisdictions
4. Assistance will be provided to assure that relevant private sector organizations can develop, evaluate, and disseminate a variety of accurate and effective AIDS education curricula and materials. Relatedly, CDC will establish, continuously update, and increase the availability of an annotated computerized bibliography of relevant AIDS educational materials, curricula, programs, and resources. A compendium of selected educational materials, curricula, programs, and resources periodically will be published and disseminated.
5. CDC will compile, synthesize, apply, and disseminate the results of research that could improve the effectiveness of school health education to prevent the spread of AIDS; and will assist national, State, and local agencies to evaluate and consequently improve their program efforts.

DO SOMETHING!

AIDS is 100% fatal. No cures or vaccines to protect against it are expected to be developed for at least five years and, even then, the prospect for them does not look good at all. The virus is transmitted through blood, tears, semen, saliva (N.B.!), and biting insects such as ticks and mosquitoes. Even the medical and media establishments are finally beginning to admit most of these terrifying facts (cf. Newsweek, 11/10/86, pp. 20-21). If present growth rates are not checked, 35% to 40% of American will die from this disease by the year 2020. The odds are very good that you or your child will be one of them. In its potential epidemic proportions, the present AIDS crisis rivals even the Black Death which wiped out one quarter of the population of Europe between 1347 and 1350. AIDS is a far greater threat to our survival than nuclear weapons (frightful though they are) because this dreaded scourge is killing thousands of people this very minute.

It is not just a matter of "safe sex" and very careful kissing. A truck load of Surgeon General Koop's condoms will not solve the problem. Eating in restaurants, drinking from public fountains, and (yes) casual contact with infected persons are now risky business. WRITE OR CALL YOUR LOCAL, STATE, AND NATIONAL HEALTH AUTHORITIES TO DEMAND THAT THEY IDENTIFY AND QUARANTINE AIDS CARRIERS. AIDS is more devastating than Tuberculosis, Small Pox, Polio, Leprosy, Typhoid Fever, and Cholera all taken together. If individuals stricken by those diseases can be isolated from the rest of society, why should not those who spread the AIDS virus? This is not an issue of civil liberties; it is a question of life and death for the whole nation.

A concerned citizen

(Please make copies and show to your friends, relatives, and political representatives.)

Thought you might want
to see this -

(I found it
in Van R. H.)

Nancy M.

Everything you need to know about the AIDS test—whether to have it and what a positive test result means to your job, your rights and your insurance

A CONSUMER GUIDE TO TESTING

MEDICAL MATTERS

Q I'm not homosexual, and I don't inject drugs. Should I be tested for AIDS?

Yes, if you fall into one of the following categories: You have had more than three or four sexual partners in any one of the last five years; you are planning a pregnancy; you have had sexual contact with someone you've since learned has AIDS, uses drugs or is bisexual, or you are sick and your doctor recommends it.

Q If I've had a blood transfusion, do I need to be tested?

If you got the transfusion between the fall of 1978 and May of 1985, there is a very slim risk that you may have been exposed to the virus. A test is advisable if: (1) More than one transfusion was performed, (2) the procedure was carried out in New York, San Francisco or another city with a high incidence of AIDS or (3) the transfusion occurred toward the end of the 1978-85 period, when the risk of contaminated blood was greatest because of the buildup of AIDS carriers.

Q Should I be tested at a public clinic, or by my private doctor?

In terms of accuracy, both are equally good. But they vary tremendously in the amount of pre-test and post-test counseling they offer. To find out whether doctors offer such services, contact your county medical society. To learn what public clinics offer, call your county or state health department. There are also differences in confidentiality. Some doctors keep a record of the test in a patient's file, where staff members can see it. No public clinics keep records by name. On the other hand, you may feel uncomfortable going to a public clinic, which is open to public view.

Q How is an "anonymous" test different from a "confidential" test?

Sometimes, to the public's confusion, the terms are used interchangeably. Public-health officials define them as follows: In an *anonymous* test, your name is never requested or recorded. Your blood is coded with a number that you must have when you come, in person, to get your results. If you forget or lose your code number, you will have to have the test repeated. In a *confidential* test, your name is recorded, but all aspects of the test—including your name and the result—are kept private. Unlike anonymous testing, your physician can locate you if a medical reason arises.

Q I've seen ads for testing by nonprofit or private groups that claim to be faster or more circumspect. Some charge a lot. Others don't. Is there a reason to use these services instead of a public clinic or my doctor—or to avoid them?

They may be faster, but no more circumspect than

public clinics. Since most of these groups contract the tests out to well-regulated biotech laboratories, the results should be reliable. It's not worth the extra cost unless speed is particularly important to you or you want to be screened for additional venereal diseases. Many of these groups test for such diseases.

Q Is there any danger to me from the test itself?

No. A new needle is used to draw blood for each patient, so there is no possibility of contamination.

Q What does the test actually test for?

It detects antibodies produced by the immune system to fight off the virus. It does not directly test for the virus, which hides inside the body's cells.

Q Can I have AIDS antibodies without the AIDS virus?

It's theoretically possible. If you received a vaccine for a deadly form of hepatitis called hepatitis-B, it was made from the blood of homosexuals, the people likeliest to have the disease. Any AIDS virus in the blood was killed, but the antibodies to it might still exist and be passed on to you. This is extremely unlikely—for all practical purposes, impossible.

Q How reliable are the laboratories that do AIDS testing?

Very reliable, since the test itself is well-known and easy to do.

Q What is the accuracy of the test?

Almost 100 percent.

Q If it's so accurate, why does it have to be repeated when the result is positive? And why doesn't it have to be if the result is negative?

The test rarely produces a false negative—in blood donors, perhaps once or twice in 100,000 tests. Such a sensitive test pulls in more than the AIDS antibody alone, triggering occasional false positives. So someone who tests positive should be screened by a more specific method, known as the Western-blot test, to confirm the result and be considered definitely positive.

Q If I test negative, does this absolutely prove that I don't have AIDS or carry the virus?

It is strong evidence, but not proof. It usually takes six weeks for the body to produce antibodies against the virus. This means someone could be tested immediately after exposure and not come up positive. After 12 weeks, however, a negative result virtually guarantees that you haven't come in contact with the virus.

Q Does a positive test mean I will contract AIDS and die?

Not necessarily. After five to 10 years, 25 percent to 50



percent of infected people will develop AIDS. Most—if not all—of those people will die.

Q If I test positive, can I do anything to stave off AIDS?

No existing drugs can prevent or cure AIDS, although the new drug AZT relieves severe symptoms in some patients. A good diet and plenty of sleep and exercise seem prudent, since a healthy body can best fight off disease.

BEHAVIOR

Q Should I insist that my partner be tested when I start a new sexual relationship?

If you have any doubts, it's an obvious precaution.

Q Does a positive test mean I should conduct my sex life differently, even if I have no outward signs of AIDS?

Yes. You should try to abstain from sex, because you can infect others even if you don't have any symptoms. If you find this impossible, you should inform all partners that you tested positive and use a condom if you have intercourse. Properly used, it will provide a barrier that's almost 100 percent effective.

Q Should I tell previous sexual partners? How far back? Should they be tested as well?

There's no legal obligation, but as an ethical matter, you should tell them. You should go as far back as 1978, when the virus first appeared. And yes, they should be tested.

Q Even if I test negative, is it a good idea to be tested every few months?

No. It would be better to change your sexual behavior to minimize risk. A test can only reveal the past, while changing your behavior can influence your future health for the better.

CONFIDENTIALITY AND LEGAL RIGHTS

Q If I test positive, can or will the testing facility or doctor release the results? Will they ask for the names of my sexual partners so they can be tested?

In most states, a physician or testing center will release the information to no one but the patient. In Arizona, Colorado, Florida, Idaho, Montana, South Carolina and Wisconsin, however, positive results must be reported to the state health department. California forbids putting positive test information into hospital records.

No law requires doctors to contact the sexual partners of a person who tests positive, or to ask the person to do so. That is left up to health departments, and only in the seven states listed above do health departments get such AIDS information. There is a common-law obligation on doctors, if they are counseling a recalcitrant person, to inform a spouse who is constantly being

Q&A

exposed. There is no such obligation to tell a "significant other," though California and Colorado are considering such legislation. If a doctor knows that someone who tested positive is continuing to have sex with many different people, and the doctor informs one of those people of the risk, he or she could be sued by the original AIDS carrier on the grounds that the common-law right to privacy was violated.

Q Can test results be subpoenaed?

Yes—without the permission of the patient, even in states with confidentiality requirements. To prevent a subpoena, special laws must be on the books. No state has such legislation; Colorado is considering it.

Q Can I be denied a job or fired if an employer learns I've tested positive?

A few places, such as New York City, Los Angeles and San Francisco, have passed laws to protect AIDS victims from discrimination in housing, jobs and access to public places such as restaurants and hotels. All states except Delaware forbid discrimination against the handicapped, and gay-rights groups argue that these laws protect people who test positive. No court has yet decided this issue.

HEALTH INSURANCE

Q Will my group-health policy cover the cost of an AIDS test?

Yes. But this is often not an issue because the test is inexpensive and is usually offered free at public-health clinics.

Q Do I have to tell my health insurer if I've tested positive?

It depends. Thirteen states bar insurers from asking the results of prior AIDS-antibody testing. California, Wisconsin and the Dis-

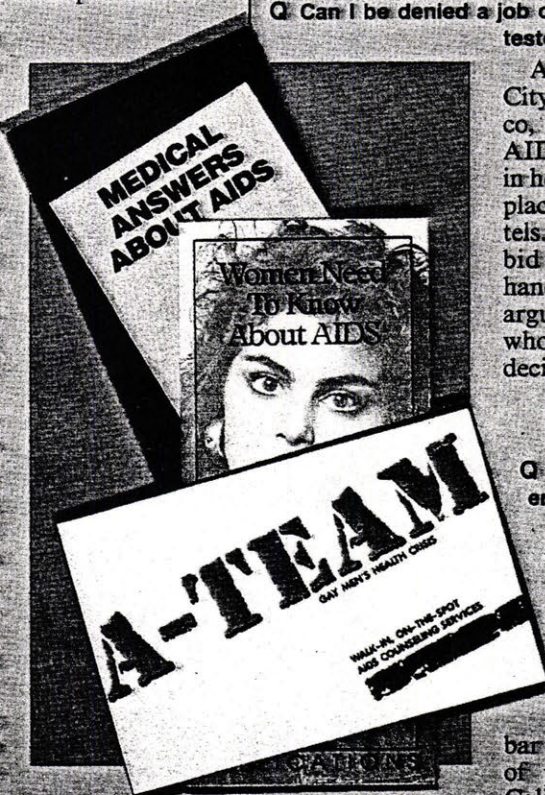
trict of Columbia prevent insurers from testing applicants. On June 1, Wisconsin will allow tests.

Q If my group-health policy pays for the test, can my employer demand to know the results?

No.

Q Can my life or health insurer cancel my coverage or raise my premium if I test positive? Can it be canceled in the future if I develop AIDS?

An insurer can't cancel a policy unless there's evidence of fraud—saying, for instance, that you hadn't taken the test or didn't test positive when the reverse is true—or failure to pay premiums. An insurer also can't raise the premium because of a positive AIDS test. In some cases, insurers have refused to pay claims on people believed to have been infected before they took out the policy. Some companies have claimed that a positive test result is evidence of a pre-existing condition. This issue is far from settled.



APPLICATION FOR MEMBERSHIP IN
SAFE LOVE INTERNATIONAL

FIRST MI LAST NAME

ADDRESS

CITY STATE ZIP

Telephone: ()

☐ Female ☐ Male

Date of Birth: / / (month/day/year)

Date of Most Recent Test: / / (m/d/y)

DIRECTIONS:

1. Mail Completed Application form with remittance of \$40 to:

SAFE LOVE INTERNATIONAL
P.O. Box 34979
West Bethesda, MD 20817

Student's rate is \$20; a copy of a current, valid student's identification card must be submitted.

2. Detach along dotted line. Sign and submit the portion below to the facility where you have your blood tested. Also furnish the facility with a stamped envelope addressed to **SAFE LOVE International**.

I, do hereby authorize the release of my negative AIDS test results to SAFE LOVE International, P.O. Box 34979, West Bethesda, MD 20817.

Date: _____

Print Name: _____

Signature: _____

AIDS FACTS

AIDS: Acquired Immune Deficiency Syndrome is a Lethal, Contagious Disease that is Epidemic

Primary transmission is through intimate sexual contact, infected needles used by intravenous drug users, infected blood products used in transfusions, and birth. Infection can occur from a single sexual experience

At Present There Is NO Effective TREATMENT or CURE for AIDS

It is estimated by some authorities that everyone who has the AIDS virus may eventually develop AIDS symptoms

Antibodies form from two weeks to three months after infection. AIDS Virus can be transmitted before antibodies form. In this three month interval, an AIDS infected person can test Negative for the AIDS Virus

It may take Five to Nine Years before AIDS Symptoms Appear

In the *Near Future*, HETEROSEXUALS will be the Primary Source of AIDS Transmission

Experts predict the AIDS Virus will be the Worst Epidemic in human history, dwarfing the Bubonic Plague of the Middle Ages, and ultimately take millions of human lives throughout the world

Be Tested: Know that you are AIDS free, as *best that modern science and technology make this possible*

Know Your Sexual Partner: Affirm that He/She has been tested with negative results

Learn and Use **SAFE Sex** techniques—Always Use Condoms

AIDS CAN BE PREVENTED THROUGH SAFE SEX!!!

FOR YOUR INFORMATION

Public Health Service

AIDS Hotline: 1-800-342-2437

American Social Health Association

AIDS Hotline: 1-800-227-8922

National Gay Task Force

AIDS Hotline: 1-800-221-7044

THE ORGANIZATION

JAMES W. PRESCOTT, Ph.D.

PRESIDENT, Chief Executive Officer

L. PATRICK GAFFNEY, JR.

VICE PRESIDENT, Chief Financial Officer

PHYLLIS J. GAFFNEY

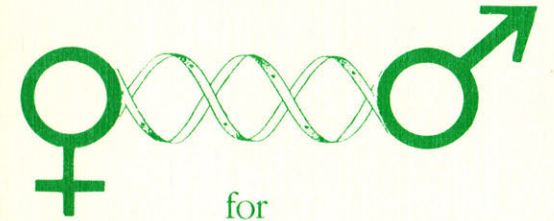
VICE PRESIDENT, Marketing and Membership

GARY E. THOMPSON, Esq.

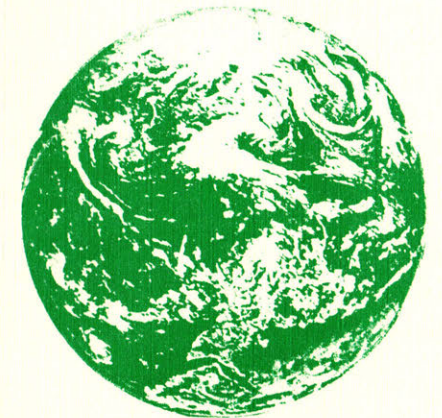
COUNSEL

SAFE LOVE International
P.O. Box 34979
West Bethesda, MD 20817
(301) 540-7802

SAFE LOVE
INTERNATIONAL



**PUBLIC HEALTH
RESPONSIBILITY**



A membership organization that

- serves you
- serves your loved ones
- serves your community

SAFE LOVE — SAFE SEX

SAFE LOVE International is a privately organized consortium of distinguished and concerned citizens, scientists, educators, and health professionals who are committed to optimizing human health and safe sexual habits.

There are millions of sexually active persons who are neither married nor in monogamous sexual relationships who are searching for a stable loving sexual relationship. The nature of AIDS is such that a sexual relationship with one person translates into having a sexual relationship with *every sexual partner* which that one person has had since the mid-1970's. When you are in a sexual love relationship, you are involved in the history of your partner's sexual relationships.

Many may have the AIDS virus and not know that they are carriers. Unknowingly, they can pass this deadly virus to the ones they love. An AIDS test is the only way you can be certain, *insofar as modern science and technology make this possible*, that you and your sexual partner are **AIDS FREE**.*

SAFE LOVE International will help you to take responsibility for your own sexual safety and selection of a safe sexual partner. In this AGE OF AIDS, **SAFE LOVE International** encourages monogamous sexual relationships wherever possible. For those for whom sexual monogamy is not a current option, we particularly urge the practice of safe sex and membership in **SAFE LOVE International**.

*SAFE LOVE International does not guarantee that any member is AIDS free.

CAUTION: Being AIDS-free does not mean that you are free from other sexually transmitted diseases.

How To JOIN

Membership in **SAFE LOVE International** is obtained by:

- having an AIDS test via your personal physician, public health clinic, or other laboratory
- sending your completed membership form and fee of \$40 (students, \$20) to **SAFE LOVE International**, P.O. Box 34979, West Bethesda, MD 20817
- receiving an official copy of your **NEGATIVE AIDS test directly from the testing clinic**
- maintaining your **SAFE LOVE International** status by frequent AIDS testing; a minimum of one AIDS test every six months is required; more frequent testing will place you in a "Safer" category as described under *Membership*

Through membership in **SAFE LOVE International** you will affirm for yourself and others that you are **AIDS FREE**, insofar as modern science and technology make this possible.

If you are a regular blood donor you can request that an official report of your negative test results be sent by the blood bank directly to **SAFE LOVE International**. Do not use the blood bank as a source for AIDS testing; however, you may wish to consider becoming a regular blood donor as a benefit to society.

If an unfortunate **POSITIVE** test results, consult your physician and/or call one of the **HOTLINE** numbers listed for additional information and support. A sister organization for AIDS Positive persons will be developed in the future.

*"I want to love you
but don't ask me to
die for you."*

MEMBERSHIP

Membership is open to all who are concerned about sexually transmitted diseases and the promotion of sexual health and well-being of the individual and society.

Membership in **SAFE LOVE International** requires completion of the membership form; an official copy of a **NEGATIVE AIDS test**; payment of membership dues of \$40 per year (students, \$20); and providing an official copy of a **NEGATIVE AIDS test** at least every six months. Membership cards will be issued upon receipt of the above items and will be valid for a six month period from the date of testing.

The following membership categories will be indicated on the membership card:

Category I. Initial first-time membership.

Category II. Members will have maintained two consecutive **NEGATIVE AIDS tests** that are taken quarterly during the first six months; or bi-annually during the first year.

Category III. Members will have maintained three consecutive **NEGATIVE AIDS tests** that are taken quarterly during the first year; or every six months during the first year-and-a-half.

Category IV. Safest Category. Members will have four or more consecutive **NEGATIVE AIDS tests** that are taken quarterly during the first year; or bi-annually over two years.

MEMBERSHIP BENEFITS include a monthly newsletter with information on AIDS, STDs, and sexual behavior; special literature, book and product offers; local chapter organizations with *sponsored Social/Educational Events* for **SAFE LOVE** members only!

SAFE LOVE INTERNATIONAL

ADVISORY COUNCIL

Elizabeth R. Allgeier, Ph. D.
*Past President
Society For The Scientific Study of Sex*

Mary S. Calderone, M.D., M.P.H.
*Adjunct Professor, Human Sexuality
New York University*

Theresa L. Crenshaw, M.D.
*President, American Association of Sex Educators,
Counselors & Therapists*

Robert T. Francoeur, Ph.D.
*Professor of Biology
Fairleigh Dickerson University*

Sol Gordon, Ph.D.
*Professor Emeritus
Syracuse University*

Rev. James B. Nelson, Ph.D.
*Professor of Christian Ethics
United Theological Seminary of the Twin Cities*

Frank G. Sommers, M.D., FRCPC
*Chairman, Section on Sexology
Ontario Psychiatric Association*

Rev. William R. Stayton, Th.D.
*Faculty, Human Sexuality Program
University of Pennsylvania*

Beverly Whipple, R.N., Ph.D.
*Associate Professor of Nursing
Rutgers University*

SAFE LOVE INTERNATIONAL
P.O. Box 34979
West Bethesda, MD 20817

M



UNIVERSITY OF HOUSTON
LAW CENTER

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

Dear Dr. Keeling:

In response to your letter of March 18, I am sending a photocopy of the article suitable for recopying. As is noted on the first page, NACUA owns the copyright, but releases it for educational purposes, with the other restrictions noted. I am sure that your request fits within that category, so there should be no problem with your recopying the enclosed article for other members of the Task Force.

If you want copies in the reprint format I originally sent to you, you should contact the current editor of the JOURNAL. His name is Professor Fernand Dutille, Notre Dame Law School, Notre Dame, INDIANA 46556. His phone number is (219)239-5668. The cost of having these reproduced may be high, and it would probably take several weeks to obtain reprints.

Please let me know if there is anything else that I can help you with.

Sincerely,

Laura F. Rothstein
Professor of Law

cc: Phillip M. Grier
Executive Director
NACUA

Please note that I have also mentioned the Task Force in my most recent supplement to RIGHTS OF PHYSICALLY HANDICAPPED PERSONS. I would appreciate receiving any relevant information and reports, so that I can incorporate more current information each year when I prepare the supplement.

Higher Education

3

§3.01 Section 504 of the Rehabilitation Act

Page 80, add to note 4:

For a discussion of current issues on campus, see Rothstein, *Section 504 of the Rehabilitation Act: Emerging Issues for Colleges and Universities*, 13 J C & UL 3 (1986). These emerging issues include whether an individual is handicapped within state or federal law (focusing on individuals with learning disabilities, mental conditions, alcohol and drug addiction, and health conditions), whether the individual is otherwise qualified (focusing on standardized test requirements and exclusions based on health impairments), and requirements relating to auxiliary aids and reasonable accommodation (focusing on testing, services for learning disabled students, auxiliary aids such as readers and interpreters, accommodations for persons with AIDS, and accommodations for persons with alcohol or drug addiction or emotional problems).

§3.02 —Handicapped Individual

Page 81, add to end of section:

AIDS as a Handicap

There has been a great deal of recent attention to the crisis involving persons with Acquired Immune Deficiency Syndrome (AIDS), whether they are handicapped individuals, and what legal requirements come into play where there is discriminatory treatment toward individuals with AIDS and AIDS Related Complex (ARC). These issues are discussed more fully in §4.03. However, it should be noted that the way these issues affect the college campus is being monitored by the American College Health Association and the American Council on Education, among others. Up-to-date information can be obtained

from these organizations by contacting the Task Force on AIDS, American College Health Association, 15879 Crabbs Way, Rockville, MD 20855 (301) 963-1100.

§3.03 —Otherwise Qualified

Page 83, add to note 23 before Pavela reference:

See also Goldsmith v New York Psychoanalytic Inst, 22 Empl Prac Dec (CCH) ¶30764, 73 AD2d 16, 425 NYS2d 561 (1980) (MD with Hodgkin's disease in remission was improperly excluded from a program of analysis; the basis for the exclusion was personal fears, not objective information).

Page 83, note 23, delete reference to article by Pavela and substitute:

G. Pavela, *The Dismissal of Students with Mental Disorders: Legal Issues, Policy Considerations and Alternative Responses* (1985).

§3.06 —Testing

Page 85, add to note 36:

The Law Student Division of the ABA recently recommended that Law School Approval Standards be amended to require that schools demonstrate a commitment to full and equal opportunity for physically handicapped persons. It is unclear whether these recommendations would protect learning disabled students. *See generally* 52 USLW 2473 (Feb 28, 1984).

Page 86, add to note 43:

In recognition of the difficulties that learning disabled students have in taking standardized tests, the State of Massachusetts has recently passed legislation that provides that learning disabled students are no longer required to take standardized aptitude tests for admission to Massachusetts colleges and universities. Mass Ann Laws ch 15A, §19 (Michie/Law Co-op 1983). New York University was awarded a grant in 1984 by the Henry and Lucy Moses Fund to enable NYU to admit more learning disabled students and provide work, experience, and classroom accessibility for these students.

Page 86, add to end of section:

A recent Supreme Court decision raises the issue of whether persons with certain chronic diseases or health conditions are otherwise qualified for educational programs. In *County of Los Angeles v Kling*,

AMERICAN COLLEGE HEALTH ASSOCIATION
TASK FORCE ON AIDS

REPORT FOR 1986-87

May, 1987

Richard P. Keeling, M.D., Chairman

The Task Force on AIDS been working on a number of major projects this year, several of which were identified as important needs during the evaluation process we completed last summer. They include:

1. The Working Group on Psychosocial Issues and Support Services of the Task Force has completed a report on the psychosocial issues of AIDS as they apply specifically to students in higher education. This document will be published as a supplement to "Coping With AIDS," a booklet produced by the National Institute of Mental Health. Our work on the supplement was commissioned by the National Institutes of Mental Health under a federal contract, which we acquired in a competitive bidding process last summer. Our associates in the project are Johnson, Bassin, and Shaw, Inc., a Washington-area consulting firm, and the National AIDS Network. It is important to note that this is the first federal grant or contract ever received by the ACHA. After an excellent working session in San Francisco held in conjunction with the Berkeley AIDS Conference and the Mid-Year ACHA Board Meeting, we submitted a first draft. Several revisions followed, and the final draft is now in the hands of the NIMH reviewers. Copies of this important material will be made available to participants in the AIDS Colloquium during the Annual Meeting in Chicago. The actual date for publication by the NIMH is not yet determined.

2. The Working Group on Psychosocial Issues and Support Services is also working on a more detailed, practical, "hands-on" document which will function as a workbook for college and university health services to use in developing, identifying, and structuring support services for people with concerns about AIDS. Completion of this project has been delayed by the need to devote our energy and time to the NIMH contract and the revision of our brochures, but we anticipate completing the Workbook in time to have it delivered to the ACHA membership by the beginning of the Fall Semester.

3. The Working Group on Clinical Issues has the ambitious goal of preparing a useful guide for clinicians in college and university health services to

use in responding to students with concerns or symptoms. Time and travel constraints have forced the Group to meet in small sets in Charlottesville, Richmond, Madison, and Washington, but from those meetings have emerged the general design and structure of what should be an excellent and helpful document; it also should be complete by early Fall.

4. The Working Group on Educational Programs is reviewing the educational guidelines and content suggestions made in the Special Report last spring and is revising those to take into account new epidemiologic data and new clinical information (for example, about neuropsychiatric complications and presentations of AIDS). Working Group Chair Annie Lomax, of the University of Delaware, plans to have this material ready for distribution in draft form by the time of the Annual Meeting in Chicago. A polished, printed version will follow.

5. Several members of the Task Force participated in an important meeting on AIDS on the college campus in January. Sponsored by the University of California at Berkeley and the State of California, this conference was a resounding success. It attracted a great deal of media attention and provided good opportunities for education and discussion.

6. The Task Force is arranging a three hour update workshop on AIDS for the ACHA Annual Meeting in Chicago. To be presented on Wednesday, May 27, this session will use a multiplicity of presentation formats and styles and will emphasize the important issues and questions facing those in our field.

7. We have appointed a new Working Group on Women's Issues in AIDS. Chaired by Christine Lyman, MSW, ACSW of the University of Pennsylvania, this group will make an initial presentation at the Annual Meeting in Chicago and will prepare written materials and guidelines for college health professionals and a brochure for students emphasizing the special needs of women for education and risk reduction.

8. We completed a thorough revision of the basic ACHA AIDS Brochure, "What Everyone Should Know." The new brochure features a better quality of paper stock, an updated and more attractive front cover, new sections on women's issues and concerns for people of color, and a completely revised text which reflects new information in epidemiology, transmission, and risk reduction. The new brochure should be available by the time of the meeting in Chicago.

9. We contributed to the production of the new ACHA brochure on sexual risk reduction, "Making Sex Safer." Derived from materials supplied by Stanford University, the University of Virginia, and the Task Force on AIDS, this new brochure has been a popular addition to the information series.

10. We completed the production of a new ACHA Videotape on AIDS: "Reducing the Risk." This 32-minute VHS format tape features a discussion by Richard P. Keeling, M.D. and is directed at individual college and university students. It addresses common fears and misconceptions and emphasizes the need for safe and responsible decision-making.

11. We have represented the ACHA in several major news stories about AIDS on the College Campus. A recent issue of "Newsweek on Campus" featured interviews with Rich Keeling, Cathy Kodama, and Terry Weisser. Members of the Task Force have been interviewed for and quoted in articles in *Self*, *Prevention*, *Time*, *Newsweek*, *American Health*, the *New York Times*, the *Washington Post*, the *Boston Globe*, the *Philadelphia Inquirer*, the *Los Angeles Times*, and the *Atlanta Constitution*.

12. We continue to represent the ACHA at important national conferences about AIDS. For example: Rich Keeling was an invited speaker at the International Interdisciplinary AIDS Conference in Atlanta in February, and he and Cathy Kodama have been invited to speak at a Symposium on AIDS at Montefiore Medical Center in New York in June.

In addition to these projects, the Task Force continues to provide information, speakers, and answers for our colleagues and to work with individual institutions in doing workshops and programs. We have contributed to AIDS programs on more than 50 college campuses during the past year.

VIC FAZIO
4TH DISTRICT, CALIFORNIA
MAJORITY WHIP AT LARGE

COMMITTEES:
APPROPRIATIONS
BUDGET
DEMOCRATIC STEERING AND POLICY
STANDARDS OF OFFICIAL CONDUCT
SELECT COMMITTEE ON HUNGER



Congress of the United States
House of Representatives
Washington, DC 20515

March 31, 1987

Copies for
ACHA
Task
Force

HOUSE
NO
20515
18
OR THE
RED
904

Richard P. Keeling, M.D.
Director
Student Health Service
Box 378, Medical Center
University of Virginia
Charlottesville, Virginia 22908

Dear Dr. Keeling:

Knowing of your concern for Acquired Immune Deficiency Syndrome (AIDS), I thought you would be interested to know about legislation I recently introduced which addresses the issue of the spread of AIDS.

Earlier this month, I introduced H.Con.Res.70, a resolution with bipartisan support which encourages the television networks to accept advertisements for condoms during certain adult programming as a means to thwart the spread of AIDS.

As you know, concern over the spread of AIDS is increasing with reports that between 1,000,000 and 1,500,000 individuals in the United States are believed to be infected with the virus which causes AIDS. According to Surgeon General C. Everett Koop, beyond abstinence, condoms are the most widely available safeguard against the spread of all sexually transmitted diseases, including AIDS.

A number of affiliate stations have already agreed to accept condom advertisements and all three of the major networks have announced that their local affiliates can accept AIDS-related condom advertisements. ABC has also announced that it will permit public service announcements featuring a statement by the Surgeon General in support of the use of condoms as a means of curbing the spread of AIDS.

H.Con.Res. 70 encourages the networks to accept condom advertising because the threat of AIDS overwhelms all other considerations, including past general policies regarding appropriate and inappropriate subjects for advertisements. The networks can reach audiences from one end of the country to the other. It is my hope that the resolution will move the networks to accept condom advertising to reduce the spread of AIDS.

Sincerely,

Vic Fazio
VIC FAZIO
Member of Congress

VF/sg

844 B UNION AVENUE
☐ FAIRFIELD, CA 94533
(707) 426-4333

PLEASE RESPOND TO:

4811 CHIPPENDALE DRIVE, SUITE 503
☐ SACRAMENTO, CA 95841
(916) 978-4381

117 WEST MAIN STREET
☐ WOODLAND, CA 95695
(916) 666-5521

EDUCATIONAL MATERIALS ON AIDS AND STDS

American College Health Association

ORDER FORM

NEW IN
1987!

"AIDS: Reducing Your Risk"

A videotape that focuses on AIDS prevention for college students and other young adults. Appropriate for use as an introduction to stimulate discussion about risk reduction and safe sex. 25 minutes.

Quantity ordered _____ Videotape (VHS ½" format only.)

Amount Enclosed \$ _____

Prices: ACHA Member Institutions
All others

\$110 each
\$150 each

"THE AIDS DILEMMA: HIGHER EDUCATION'S RESPONSE"

A 90 minute video tape featuring Richard P. Keeling, M.D., Chairman, American College Health Association Task Force on AIDS. Produced jointly with Region IV-West, National Association of Student Personnel Administrators. Covers the history and current development of the AIDS dilemma, information on diagnosis, treatment, prevention; implications for institutions of higher education, and recommendations on policy and action appropriate for such institutions. Based upon the latest guidelines and research published by the ACHA Task Force on AIDS. Appropriate material for all campus administrators as well as for student and other campus organizations.

Quantity ordered _____ Videotape(s) Specify: Beta ½ in. _____

VHS ½ in. _____

U-Matic ¾ in. _____ *

Amount Enclosed \$ _____

Prices: ACHA or NASPA Member Institutions
All others

\$75 each
\$100 each

*Add \$20 for ¾ in. tape

"AIDS on the College Campus" - ACHA Special Report

A publication produced especially for higher education. Covers the following areas: (1) Introductory chapter by Richard P. Keeling, M.D. (2) Institutional Policies and Administrative Issues (3) Confidentiality of Information (4) HTLV-III Antibody Testing (5) Housing Policies (6) Educational Resources (7) Risk Assessment Form. Appropriate for use by campus administrators, residence hall directors, peer educators, and other staff and student leaders on college campuses.

Quantity ordered _____ ACHA Special Report

Amount Enclosed \$ _____

Prices:

Qty

1-4

5-9

10 plus

ACHA Member
Institutions

\$5.00

4.00

3.50

All Others

\$7.50

6.00

5.00

Health Information Series pamphlets

NEW IN
1987!

"Making Sex Safer"

Playing safe is for everyone--men and women, gay or straight. This new four-color brochure features plain talk about common sexually transmitted diseases--what they are and how to prevent them. Specific precautions are described for men and women to reduce the risk of STDs. Includes how-to information on the correct use of condoms.

"Safe Sex"

Up-to-date discussion of facts about safe and unsafe sexual practices. This attractive four-color brochure describes ways to reduce the risk of AIDS and other sexually transmitted diseases. Written in plain, non-medical language.

Quantity ordered _____ Making Sex Safer
_____ Safe Sex

Amount Enclosed \$ _____

Prices:

Qty

1-99

100-999

1,000 plus

ACHA Member

Institutions

\$.40

.20

.15

All Others

\$.50

.25

.20

"AIDS — What Everyone Should Know"

A helpful brochure answering many important questions raised about AIDS. What is AIDS? What causes AIDS? Who gets AIDS? How is AIDS transmitted? How is AIDS prevented? Clearly written, based on currently available information.

Quantity ordered _____ AIDS - What Everyone Should Know

Amount Enclosed \$ _____

Prices:

Qty

1-99

100-499

500-999

1,000-19,999

20,000-29,000

30,000 plus

ACHA Member

Institutions

\$.30

.15

.12

.10

.09

.08

All Others

\$.40

.20

.17

.15

.14

.13

Ship to:

Address _____

City _____

State, Zip _____

Total Amount
of Order \$ _____

Add 5% shipping
and handling \$ _____

TOTAL AMOUNT ENCLOSED \$ _____

Please send check or money order, payable to ACHA and this completed order form to:

AMERICAN COLLEGE HEALTH ASSOCIATION
15879 Crabbs Branch Way • Rockville, MD 20855
(301) 963-1100

Allow 2-3 weeks for delivery.

ALL ORDERS MUST BE PREPAID

COMMUNICATION #2-17

To: All members of ACHA Task Force on AIDS

From: Rich Keeling

Date: March 23, 1987

Method: First Class Mail

Revisions to "What Everyone Should Know:" Thanks very much. I had a few more comments from several of you about the revised revision, most of them minor. Chris Lyman's important suggestion that we include a paragraph on the issue of Women and AIDS and one on People of Color and AIDS resulted in the addition of those sections. The attached sheet contains the text for those new paragraphs, which will follow "Gay Men and AIDS" in sequence. If you have any comments/suggestions about them, please let me know soon. I have sent the text off to Jo Anne Ciperson at the ACHA office, and she has met with the typesetter to work on the new brochure. The idea is to have it be on a little better quality paper and to revise the front cover extensively, but to try not to price it out of range of health services with small budgets.

College AIDS Programming Survey: some of you may have received a survey from a consulting group in New Jersey working with people from AT&T on establishing information needs on college campuses. I completed one for UVA and returned it, requesting a copy of the results. I enclose for your information the results they sent me. I have some reactions, and would be real interested in your comments as well.

Interviews: watch for the appearance of interviews with some of us in major magazines. Terry Weisser and I were both interviewed by *Newsweek's On Campus* for a story in the upcoming issue to be distributed before the end of the academic year. *U.S. News and World Report* interviewed me and a student from UVA for stories on antibody testing and on educational programming.

Chicago Annual Meeting: hope you have all received copies of the preliminary program from the ACHA office. I have proceeded on the general basis described in the past two communications in planning the format and room/equipment requirements for the meeting. Enclosed with this mailing are copies of the room/equipment form, abstract, and CME summary I sent to the ACHA Annual Meeting people in Rockville. Some additional thoughts I've had and been given by others:

The General Session portion: should include an update about AIDS, epidemiology, transmission, prevention, and educational strategies.

Also: Terry Weisser has agreed to present a "revisit" of his personal perspective, a year later. This would come at the conclusion of the general session.

Needs: Several speakers and formats during this General Session to keep it lively. I would plan on doing the introduction/scientific update part; would suggest others on programming, major new issues, etc. Perhaps a panel? Role plays? Help!

The Workshops: some preliminary ideas look like this. These are NOT absolute commitments. Please look, think, and choose among workshops. I'd really appreciate it if all of those coming to Chicago would be willing to participate in one or another of these.

1. **Women and AIDS:** Chris Lyman and Harriett Mogul, I hope. Others?
2. **Educational Strategies/Programs/Problems:** need presenters, perhaps several; fast pace, lots of material. Jeff, Annie, Cathy, others?
3. **Antibody Testing:** clinical, psychological, administrative issues. Paul Grossberg has volunteered to be one of the presenters. Who else?
4. **Safer Sex:** a real need for frank discussion of condoms, lubricants, and how to talk effectively about them, etc. Thinking about Lee; others?
5. **Audiovisual Materials:** making, reviewing, and selecting. I have a tentative commitment from Dominic Cappello at Multifocus, Inc., in San Francisco; he demonstrated a lot of tapes, etc., at the conference in Berkeley. Others to work with him?
6. **Psychosocial Issues:** to highlight some of the important work of the Task Force this past year and prepare for more in the future. Terry might be willing; Howard? Cathy? Others?

Big questions still remain about the workshops; should we rush through them in 45 minutes so they can be repeated, or should we just do each once at a more leisurely (and probably more effective) pace?

I need: your travel plans, your workshop volunteering, and your comments/suggestions.

NIMH Draft: we got back suggestions/comments from the NIMH reviewers. I am combining them with the reviews from members of the Psychosocial issues working group in devising a second draft. Most of the NIMH comments related to editorial rather than substantive matters. More news soon.

As always, my sincere thanks for your help with the brochure. I look forward to hearing from all of you about your plans for the Annual meeting. Write, call, or something. Thanks!

ADDITION TO SECOND REVISION TEXT

WHAT EVERYONE SHOULD KNOW

March 18, 1987

Insert the following new sections immediately following the section entitled Gay Men and AIDS.

WOMEN AND AIDS

Increasing numbers of women are developing AIDS. HIV is transmitted to women through sexual contact and exposure to the blood of an infected person, just as in men. The heterosexual transmission of HIV from men to women and women to men is becoming more common; women may also transmit HIV to each other by sexual contact. It is possible for HIV to be transmitted to a woman during sexual assault.

Women face some unique issues in AIDS. A woman with a positive HIV antibody test -- whether or not she has symptoms -- should protect against pregnancy for two reasons: first, because of the likelihood of transmitting HIV to her child, and second, because pregnancy may speed up the development of ARC or AIDS in the woman herself. There is a very slight chance that a woman could be infected with HIV by artificial insemination. Childbearing is important in the future plans of many men and women; the limitations imposed by HIV infection are very difficult and painful.

PEOPLE OF COLOR AND AIDS

Some people believe that AIDS is mostly a disease of gay white men, but AIDS is a serious problem for people of color. AIDS is almost twice as common among people of color as it should be, given their proportion in our population. Many women and most children with AIDS have been people of color. It is a terrible mistake to think that your racial background protects you against AIDS.

AMERICAN COLLEGE HEALTH ASSOCIATION

Sixty-Fifth Annual Meeting
May 26-30, 1987
Chicago Marriott Downtown
Chicago, IL

BEHAVIORAL OBJECTIVES

PLEASE COMPLETE THIS FORM
AND RETURN BY March 25, 1987, TO:

Program 1987
American College Health Association
15879 Crabbs Branch Way
Rockville, MD 20855

Referring to the instructions on this page, please state below behavioral objective(s) for each of your presentations or portion of the program. (Use other side if needed for additional presentations.)

Author: Richard P Keeling, MD
Presentation Title: AIDS Update
Date/Time of Presentation: Wednesday May 27 1:00-3:45 PM
Behavioral Objective(s):

The learner will be able to identify and explain recent epidemiologic trends in AIDS, to describe educational strategies which are effective on college campuses, to discuss issues in AIDS prevention, and to compare and contrast educational materials.

Instructions. Remember, a behavioral objective differs from an abstract in that (1) it is very brief, and (2) it states the purpose of the presentation in terms of enabling the learner to do something which can be measured. Therefore, the objective should begin with the words "The learner will be able to..." Fill in a short description of what specific tasks a learner could expect to perform after participating in this portion of the annual meeting program.

"Behavioral" terms used in writing objectives include:

to describe	to explain	to identify	to discuss
to compare	to contrast	to recite	to solve
to differentiate			

Avoid words which are subject to many interpretations or which denote activities which are subjective, such as: to know, to understand, to be aware of, to appreciate, to grasp the significance, to enjoy, to believe, to explore. These are not acceptable to accrediting organizations for continuing education.

How The Behavioral Objective Statement Will Be Used. ACHA is accredited as a provider of continuing education for physicians, nurses, and physicians' assistants. The national professional organizations which grant this accreditation require that each continuing education offering be evaluated by those in attendance. The statement of objective(s) for each presentation will be included in an evaluation questionnaire distributed to all registrants. Each person who attends your session will be asked to rate your presentation as to the extent the behavioral objective(s) were achieved.

MEMORANDUM

SUPPLEMENT TO EQUIPMENT NEEDS INFORMATION FORM

To: ACHA Program 1987 Staff

From: Richard P. Keeling, M.D.
Chairman, Task Force on AIDS

Subject: Room and equipment requirements for AIDS Session

Date: March 18, 1987

The AIDS Colloquium will occur on Wednesday afternoon, May 27 from 1:00 to 3:45 PM. This session is organized as follows:

1. An initial general session involving all participants. During this portion, we will present an Update concerning AIDS, educational programming, and major issues on college and university campuses. We will highlight recent and future activities of the Task Force and new and revised publications and videotapes.

Estimated duration: 75 minutes (1:00 to 2:15)

Room requirement: Large theatre-style room with podium/panel table on stage.

Equipment: 35mm slide projector; microphones on panel table and podium; lapel microphone; electronic pointer.

2. Simultaneous workshops; participants may choose which session they will attend. We plan on a minimum of five and maximum of six workshops requiring a like number of rooms.

Estimated duration: 75 minutes (2:30 to 3:45)

Rooms required: will need 5 or 6 smaller rooms. In each, there should be a table in front with three chairs.

Equipment: 35 mm slide projector and blackboard in each room; microphones on table.

Special requirement for one room only: in addition to above, two video-cassette players, VHS 1/2" format.

Thanks for noting these requirements, which were too complicated to spell out on the standard form.

ABSTRACT OF PRESENTATION

AIDS Update, Richard P. Keeling, M.D., Chairman, and Members of the Task Force on AIDS of the American College Health Association.

During the AIDS Update, we will present current data on the epidemiology, transmission, and prevention of Human Immunodeficiency Virus (HIV) infection, focusing on the primary concerns of college communities. We will discuss the new awareness of heterosexual transmission and issues of special interest to women. We will review the special psychological and developmental characteristics of traditional and non-traditional students and emphasize the importance of marketing education and behavior change in ways that will appeal to and be effective in those populations. We will comment on the significant problem of HIV infection and education in people of color. We will present options in written and audiovisual materials and assist participants in reviewing, selecting, or creating their own. We will discuss in detail recommendations for safer sex, including how to encourage students to make careful decisions about sexual activity, negotiate for safer behaviors and use condoms correctly. Special attention will be paid to problems in educational programming -- institutional politics, educational resistance, costs, and the stigmatization of HIV infection. The psychosocial issues of HIV infection will become increasingly important on campuses and we will review the major concerns. The appropriate place of antibody testing and the requirements for effective and safe testing will be discussed.

Thomas P. Pearsall

AT&T Bell Laboratories



600 Mountain Avenue
Murray Hill, NJ 07974-2070
201 582-3000

11 March 1987

Richard P. Keeling, M.D.
Director, Department of Student Health
Medical Center, Box 378
University of Virginia
Charlottesville, Virginia
22908

Dear Dr. Keeling,

The results of our questionnaire dealing with AIDS awareness are enclosed. We hope you find these results useful. Thank you for your participation.

In your capacity as chairman of the AIDS task force for the American College Health Association, would you be able to share your data on the level of HIV infections in the university population? Do you have any estimates on current and projected numbers of carriers?

Sincerely,

A handwritten signature in cursive script that reads "T. Pearsall".

Thomas P. Pearsall

TPP/jw

QUESTIONNAIRE RESULTS:

Remarks and observations:

Because of the long incubation period for AIDS, (5 years on the average), and the age for the onset of sexual activity, a large number of AIDS-related diseases are unlikely to be seen in the near future among the undergraduate university population. However, the university residential campus will be one of the principal environments, if not the major one, where transmission of AIDS viruses will take place. The objective of this survey was to sample the awareness of college and university health services concerning the potential modes of introduction and spread of AIDS to the sexually active, primarily heterosexual student population.

The answers to the survey indicate that the primary orientation of health-care delivery on campus is the treatment of existing health conditions and diseases, rather than epidemiology or preventive medicine. This would seem to be a rational approach to health care in most instances. However, the only existing tool against AIDS is prevention. AIDS is a sexually transmitted disease. Conditions that will promote its spread on campus are (1) a high level of sexual activity, (2) Presence of high-risk individuals among faculty and students, and (3) multiple sex partners. Note that in the context of AIDS, multiple means having more than one sexual partner per five years of school.

Fighting the growth of AIDS infections on campus involves battles on two fronts:

Number one is education of the university community to the threat of AIDS. Eighty-five percent of respondents reported that such programs are already in place. Fewer report the availability of anti-body testing or distribution of condoms.

Number two is the gathering of critical intelligence that is necessary to understand and evaluate both the rate and modes of transmission of AIDS. Areas of particular interest are:

- 1) Incidence of Hepatitis-B. This disease is transmitted just as AIDS is.

- 2) Prevalence of faculty-student sexual activity. Our estimate from independent sources is that about 5% of the faculty (mostly male) are involved each year. These faculty have partners both on and off campus and a higher than average rate of bisexuality, and drug-use.

- 3) Monitoring of AIDS antibody testing results, co-ordinated with state alternative site testing and blood-banking services.

The single most significant result of this questionnaire is the large discrepancy between clinical evidence of AIDS infections and the actual level of infection. It appears that some institutions may have been misled into a dramatic under-estimation of AIDS infections by reliance on clinical data alone. The total number reported in the survey is less than 250. However, we estimate that the number of HTLV-III infections for this group is 6,000. Our estimate is based on CDC data for number of infections by age group and census data on the same age group. Presuming the infections to be spread uniformly over all campuses, a university of 20,000 students might expect to find about 170 AIDS virus carriers on campus at the present time. The average response from this group was 3 infections. Looking at this number from another angle, the ratio of AIDS infections to AIDS deaths is about 100 to 1 for the U.S. population. Multiplying the 64 cases of AIDS reported in this survey by 100 gives a number not too far from our estimate. The inability of university medical personnel to accurately assess the incidence of AIDS infections strikes us as a serious problem that will inhibit the development of effective countermeasures against AIDS.

A common sentiment was a sense of frustration over the ineffectiveness of AIDS-awareness programs sponsored by university health services. The impact of these programs might be improved if faculty, students and staff were kept aware of the number of infected persons on campus on a monthly basis. Such monitoring can be carried out without compromising the confidentiality or anonymity of the individuals being tested. Very few respondents to this survey indicated any activity in this crucial area of gathering epidemiological data.

Thirty percent of the questionnaires were returned. The total student population represented is about 700,000, or about 10% of the university population. Students come from 37 states and 28 countries, on the average. This wide distribution ensures that no college or university should consider itself safe from infection simply because of a low incidence in the region where the campus is located.

Thank you for your participation.



Gareth Parry, M. D.
Dept. of Neurology
Hahnemann University
Philadelphia, Pennsylvania
19102



Thomas P. Pearsall
ATT Bell Laboratories
Murray Hill
New Jersey
07974

QUESTIONNAIRE RESULTS:

30% of the questionnaires sent out were returned. Replies were received from 2 Canadian provinces, 32 states, and the District of Columbia. In particular no replies were obtained from a group of southern states: Alabama, Mississippi, Louisiana, Arkansas, Texas, and New Mexico.

RAW SCORES: DK = don't know (always given in total number of this reply)

1. What is the size of your institution? number of replies

Over 10,000_37 Over 4,000_8 Over 1,000_24 Under 1,000_2 DK_0

2. What is the composition of your institution? number of replies

By sex:

Co-educational_62 >80% male_3_ >80% female_3_ DK_2

By race: in percent

White_83.8 Black_7.5 Hispanic_2.9 Asian_4.4 Other_1.4 DK_13_

3. Geographical Distribution of student population: averaged

How many states are represented?_37 DK_6

How many countries are represented?_28_

4. What is your location environment? number of replies

metropolitan_18 suburban/exurban_15 country/small town_37

5. Incidence of drug use in the last five years: total number of cases

DK, total:_36

intravenous users on campus: students, faculty, other: total_122

students or faculty detained on intravenous drug charges_17

drug-related deaths among students (any drug)_20

6. Profile of sexual activity at the present time:

Please check whether your responses are: number of replies

based purely on estimate_39 survey_2 combination of both_14

What percentage of students:

have little or no sexual activity_26% 0-100%

are heterosexual_86.2%

are homosexual (male)_6.3% 0-100%

(female)_4%

DK_22

are bisexual_3.5%

What percentage of faculty and administration:

have little or no sexual activity_7.9% 0-100%
are heterosexual_86%
are homosexual (male)_6.1% 0-100% DK_45
(female)_5.8%

Faculty/Student sexual activity: number of replies

non-existent_3
fewer than 10 heterosexual incidents per year_13
more than 10 heterosexual incidents per year_7 DK_41
fewer than 10 homosexual incidents per year_9
greater than 10 homosexual incidents per year_0

What percentage of your faculty is involved sexually with
students in any year? <1%_15 <5%_5 <10%_1 >10%_0 DK_49

8. Incidence of AIDS virus or related diseases in the past five years.
students or faculty, number of cases

Hepatitis B:_277 DK_22
positive blood test for antibodies:_119
AIDS-related complex, ARC:_50
AIDS disease_64

9. Incidence of Herpes II Virus and other venereal diseases:
It is estimated that 30% of the young adult population is carrying the
Herpes II virus at this time. What is the incidence of Herpes II
infection your institution:

less than 10%_35 less than 30%_14 less than 50%_1 DK_20

How many cases of two common diseases were there during the last
year? in total numbers

Gonorrhea_1435 Chlamydia_6277 DK_20

10. During the last three years, how has the infection rate for Herpes
II changed? in number of replies

decreased_15 increased_13 stayed about the same_31 DK_11

11. Public Health Programs UA: unanswered

Do you currently provide information regarding AIDS
to the University community? yes_65 no_2 UA_3

If yes, please indicate the level: in total numbers

general awareness_60
mandatory instruction_1
encouragement to use condoms_52
distribution of condoms_29
other, please describe briefly _10 replies

Do you provide instruction in

birth control? yes_62 no_5 UA_3

sexual education? yes_60 no_7 UA_3

Screening for AIDS: total replies

Is it available on Campus? yes_38 no_18 DK_14

What test is used? ELISA_38 Western Blot_24

Is testing confidential/anonymous? yes_25/no_13 yes_21/no_16

How much does testing cost?

free_17 <\$20._4 <\$50._15 <\$100_2 <\$300._0

12. We would like to share some of the comments we received regarding this questionnaire.

Certainly the medical problem of most urgent priority that exists on any college campus.

Here and elsewhere there is an extra-ordinary need to learn how best to teach about matters that relate to the AIDS epidemic. This might be better re-phrased: how best to help a person become motivated to learn.

--- Northeastern U.S.

We are a small, Christian university and have seen no AIDS.

--- Southeastern U.S.

So far, the population most at risk appears to be older than traditional college undergraduates. Cases I have heard of elsewhere are in older students, graduate students, faculty, and staff.

--- Northeastern U.S.

We are not a graduate school. Therefore our student ages are 18 to 22/26. We feel we are here to educate and prevent. Therefore we have a strong condom education program.

--- Midwestern U.S.

We have had one AIDS death and with this the gay community is assuming more responsibility and seeking more medical support.

--- Midwestern U. S.

How do you get students to realize that changing their sexual practices may be a matter of life or death? They all think it will never happen to them.

--- Mid Atlantic U.S.

AIDS symposium being planned for April with the help of the American Red Cross. They are a great resource and have a wonderful free film.

--- Mid-Atlantic U.S.

Our experience has been minimal. Also requests for information or screening have been minimal.

--- Southeastern U.S.

AIDS and all sexually-transmissible disease information must be disseminated to all segments of the community including Trustees, administrators, faculty, staff (all levels), and students. The American College Health Association has prepared pamphlets and other documents which are excellent for distribution. HIV infections must be addressed frankly, and condom usage needs to be encouraged.

---Southeastern U.S. (from same city as preceding remark)

AIDS education should be a very high priority nationwide. We need to convince students (and the general population) that it is not a "gay disease", and that from both personal and public health perspectives, all individuals - male or female, sexually active or celibate, straight or gay - need to be aware of and accurately informed about this disease.

--- Southeastern U.S.

This is going to be the biggest epidemic we will see in our lifetimes. Tragic proportions -- maiming and killing our young productive people. We must take more active steps to prevent and educate about this infection. We drastically need strong Federal leadership for this -- but it is not there.

--- Southwestern U.S.

A very serious health problem to the whole world. However, even some of the physician staff believe the whole issue is media hype. If you cannot educate doctors, how can you educate their patients!!

---Western U.S.

AIDS is on the increase in our area and on our campus as evidenced by deaths from AIDS that we are aware of and by homosexual students known to us who have developed chronic medical problems and withdrawn from school. Despite this, the average student is not interested in what they can do to prevent being infected by another person. In fact the homosexuals we see take a rather casual air to the possibility that they may be infected and potential carriers.

--- Mid-Atlantic U.S.

AIDS is not evident on our campus yet, primarily due to low activity in Ohio, and age of population.

--- Midwestern U.S.

It is a serious illness and safe sex must be stressed to all students. Our big push at the moment is education, safe sex practices, and reduction of multiple partners.

---Midwestern U.S.

AIDS cases have not surfaced on campus in any alarming, "epidemic" manner (one staff member death; numerous positive HTLV-III tests)

---Southeastern U.S.

COMMUNICATION #2-8

To: All members of ACHA Task Force on AIDS

From: Rich Keeling

Date: December 16, 1986

Method: Federal Express

Happy Holidays to All! I'm using Federal Express for this particular communication because I'm afraid that the U.S. Postal Service wouldn't get it to most of you before Christmas, at this point. As we get to T-minus 8 days and counting, my children are going progressively more nuts about Santa Claus and our students are going batty with final exams. The weather, after a peculiarly long sour period, is actually not too bad this week. Wayne Ericson greatly improved my state of mind by telling me that the recent spell of gray, drizzling, cold mess that we had here was duplicated in Illinois; Lee Wessel, on the other hand, continues to brag unnecessarily about the alledgedly beautiful weather of San Diego in December. Is anybody going to have a white Christmas?

White or not, I hope all of you have a wonderful holiday. As I watched the aging and creaky little electric train run around under my tree last night, it occurred to me that one of the best things about our group is that we haven't individually or corporately forgotten how to play sometimes; I think one of the reasons we stick together so well, and get so much good stuff done, is that we take care of those parts of ourselves and each other that need a little stroking every now an then. I really appreciate that in all of you, and I send my best wishes for a peaceful, loving season to all. One of the neat things about this New Year's is that only shortly afterward, many of us will see each other in Berkeley. Until then, take really good care.

Some Real Good News: Paul is a Daddy. Our Wisconsin colleague, Paul Grossberg, announces the happy and hopeful arrival of Sean, a bouncing 9-pound boy who joined the human race on December 1. Paul sounds about as excited as any human being has ever been, and I'm sure all of you join me in wishing them the best that life has to offer. For personal congratulations to Paul, write:

Paul M. Grossberg, M.D.
[REDACTED]

Birthday News: December 22 is Cathy Kodama's birthday. We all know that December birthdays are hellacious because

everybody forgets them and merges them with Christmas and stuff. So: A real big happy birthday to Cathy from all of us, and an assurance that we didn't forget. How old are you now? If you want to ask personal questions like that, write Cathy at Cowell Hospital, University of California at Berkeley.

Sadness to Share: our love and sympathy go to Maggi Bridwell in this season; she lost her husband, unexpectedly, just prior to the Mid-Atlantic College Health Meeting in November. Maggi has felt all the things you would imagine, and, though I'm confident she is doing OK, I'm also sure she'd appreciate a kind word. Her address:

Margaret W. Bridwell, M.D.
[REDACTED]
[REDACTED]

Report of the Task Force: among other enclosures in this mailing is a copy of a report of the Task Force on AIDS I submitted to Steve Blom for inclusion in materials for the mid-year Board meeting in San Francisco in January (just following the Berkeley AIDS meeting). It gives you a good update about what's going on in the Task Force in general.

NIMH Contract Meeting: The Working Group on Support Services met as a Project Team in Washington, D.C., early in December along with representatives of the NIMH and the consulting firm to construct an outline for the supplement to "Coping with AIDS." Howard Surface, Chris Lyman, Annie Lomax, Terry Weisser, and I met the night before to talk about the other major document to be produced by the Group, as well; one of our main functions that evening was to call up Bob (The Animal) Wirag and aggravate him as thoroughly as possible. The NIMH meeting itself went extremely well. We reached agreement on major points for the outline, and I worked it up into a presentable format thereafter; the resulting document went on the NIMH right on time. Our next project: is to convert the outline into usable words as a draft. Which brings up the next topic, strangely enough.

NIMH Contract Outline Distribution: those of you in the Working Group on Support Services will be receiving with this mailing a copy of the aforementioned outline. Your job: to review it, comment on it, and decide which sections you would like to draft. IMPORTANT MESSAGE NOW: I NEED YOU TO BEGIN DRAFT WORK SOON, LIKE RIGHT AFTER NEW YEAR'S; SO, I NEED YOU TO LET ME KNOW WHAT YOU'D LIKE TO WORK ON EVEN SOONER. PLEASE?? WRITE, CALL, OR WHATEVER.

Special Message to the Working Group on Support Services: I have NOT forgotten the conclusions of our hotel room meeting on December 1. Au contraire. However, I've been pretty well

occupied with the NIMH work and the usual end-of-semester business. VERY SOON, though, I will get out my first pass at an outline and comments for our revised direction for our document...you remember we selected a workbook format, and I was to put together some ideas/outline and circulate it to you. Fear not; it is coming, probably just after Christmas. So get ready.

Handout from the NIMH Meeting: also included in this mailing is a copy of an article from the *Advocate* by a man who describes in effective language and style the nature of the worry of the worried well and the psychosomatization of those concerned. More importantly, it discusses his pathway from letting himself be a victim to achieving control over his reactions and thoughts; I found it really helpful, and we handed it out in DC. The rest of you might like it too.

ADAMHA Priority Statement: also included is a statement about AIDS activities from the Alcohol, Drug Abuse, and Mental Health Administration regarding funding and priorities for AIDS-related activities in the near and short term, for interest.

Berkeley AIDS Conference: Hallelujah. I'm happy to say that the following of us will be able to get together in Berkeley at the AIDS Conference and in San Francisco over the subsequent weekend (Jan 31-Feb 2) to meet and work.

Cathy Kodama, Mary O'Donnell, and Terry Weisser all live there and will be with us.

Howard Surface will fly in from UNC-Charlotte, and likely will do battle with Bob (The Animal) Wirag, who is arriving for the Board meeting.

Wayne Ericson, who had to miss most of our meetings last year, will be able to join us; he's going out for the Board meeting, too, but will be at the AIDS conference as well.

Chris Lyman is coming from Penn and we've been able to make it possible for Annie Lomax to come from Delaware, too. These two fantastic ladies did an incredible job at our Washington meeting.

Last but NEVER, NEVER least, Leland George Wessel, M.D., is coming up from San Diego... no doubt bringing sunshine with him.

That's a lot of people...10 of us on the Task Force, plus Steve Blom and Maggi Bridwell. We should be able to get a lot of good work done on the Support and Clinical groups. I'm real excited; it should be a great time.

AIDS Videotape: Steve Blom and I have been discussing the production of a short (25 minute) videotape on AIDS for the use of health educators/nurses/nurse practitioners/residence life offices for short programs on AIDS in residence halls, etc. We have lots of interest in that, and have, finally, been able to clear enough other stuff out to get on to planning for this taping, which we hope to accomplish just after the first of the year.

Annual Meeting: No news yet; the program planning group will be meeting in San Francisco and our Task Force group can probably make some progress in planning for our presentation then.

Also Included for your Perusal: the following:

1. A copy of the University of Rhode Island guidelines for assisting persons with AIDS; this will be of particular interest to the Support Services group.
2. An article from the November 8 issue of the British Medical Journal making an important point about the lack of correlation between attitudes and knowledge about AIDS, and pointing out the importance of attitudes about homosexuality and education about that, too.

Recommendation: look at the current issue of *Science* for a wonderful, hopeful article on immunologic competency of certain cell types in controlling HIV. Provides both hope and more justification for "health promotion" for people with HIV infection who are not symptomatic.

Again, Happy Holidays, dearly beloved. I hope the peace of the season reaches all of you, and that in these times of trouble and fear we can each escape into the magic of the holidays long enough to be kids again. Take good care, and I'll be back in touch soon. Let me hear from all of you, and please, Support Group, get comments and ideas back to me soon.

COMMUNICATION #2-7

To: All Members of ACHA Task Force on AIDS

From: Rich Keeling

Date: November 17, 1986

Method: First Class Mail

First the Bad News: sigh. We didn't get the AmFAR Grant. I guess it may have been too much to hope for that we would get both the NIMH Contract and the AmFAR Grant in the same year, but I, for one, was really counting on it. The effect of this will be mostly felt in the lack of travel funds we hoped to get; we may have to try to offset some of that by seeking better funding from ACHA for the efforts of the Task Force. Instead of proceeding right away with the computer-assisted updating system for periodic reports on AIDS as a college issue (which would, I think, have been really helpful right about now, given all the new stuff about heterosexual transmission, the significance of new variant viruses, new clinical presentations, neurologic and psychiatric sequelae, etc), we will have to concentrate our efforts on producing a really good, helpful, but less ambitious clinical document to go along with the psychological and support issues materials we are working on; we may have to think about putting out a supplement to AIDS on the College Campus which will contain the updated educational information from Annie's group, the clinical stuff, and the psychological/support documents. The only good thing I can say about our inability to be funded by AmFAR is that at least we have a decision; I have had a lot of our work on hold pending the outcome of the grant proposal, because the direction we go in would be so different if we were going to be doing the grant work.

Not to Regret Too Much, Though...the AmFAR attempt was an add-on late in the summer, and we can still accomplish a great deal without their funds. Don't forget that we did all that we did last year without money from any foundation, and with very little support from anybody except our own institutions. The NIMH funding for psychological issues will help a little. And I've talked to Steve Blom about the possibility of taking the same kind of proposal we submitted to AmFAR and submitting it elsewhere. He and I each have some contacts at the CDC, for example, and we might be able to seek funds there.

Related Issue: Lee Wessel made a great suggestion that we consider applying for funding for having a part-time health educator-type person at the ACHA office in Rockville whose

responsibility it would be to answer, or seek answers for, questions about AIDS and related STD's asked by professionals in college health services and to answer questions posed by students themselves. This might be kind of an 800-number hot line type thing, to be funded by a grant; it would have to be set up in such a way as to allow evaluation, etc. What do you think?

Reading Material This Time: I've included the following for your interest and background:

1. AIDS Action Update, #7, from the AIDS Action Council; talks a lot about General Koop's report, the National Academy of Sciences/Institute of Medicine proposals, and the budget for AIDS research/education.
2. A summary on the use of AZT (Compound S, Azidothymidine) for treatment of AIDS from the *Medical Letter*; nice short summary with good information.
3. A statement on the pastoral role of the church toward people with AIDS, read in all Episcopal churches in Maryland, and sent me by Maggi Bridwell (Thanks, Maggi).
4. A copy of a representative editorial on Koop/education from our local newspaper

Travel Report: I've just come back from a busy trip to the Midwest. I did AIDS workshops for Northeast Missouri State University (Kirksville, MO); the University of Nebraska (Lincoln); and Iowa State (Ames). Just prior to that, I was in North Carolina and UNC-Wilmington; next week, I'll be going to Kentucky, Maine, and Washington, DC before Thanksgiving. Everywhere I go, I get a lot of positive feedback about what the Task Force has done and a lot of enthusiasm and interest in our new projects. Everybody is particularly waiting for the updated educational document, it seems.

ACHA Annual Meeting: at the Annual Meeting in Chicago in May, 1987, there will be a three hour time block on Wednesday devoted to AIDS and the Task Force for an update. No need to worry too much yet, but we will begin to think about topics, formats, and the best use of that time shortly after Christmas.

Berkeley AIDS Conference: the more of you who can make it to Berkeley for the AIDS Conference at the end of January, the better. If you have questions about the conference, call Cathy Kodama at Berkeley.

Working Group on Clinical Issues: after an excellent, five or six hour working session with Lee Wessel down in Richmond

week before last, I have a good sense of organization, format, and content for the clinical document. I'll be sending some ideas and sample sections out to Paul, Sue, Joy, Lee soon. Thanks a lot to Lee for some great thinking. I think all of you will be pleased with the results.

Working Group on Support Services: Note that:

1. The Editorial Board meeting for NIMH Grant is in DC on December 2. If you haven't heard about this or need more information, please call. I would actually appreciate it if you would all let me know whether you're going to be able to be there.

Please think ahead of time about format, content, and scope of this supplement. I hope all have read the previous NIMH brochure, "Coping with AIDS." We are NOT bound to the same format, actually, so feel free to think creatively and differently. But please DO think ahead of time.

2. I've gotten back most of your suggestions for further work on the first draft of our report. I need a couple more, and then I'll revise away and send you the results.

Working Group on Educational Programs: I talked with Federico the other day, but otherwise need updates about what's happening with this group.

Requests: Please:

1. Console me about AmFAR
2. Think about other funding options for our proposal
3. Tell me what you think of Lee's hotline idea
4. Let me know your travel plans for the December 2 meeting AND begin thinking about the content/format/scope of the supplement
5. Return the Support draft if you haven't
6. Let me know what's happening in the Education group
7. Talk to me
8. Begin thinking about the Annual Meeting

Weather Report: in the Midwest, it was hellacious. Bitter cold, snow in Missouri, icy roads. Here, it's been coldish and dreary, kind of befitting the AmFAR letter. Good news, though: it's supposed to warm up later in the week.

Ciao; call and write.

COMMUNICATION #2-6

To: All Members of ACHA Task Force on AIDS

From: Rich Keeling

Date: November 4, 1986

Method: Federal Express

The Fall weather has brought renewed vigor and excitement about our work, and I appreciate my calls and notes from several of you. I'm writing at this juncture primarily to transmit a whole pile of reading materials, which is enclosed. It includes:

1. A xerox copy of the Surgeon General's Report on AIDS; this is a critically important document, and I would strongly suggest your reading especially the introduction in which he spells out the need for explicit, effective, widespread educational programs...such as we are doing.
2. A copy of the article in Science discussing the report of the Institute of Medicine and the National Academy of Sciences on AIDS. The actual report is \$25.00 per copy, so I have not procured those for all of us...
3. For those on the Working Group on Support Services, a copy of the NIMH publication, "Coping With AIDS." This is the document for which our document is a supplement. You will be receiving more information about this from me and from Gail Bassin, the project director, soon.
4. A copy of an important editorial from last week's Lancet on "Who Will Get AIDS." Nice short review, with the usual terse British prose.
5. A copy of a nice summary piece from Jim Curran's people at the CDC on the Sexual transmission of AIDS from the JAMA.
6. A copy of an excellent, well-written, well-researched article on the development of an AIDS vaccine by Michael Helquist. This was published in the Advocate, which has printed some excellent medical updates and summaries about AIDS. Mr. Helquist addresses some vital and important social issues as well as the medical ones, and I have written to the Advocate to commend him and them for the work.

8. An article from the Journal of American College Health on the development of gay-affirmative services. This is of particular relevance to the discussions that the Working Group on Support Services had this past summer in Philadelphia.

NIMH Contract: I had a great meeting in Washington yesterday with Gail Bassin and Jerri Shaw from our Consulting firm and with Jackie Gentry, the Project Officer from NIMH. We worked out an excellent general understanding of the substance and content of our work. She is very impressed with what we have done already and evinces a lot of confidence in what we will do in the future. The timetable looks like this:

a. Between now and December 2: development of a brief outline and reference list. Gail and I are already working on this, will circulate to the Working Group soon.

b. December 2: Meeting in DC for the Editorial Board and all of the Project Staff. This means: Chris Lyman, Howard Surface, Annie Lomax, Terry Weisser, Cathy Kodama (if funds available to bring two from Berkeley at the same time), and the non-Task Force Editorial Board members (Dave Kraft, Paul Kawata, Roger Serr, Steve Blom).

THOSE INVOLVED IN THIS MEETING WILL RECEIVE SEPARATE LETTERS WITH DETAILS SIGNED BY GAIL BASSIN AND ME AND MAILED FIRST CLASS TODAY.

c. December 15: Detailed outline due at NIMH

d. January 20: First draft of document due at NIMH

e. March 20: Final camera-ready document due at NIMH

Working Group on Support: will be working hard on both ongoing projects in the next 2 months: the NIMH document and the support report. I have mailed the revised draft of the support document out (last week) and have received back markups and comments from a couple of you. As soon as most are in, we can get on with the next step.

Working Group on Clinical Issues: Lee Wessel and I are meeting in Richmond, Va., as part of his "vacation" on Thursday of this week to talk about the format, substance, and initial content issues. I've already done that to Paul Grossberg, when he was visiting DC. Sue Cowell will, I hope, be able to spend more time with us after Election Day (she's been working hard for a candidate up in Rochester). So: the signs are good for lots of good stuff from our group, too.

Working Group on Education: will, I hope, look real carefully at the Koop and National Academy reports and think about whether the existing ACHA materials and suggestions are adequate in the light of those reports and in the light of the new data regarding increased heterosexual transmission. I am very proud of the fact that most of our work last year anticipated the increased number of heterosexually transmitted cases and that we never, ever, bought into the mythology that this was a gay disease...but I think one of the re-evaluations we should do on the Educational stuff is to see if it is adequate for the current educational climate and imperatives.

Your job: read, digest, react, talk, write, think. Those of you on the Support group -- please get the draft back to me as soon as you're able. The Educational group -- please think about the new reports and let me know what you think we should be doing. Clinical Group -- await developments. All groups -- have a great week, and I'll be in touch again real soon. Thanks, as always, and my warm regards to all.

AMERICAN
FOUNDATION
• FOR •
AIDS
RESEARCH

GRANT
APPLICATION

A. FACE SHEET

LEAVE BLANK

1. TITLE OF APPLICATION (do not exceed 56 typewriter spaces)

Educational Materials for Professionals in Colleges

2. Principal Investigator/Program Director

2a. NAME
Richard P. Keeling, M.D.

2b. SOCIAL SECURITY NUMBER

2c. POSITION TITLE
Director, Department of Student Health and
Associate Professor of Internal Medicine

2d. MAILING ADDRESS

Box 378
University of Virginia Medical Center
Charlottesville, Virginia 22908

2e. DEPARTMENT, SERVICE, LABORATORY OR ORU
University of Virginia

2f. MAJOR SUBDIVISION
Departments of Student
Health and Internal Medicine

2g. TELEPHONE NUMBER
804-924-2670

3. HUMAN SUBJECTS
☒ NO ☐ YES ☐ HHS 596 ENCLOSED

4. RECOMBINANTE DNA
☒ NO ☐ YES

5. DATES OF PROPOSED PROJECT

from: Jan. 1, 1987 to: Dec. 31, 1987

6. DIRECT COSTS REQUESTED \$ 49,575.00
7. INDIRECT COSTS REQUESTED \$ 7,425.00

9. TOTAL COSTS: \$ 57,000.00

8. PERFORMANCE SITE(S)
(organizations and addresses)

(a) University of Virginia, Department of
Student Health, Box 378
University of Virginia Medical Center
Charlottesville, VA 22908

(b) American College Health Association
15879 Crabbs Branch Way
Rockville, MD 20855

11. APPLICANT ORGANIZATION: NAME & ADDRESS

American College Health Association
15879 Crabbs Branch Way
Rockville, Maryland 20855

10. TYPE OF ORGANIZATION Non-profit voluntary pro-
fessional association for those who provide
healthcare on college and university campuses

12. OFFICIAL IN BUSINESS OFFICE TO BE NOTIFIED
IF AN AWARD IS MADE: name, address, title, telephone
Stephen D. Blom
Executive Director
American College Health Association
15879 Crabbs Branch Way
Rockville, MD 20855 (301) 963-1100

13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION:
name, title, address, telephone number
Stephen D. Blom
Executive Director
American College Health Association
15879 Crabbs Branch Way
Rockville, MD 20855 (301) 963-1100

14. PRINCIPAL INVESTIGATOR ASSURANCE: I agree to
accept responsibility for the scientific conduct of
the project and to provide the required reports if
a grant is awarded as a result of this application.

15. SIGNATURE OF PERSON NAMED IN 2a

Richard P. Keeling, M.D.

16. CERTIFICATION AND ACCEPTANCE: I certify that the
statements herein are true and complete to the best of my
knowledge, and accept the obligation to comply with
American Foundation for AIDS Research terms and conditions
if a grant is awarded as the result of this application.

17. SIGNATURE OF PERSON NAMED IN 13

B. Principal Investigator Richard P. Keeling, M.D.

TABLE OF CONTENTS

	Page Numbers
A. Face Page	1
B. Table of Contents	2
C. Abstract	3
D. Budget Form	4
Budget Justification	<u>5</u>
E. Biographical Sketch	_____
Other Biographical Sketches	_____
F. Other Support	_____
G. Resources and Environment	_____
H. Research Plan	_____
Include:	
1. Specific Aims	_____
2. Significance	_____
3. Preliminary Studies	_____
4. Experimental Design and Methods	_____
5. Human Subjects (HHS 596)	_____
6. Vertebrate Animals	_____
7. Letters of Agreement	_____
8. Consortium Agreements	_____
9. Charts and Figures	_____
10. Photographs	_____
11. Literature Cited	_____
I. Appendix (five sets)	

Number of Manuscripts: 0

Number of Publications: 4

C.

Principal Investigator Richard P. Keeling, M.D.

American Foundation for AIDS Research
Grant Application
ABSTRACT

=====

Key professional personnel engaged on project:

<u>Name</u>	<u>Position Title</u>	<u>Dept. and Organization</u>
-------------	-----------------------	-------------------------------

See Continuation Sheet for List of Members of ACHA Task Force on AIDS who will be involved in this project.

Abstract of research plan: State rationale, specific aims, long term objectives, and describe concisely the methodology for achieving these goals. The abstract is meant to serve as a succinct and accurate description of the proposed work when separated from the application.

DO NOT EXCEED THE SPACE PROVIDED.

(Please underline ten key words)

To improve AIDS education and promote risk-reducing behaviors in college communities, and to make medical, psychological, and social services for AIDS-related problems more accurate, sensitive, and widely available on campuses, the American College Health Association proposes to develop an innovative system of educational materials for three groups of professionals in higher education: (1) primary health care workers, (2) mental health service providers, and (3) health educators. A computer-assisted updating system and user-maintained binder format will assure the future currency and accuracy of the compendium. A preliminary needs assessment will assist in determining the specific content and nature of material included in each section. Thereafter, the Task Force on AIDS of the Association will draft and review documents and collect materials addressing: (1) the clinical, serologic and immunologic evaluation of patients with AIDS-related conditions, emphasizing the presentations and complications of these disorders in students; (2) management strategies for psychological, social, and supportive services for those with AIDS-related problems and for the "worried well"; and (3) guidelines and resources for educational program management and execution, emphasizing strategies for identifying and modifying risk-creating behaviors. During the grant year, we will write, produce, and distribute the initial compendium; establish the computer assisted updating system; develop methodologies for recognizing and incorporating new information; and prepare the first update. Thereafter, we will issue updates during each academic semester; users will remove outdated sections of their compendia and replace them with the new materials.

Members of the ACHA Task Force on AIDS

Name	Position Title	Organization
Susan Cowell, R.N., N.P.	Nurse Practitioner Student Health Service	University of Rochester
Joy Greenway, M.D.	Physician, Student Health Service	University of Arizona
Paul M. Grossberg, M.D.	Director, Student Health Service	University of Wisconsin- Platteville
Cathy Kodama, M.A.	Health Educator, Health Promotion Section	University of California- Berkeley
Anne R. Lomax, M.A.	Director, Wellspring Project, Student Health Service	University of Delaware
Christine D. Lyman, M.S.W., A.C.S.W.	Director, Social Work, Student Health	University of Pennsylvania
Mary O'Donnell, M.P.H.	Assistant Director for Health Promotion	University of California- Berkeley
Howard M. Surface, M.P.H.	Director, Student Health Service	University of North Caro- lina at Charlotte
Paul Walters, M.D.	Director, Student Health Service	Stanford University
Terry Weisser, B.A.	AIDS Education Specialist	University of California - Berkeley
Leland G. Wessel, M.D.	Physician, Student Health; Chief Resi- dent, Preventive Medicine	San Diego State Univ., Univ. of Cal. San Diego
J. Robert Wirag, H.S.D.	Director, Student Health Service	University of Arkansas

Richard P. Keeling, M.D.

12-MONTH BUDGET

through: December 31, 1987

Personnel		Time		Amount Requested		
Name	Position Title	%	Hours per week	1. Salary	2. Fringe Benefits	Total
Richard P. Keeling	Principal Investigator		(No salary support requested)			
(Not yet hired)	Secretary	50	20	6,500	1,820	8,320
(Not yet hired)	Administrative Assistant	50	20	12,000	3,600	15,600
			<u>subtotals</u>	18,500	5,420	23,920

None

None

5,000

8,550

None

12,105

49,575

7,425

57,000

D.

Principal Investigator: Richard P. Keeling, M.D..

BUDGET JUSTIFICATION

Lines 1 and 2: Salary and Fringe Benefits

We are not requesting salary support for any of the professionals involved in this project, nor for the existing American College Health Association administrative staff. Each of these individuals is employed full-time by their respective institutions, as indicated in the List on page 3; each has volunteered additional time and effort to work with the ACHA Task Force on AIDS over the past year, and will continue to do so in developing the compendium for which this grant is requested.

We request salary support for two support staff individuals, each for 50% of their time. One, an Administrative Assistant, would work in the ACHA Executive Office in Rockville, Maryland; his/her responsibility would be to manage the production of the compendium, set up the computer/word processing system, establish the distribution system, and oversee the budget for the project. This will be a new position; we envision high level office skills and some accounting ability as major qualifications. In the Washington area market, an annualized full-time equivalent salary of \$24,000 would be appropriate; we request half of this amount, or \$12,000. Fringe benefits are paid by the Association at the rate of 30% of salary, for an amount of \$3,600 and a total cost of \$15,600 for this employee.

The other position requested is for a secretary to work for the Principal Investigator in the Department of Student Health at the University of Virginia. This individual would be responsible for the clerical tasks created by the work of the Task Force; his/her job duties would include typing/word processing drafts of sections of the compendium, copying and circulating materials to writers and reviewers, handling correspondence and filing, and coordinating production of the compendium with the Administrative Assistant in Rockville. This also is a new position; it would be paid in the medium clerical grade range at the University of Virginia, or \$13,000; we request half of that (50% effort) or \$6,500. Fringe benefits are calculated at 28% of salary, for an additional \$1,820 and a total position cost of \$8,320.

Line 5: Supplies and Materials

1. Supplies for Preparation of Documents

In addition to general office supplies, this category includes consumables such as paper, envelopes, computer disks and supplies to be used in the preparation, drafting, and review of material for the compendium as well as expenses for medical bibliographic searches and reproduction of journal articles. Given that the major effort of this project is the production of written materials for distribution, multiple drafts will be required; we have therefore included this as an item greater than routine office supplies.

2. 3-Ring Binders for Compendia

The compendium of materials will be distributed in a high quality 3-ring binder. These binders must be durable, water and stain resistant, and mechanically sound so that the user can remove outdated sections and insert updates periodically without damaging the binder. One thousand will be needed to fulfill the initial project goals.

Line 6: Travel

Our proposal is not for a research project of the sort that dictates restrictions in funds allotted for travel. On the contrary, the very nature of our proposed work will make travel a necessary and critical component of the preparation of the compendium.

The professional staff involved in this project are employees of Student Health Services at a number of colleges and universities scattered across the United States. In our work together last year, we met several times in various groups to draft statements and documents, make major decisions about materials and policies, and perform the final review and approval before documents were printed. The budgets of our Health Services do not allow for extensive travel, so we have tried to meet in conjunction with other regional or national meetings in our field; a few special meetings have been necessary. The Chairman of the Task Force, who is the Principal Investigator for this proposal, has traveled more extensively, both to meet with others on the group and to work with the ACHA office in Rockville. It will not be possible for us to undertake the major task of writing, researching, and reviewing this compendium without several meetings among small groups of the Task Force; accordingly, we are requesting more travel funding than would be expected in a research award.

We request a total of \$8,550; this would be distributed as follows:

1. In January, 1987, the American College Health Association will co-sponsor a conference on AIDS on the college campus in Berkeley, California. The Principal Investigator will be present as the keynote speaker. Several members of the Task Force, including especially members of the working group on clinical issues, could be brought to that meeting to begin planning and decision-making for this project; this will involve transcontinental travel for several. We ask half the cost of travel for 4 people for this 2-day meeting:

a. Airfare: 1/2 of 4 x \$800 =	\$1,600
b. Lodging: 1/2 of 4 x 2 nights x \$85/night =	\$ 340
c. Meals, etc.: 1/2 of 4 x 2-1/2 days x \$30/day =	<u>\$ 150</u>

Subtotal Berkeley travel:	\$2,090
---------------------------	---------

2. Shortly after the Berkeley meeting, we would plan a meeting in Washington or Philadelphia to bring together 5 other members of the Task Force for two days and one night. The emphasis in this conference would be on the sections on mental health and health education. This meeting would extend the work and implement the initial directives of the previous session in Berkeley: planning, decision-making about major content and format matters, and initial drafting of sections of the compendium. We request expenses for 5 people to meet, as follows:

a. Airfare to DC, \$300/person x 5 persons =	\$1,500
b. Hotel: \$80/night x 1 night x 5 persons =	\$ 400
c. Meals, etc.: \$25/day x 2 days x 5 persons =	<u>\$ 250</u>

Subtotal Eastern meeting:	\$2,150
---------------------------	---------

3. In May, 1987, the ACHA will have its Annual Meeting in Chicago. Some members of the Task Force on AIDS will be funded by their institutions; some will be partially funded, and others will have no funds at all. In order that all those involved in this project are able to meet for portions of the 5 day convention to review drafts prior to final preparation and publishing, we request funds to support 1/3 the costs of bringing 12 people to Chicago for 5 days for this meeting. Thus:

- a. Airfare: $1/3$ of $12 \times \$350/\text{person} =$ \$1,400
- b. Hotel: $1/3$ of $12 \times 5 \text{ days} \times \$80/\text{day} =$ \$1,600
- c. Meals, etc.: $1/3$ of $12 \times 5 \text{ days} \times \$25/\text{day} =$ \$ 500

Subtotal Chicago travel \$3,500

4. The Principal Investigator will need to travel to Rockville on several occasions to meet with the Project Manager, review final copy, determine formats and styles of text and presentation, work out the computer updating system, and authorize printing. We request funding for three (3) such trips during the project year, with costs as follows:

- a. Airfare, Charlottesville-Washington, round trip,
 $\$140/\text{trip} \times 3 =$ \$ 420
- b. Hotel expenses, Washington area, 1 night/trip,
 $\$80/\text{night} \times 3 \text{ trips} =$ \$ 240
- c. Meals, etc.: $\$25/\text{day} \times 2 \text{ days/trip}$
 $\times 3 \text{ trips} =$ \$ 150

Subtotal Charlottesville/Rockville travel \$ 800

Line 7: Other Direct Costs

1. Copying/Collating Initial Compendium

150 pages per compendium $\times$ 1000 copies of the
compendium, at \$.03 per page \$4,500

2. Copying/Collating First Update

25 pages per update $\times$ 1000 copies of the update,
at \$.03 per page \$ 750

3. Distribution/Mailing Initial Compendium

Estimated fourth class cost for 1000 sets (weight
of the package with binder and 150 page materials
will be too heavy for third class) \$1,500

4. Distribution/Mailing First Update

Estimated third class cost to mail 1000 copies of a
25 page document \$ 750

5. Long Distance Calls

Just as the nature of this project dictates higher travel costs than are obtained in a research project, so the need for frequent communication among members of the Task Force in the preparation and review of the compendium, and between the Principal Investigator and the Project Manager in the management of the project, necessitate the isolation of long distance telephone service as a separate budget item; based on the experience of the past year with the Task Force on AIDS, we estimate this expense at no less than \$3,500.

6. Copying/Collating for Drafts

We will need to circulate multiple copies (at least 12) of drafts of various sections of the compendium during their development, writing, and finishing. We isolate this budget item from other office costs because of its likely size; we estimate \$1,000 as a conservative cost given the eventual 150-page size of the compendium and the number of writers and reviewers involved.

7. Postage for Drafts

First class postage for collections of draft materials mailed to the professional staff of the Task Force at intervals during the grant year are estimated at \$105. This is a low figure because some materials could be included in other mailings sent for other reasons.

Line 8: Indirect Costs

We have requested only 15% of direct costs for indirect cost, because of the isolation of several budget categories as direct costs as noted above: copying/collating, certain supplies, and long distance telephone service.

E.

Principal Investigator Richard P. Keeling, M.D.

American Foundation for AIDS Research
Grant Application
BIOGRAPHICAL SKETCH

=====

Give the following information for key professional personnel beginning with the Principal Investigator/Program Director. Photocopy this page for each person.

Name	Title	Birthdate (mo/day/yr)
Richard P. Keeling, M.D.	Director, Department of Student Health, Univ. of Va.; Assoc. Prof. of Internal Med. U. of Va.; Chair, ACHA Task Force	04/25/48

Education Begin with baccalaureate or other initial professional education and include postdoctoral training.

Institution and Location	Degree (circle highest)	Year Conferred	Field of Study
University of Virginia Charlottesville, VA	Bachelor of Arts with Highest Honors	1969	English
Tufts University School of Medicine, Boston, MA	M.D.	1973	Medicine
University of Virginia Hospital, Charlottesville VA	Residency and Chief Residency Fellowship in Hematology	1973-79	Internal Medicine;

RESEARCH AND/OR PROFESSIONAL EXPERIENCE:

Concluding with present position, list in chronological order previous employment, experience and honors. Include present affiliations with the American Foundation for AIDS Research (if none, please state). List in chronological order, the titles and complete references to not more than 15 publications, published during the past three years or earlier in they are pertinent to this application. A separate sheet may be attached for continuation. DO NOT EXCEED TWO PAGES OVERALL (INCLUDING NOT MORE THAN 15 SELECTED PUBLICATIONS).

Experience:

Director, Department of Student Health, and Chief Student Health Physician, University of Virginia; 1979-present

Assistant Professor of Internal Medicine, University of Virginia School of Medicine; 1979-1985

Associate Professor of Internal Medicine, University of Virginia School of Medicine 1985 to present

Honors:

Phi Beta Kappa, 1969

Alpha Omega Alpha, 1972

Distinguished Faculty Award, University of Virginia, 1983

Attending Physician of the Year, University of Virginia, 1983

Distinguished Service Award, American College Health Association, 1986

AIDS Related Activities

Chairman, Task Force on AIDS, American College Health Association, 1985-present
Member, Ad Hoc Advisory Committee on AIDS, United States Public Health Service 1985-present

Chairman, Charlottesville AIDS Resource Network, 1985-present

Member, Advisory Committee on AIDS, Charlottesville Public Schools, 1985-86

Consultant on AIDS to numerous colleges and universities, 1983-present

Speaker and consultant on AIDS for many organizations and institutions in higher education 1984-present

AIDS-Related Activities (continued)

Primary physician to a large number of patients with AIDS-related conditions
Author and editor of textbook chapters, educational materials, institutional guidelines and special reports on AIDS and AIDS-related issues
Sole author of forthcoming book on AIDS for the primary physician (Oxford Press)

Publications:

Keeling RP: General statement on institutional response to AIDS. Rockville, MD: American College Health Association, 1985.

Keeling RP: AIDS on campus, AGB Reports (Association of Governing Boards of Colleges and Universities), March/April, 1986, 24-30.

Keeling RP (editor), AIDS on the college campus: an ACHA special report. Rockville, MD: American College Health Association, 1986.

Keeling, RP: Chapter IV. Differentiation, biochemistry, and physiology of the granulocytes; Chapter V. Differentiation, biochemistry, and physiology of monocytes and macrophages; Chapter XVI. Non-neoplastic disorders of granulocytes; Chapter XVII. Non-neoplastic disorders of lymphocytes, including AIDS; Chapter XXVIII. Transfusion therapy, in Thorup OA, editor, Fundamentals of Clinical Hematology, Philadelphia: W. B. Saunders, 1986, in press.

Keeling, RP, Childress J, O'Connell J, Rein MF: AIDS: Public Health and Private Rights (panel discussion). Pharos 49:32-37, 1986.

Keeling RP: AIDS for the Primary Physician, New York, NY: Oxford University Press, 1987 (in preparation).

Editor of the following educational pamphlets:

1. AIDS: What Everyone Should Know. American College Health Association, 1985; revised 1986.
2. Safe Sex. Charlottesville AIDS Resource Network and American College Health Association, 1986.

F.

Principal Investigator Richard P. Keeling, M.D.

American Foundation for AIDS Research

Grant Application

OTHER SUPPORT

=====
(See Application Instructions -- Page 6, item F)

1. All present active support - None
2. Applications and proposals pending review or funding - None
3. Applications and proposals planned or being prepared for submission - None

(use continuation page if necessary)

G.

Principal Investigator Richard P. Keeling, M.D.

American Foundation for AIDS Research
Grant Application
RESOURCES AND ENVIRONMENT

=====

(See Application Instructions -- Page 7, item G)

Facilities:

☐ Laboratory: None

☐ Clinical: None required for this project

☐ Animal: None required for this project

☐ Computer: At the University of Virginia Department of Student Health:
IBM Personal Computer with Epson letter quality printer at office. IBM Personal
Computer with Epson dot matrix printer at Principal Investigator's residence.
At American College Health Association: IBM PC network consisting of 1 IBM AT with
3 PCs (640 K memory each), 2 Okidata PC Printers and 1 Xerox letter quality printer.

☐ Office:
The University of Virginia is a major referral medical center with an extensive
Health Sciences Library offering both a large periodical and book collection and
on-line search services through the National Library of Medicine and other data-
bases. The Department of Student Health occupies its own separate (See continuation)

☐ Other: ():
The members of the ACHA Task Force on AIDS who will work with the Principal
Investigator in preparing the compendium each have office and clerical support
in their universities. No specific funding of any of these resources is requested
in this proposal.

Major Equipment: List the most important equipment items already available for this project,
noting the location and pertinent capabilities of each.

Computers as above

Additional Information: Provide any other information describing the environment for the
project. Identify support services such as unpaid consultants, secretarial, machine and electronics
shop, and the extent to which they will be available to the project.

The entire basis of the work of the American College Health Association's Task
Force on AIDS has been that of a network of unpaid volunteer professional men and
women whose breadth of knowledge and sensitivity about the issues of AIDS is of
(use continuation page if necessary)

Continuation, item G

Office:

facility with adequate office space for the clerical and research components of the work of the Principal Investigator.

The American College Health Association occupies offices located in Rockville, Maryland, which provide access to Washington, D.C. and Bethesda Maryland, the National Institutes of Health, and the National Library of Medicine.

Additional Information:

incalculable value. Taken together, the members of the Task Force represent several different disciplines, points of view, and sets of skills; their efforts have melded to produce credible, popular, helpful materials about AIDS for college students and the personnel who serve them. The entire value of this tremendous resource is provided to the Association without cost; we do not, therefore, budget professional salary support as part of this proposal. However, it is important to note that the development of this compendium will occupy between 1000 and 1500 professional hours, worth between \$40,000 and \$50,000.

In addition, the clerical and other support for members of the Task Force other than the Principal Investigator is not budgeted in the proposal; that allows the saving of an additional large sum.

PROJECT PLAN

1) SPECIFIC AIMS

The American College Health Association proposes to use a grant from the American Foundation for AIDS Research to develop and distribute an innovative system of educational materials concerning AIDS. The primary recipients of these materials will be three categories of professional employees of Student Health Services at colleges and universities: primary health care providers (both physicians and non-physicians); mental health professionals of several disciplines; and those working in health education and promotion activities. We anticipate that the materials will also be of interest and use to the professional staff of college counseling centers, residence life programs, student affairs offices, and departments of health and physical education. The most important beneficiaries of this project will be students in institutions of higher education.

We propose to provide a regularly updated compendium of information and recommended management strategies concerning AIDS. Our objectives are:

- (1) to improve education about AIDS for undergraduate and graduate students, making it more effective and more widely and consistently available
- (2) to promulgate risk-reduction guidelines for those (gay or straight, male or female) whose behavior creates a risk for the transmission of HIV
- (3) to assure the competent medical evaluation of AIDS-related conditions, including asymptomatic HIV infection, by college health services
- (4) to establish recommendations for the provision of appropriate and compassionate psychological and social services in the college environment for those who are concerned, asymptomatically infected, or ill
- (5) to develop and implement a system for keeping information about AIDS current, accurate, and complete through the use of word processing technology and a user-maintained compendium.

2) SIGNIFICANCE

The importance of this effort derives from several considerations. College students, in particular, are an important target group for education about AIDS because of their tendency toward experimental behavior, their openness to health education, their potential for childbearing, and their difficult place in the continuum of adolescent and young adult development. Many do not receive adequate AIDS education currently because of limited or absent budgets for health education programs, because the need is underestimated, because the information provided is "too hot to handle." Students who worry about--or have--AIDS-related conditions may not get accurate information, compassionate and helpful counsel, or capable medical evaluation; most colleges are unaware of the need for good psychological and support services, and even those with that awareness are commonly puzzled about the best methodologies.

The behavior of college students is commonly inconsistent, and their choices often unpredictable; in their exploration of various aspects of themselves, they may sample different types of sexual styles, work through definitions of relationships, and test both their own limits and those of people around them. It makes sense to suppose that the experimental behavior of college students creates special risks for them, whether they are men or women and whether they are eventually defined as gay or straight. There is also the possibility that some college students will experiment with intravenous drugs. For female students seropositivity will herald not just the fears of eventual consequences to health and survival, but also the limitation of childbearing. There is great need for education for risk reduction.

Health educators in colleges need guidelines for program management and content, suggestions about print and audiovisual materials that work, strategies for reaching important sub-groups of the student population in effective ways, and realistic advice about dealing with educational resistance, homophobia, and hostility. They need information about what concepts to teach, what vocabulary to use, and what resources are available. New data, revised recommendations, updated publications, and improved materials will create the need for access to current information and sources. The rapidity with which information about AIDS develops demands a unique approach to keeping those providing direct education well educated themselves.

For most college health services, AIDS has been more a theoretical than a practical issue. On many campuses, there have been no students with AIDS or AIDS-related complex, or at least there have been none who have been known or seen in the health service. Physicians and nurse practitioners are commonly unaware of the likely manifestations of AIDS, the presenting symptoms and signs, and the appropriate evaluation required. In some health services, precautions for the prevention of transmission of HIV to personnel do not exist; in many, good, non-judgmental information about AIDS is not readily available. We need to educate our health care providers: they need to know what to look for, when to worry, how to test, when to refer, and where to get assistance.

Mental health workers may be comfortable with and capable of dealing with concerns about sexuality, but in places where those issues cause discomfort or information about AIDS is sparse, compassionate counsel about AIDS will be hard to come by. Guidelines for the provision of appropriate mental health services in this area are overdue. In addition, the existence of an entire spectrum of neurologic and psychiatric disorders caused by HIV demands that all mental health care providers be aware of this diagnostic possibility and of the likely manifestations. The differing reactions and needs of those who are worried but healthy will demand special attention on our campuses, and mental health professionals will need guidance in approaching them.

Even where mental health services are superior and sensitive, the development of management strategies for handling cases of AIDS in the university environment is incomplete. The interaction of institutional and community services has been inadequately explored, and students with AIDS-related problems may receive less than the best in social and support services as a result. There has been little effort to address the maintenance of the mental health of those professionals who deal with AIDS-related problems; programmatic strategies to prevent "burnout" are needed.

3) PRELIMINARY STUDIES

Recognizing the relevance and importance of AIDS issues for higher education, the Association appointed, in late 1985, a Task Force on AIDS chaired by the Principal Investigator for this grant proposal. Using procedures which emphasized early problem identification, assignment of priorities, rapid response to draft documents through use of overnight mail services and long distance telephone calls, and careful conferencing tied to important milestones in document development, the Task Force produced several important materials by May of 1986. The educational brochure "AIDS--What Everyone Should Know," written by the Task Force in October, has already been revised once; more than 800,000 copies have been distributed. An innovative, carefully designed, full-color risk reduction pamphlet called "Safe Sex," written and photographed under Dr. Keeling's supervision, was reviewed by the Task Force and published by the ACHA; more than 400,000 copies are in circulation.

The Task Force issued an important General Statement on Institutional Response to AIDS in December, 1985; that document has become the standard for the structuring of AIDS policies on American campuses. Subsequently, the Task Force developed six discussion and resource papers concerning administrative issues, residential housing, educational programs, antibody testing, confidentiality of information, and risk assessment; these were combined in a special report, AIDS on the College Campus, released in May, 1986. Copies of both brochures, the General Statement, and the Special Report are appended to this application.

A survey of ACHA membership in the summer of 1986 revealed that the overwhelming majority found these materials useful, well presented, and practical. The same survey identified other areas needing further attention: clinical issues, mental health/social services, and updated health education information. Having addressed the policy issues, the ACHA seeks grant support now to deal more thoroughly with these direct clinical and educational concerns.

The Principal Investigator, Dr. Richard Keeling, organized and directed the efforts of the Task Force, drafted the text of several of the statements and brochures, and revised all of them. He is also author of several chapters for the fourth edition of Leavell and Thorup's Clinical Hematology, including the entire section on AIDS. Dr. Keeling has visited more than 50 college campuses during the past year speaking and providing workshops about AIDS for students,

administrators, and clinicians; he has an unusual wealth of first-hand experience in translating evolving facts about AIDS into meaningful, practical guidelines for professionals and useful information for students. His training and board certification in internal medicine and hematology prepared him for the large number of patients with AIDS-related conditions he now cares for.

4) PROJECT DESIGN AND METHODS

We would build on the experience of our first year in AIDS education in executing this project. We will proceed quickly after the award to meet with AmFAR officials and employ the two personnel requested. Using a special mailing list developed from the results of a survey of all institutional members this summer, we will first perform a needs assessment for each of the professional groups (primary health care, mental health, health educators). The Project Manager in Rockville will receive the needs assessment forms, collate them, and tabulate responses.

The Principal Investigator will assign Working Groups of the Task Force to have primary responsibility for drafts in each of the three areas. As the project begins, the Principal Investigator will meet with the leaders of each working group (in California or the East) to identify priorities, decide formats, and assign tasks. As sections of drafts are completed, they will be sent to the Principal Investigator for review and revision; revised materials will be copied and distributed back to the working group for review and to the Project Manager for entry into the database. In the process, many individual and conference telephone calls will allow fast communication over problem areas. Final drafts in each area should be ready for review by the Task Force at the time of the ACHA Annual Meeting in Chicago in late May, 1987.

During the first few months of the year, the Principal Investigator will meet with and talk to the Project Manager frequently as details of the format, production, and distribution of the compendium and its binder are decided. The Project Manager will attend to the development of the computer-assisted database system during this period, such that the system is ready to produce the initial documents when they are ready in late May. During the early summer, the Association will produce, copy, collate, and mail the initial compendium to all institutional members (about 600) and to other campus health officials identified by the survey mailing list; approximately 1000 copies will be distributed.

The Principal Investigator will assign members of the Task Force to have responsibility for updating the information in each section and will establish procedures for the regular review of appropriate scientific journals, governmental reports, and health education releases. In the early Fall of 1987, the Task Force will draft updates for each section of the compendium, based on new data or new approaches made available since the completion of the original drafts in May. Using procedures similar to those described above for the initial document, the Task Force will then draft, circulate, revise, and finalize the updates, which will be printed and distributed by the end of the year. Along with the mailing of the first update, the ACHA will distribute a survey evaluating the quality, practicality, and effectiveness of the initial compendium and its first update.

In each of the subsequent calendar years, the Association plans to provide two updates, in May and December. The recipients of these materials will replace outdated sections of their compendia with new ones. Periodic surveys of the membership will evaluate the continuing utility and effectiveness of the document.

5) HUMAN SUBJECTS: None

6) VERTEBRATE ANIMALS: None