

AIDS on the College Campus

ACHA Special Report



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Foreword

In the spread of the Acquired Immune Deficiency Syndrome (AIDS) a serious public health problem has developed for American society. The medical, social, legal, and ethical issues which face our society as a whole are equally manifest at America's colleges and universities. The nature of the disease and the characteristics of campus populations have reinforced the administrative impulse toward establishing a policy first and weighing alternatives later. A rational approach to the AIDS crisis requires full and accurate information for policy development, effective systems for educating students and campus personnel, and flexibility in dealing with the multitude of human relations concerns which are involved.

To assist campus health care providers, counselors, educators, and policy makers, the American College Health Association established a special task force in September 1985 under the capable leadership of Richard P. Keeling, M.D., Director of the University of Virginia's Student Health Service. The Task Force on AIDS is national in scope and includes contributors from many fields other than college health professionals. Two published statements of general guidelines for higher education and an information brochure entitled "AIDS — What Everyone Should Know" have been issued by the Task Force and distributed by the Association.

This book represents the result of efforts by the Task Force to further develop and present information and guidelines to assist campuses with their educational programs and policy development. It consists of a series of separate statements, addressing specific issues related to AIDS as college health care providers, students, and student services personnel officers see them. These statements have been collected for publication in this book to provide a body of reliable information which can contribute to enlightened campus discussion of these issues. The statements represent the culmination of several months of concentrated effort by specialized working groups of the Task Force.

Two of the principal issues discussed in this text are drug abuse and sexual activity. In discussing AIDS, we have dealt with sensitive issues. The American College Health Association does not condone the use of illicit drugs nor promote specific personal lifestyle choices. We do, however, feel that individuals need to have all the facts in order to make their own decisions.

We extend our thanks to the entire ACHA Task Force on AIDS for making this publication possible. The members of the Task Force are listed herein. Special thanks is extended to Dr. Keeling for his outstanding leadership and bountiful energy and vision. The American College Health Association also acknowledges with appreciation the contribution of the University of Virginia, whose support has played a vital role in the work of the Task Force and in finalizing the statements for publication.

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Introduction

Richard P. Keeling, M.D.
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The American College Health Association, recognizing the difficulty that many colleges and universities might have in addressing the complex medical, educational, and procedural issues raised by the Acquired Immunodeficiency Syndrome (AIDS), established a Task Force on AIDS in late 1985. Its purpose, simply stated, was to provide recommendations and guidelines for institutions to use in formulating a response to AIDS. A major goal of the Task Force has been the completion of this book which contains important, detailed discussion papers on the most relevant and difficult issues. The specific statements included augment and extend the General Statement on Institutional Response to AIDS, released in December, 1985. Each statement is the result of extensive research and consideration by one of the working groups of the Task Force; a strong commitment by all involved has made it possible for the entire Task Force to review and revise each paper. We feel that the positions taken and the recommendations made derive not only from the best medical information available, but also from careful consideration of each issue from a number of points of view.

The members of the Task Force are diverse in their training and professional roles; they represent agencies and institutions of several types. They come from colleges, universities, and organizations in all regions of the United States. All have been involved in health promotion and education, and all share a strong belief in the value of effective communication.

The American College Health Association hopes that the work of the Task Force will enable individual institutions to avoid "re-inventing the wheel." In addition, the provision of national guidelines may assist colleges and universities in arranging programs and setting policies with the assurance that other institutions are proceeding in the same general manner. These documents will help in the setting of priorities, the structuring of programs, and the avoidance of management errors. Some institutions have rushed into detailed policy-making, fearful of being caught without paper armor; others have chosen an approach of watchful waiting, and some fervently hope that AIDS, not having been an issue on campus so far, simply never will be. The issues generated by AIDS cause discomfort and uncertainty for many administrators, counselors, and health care providers; officials in areas as diverse as residential housing, food services, employee relations, and institutional development have wondered:

“what are we going to do about AIDS?”

AIDS slipped insiduously into medical awareness in 1981. The growing number of cases, the frightening fatality rate, and the extraordinary amount of media attention paid to it have subsequently combined to create a high degree of public awareness of the disease. The personal tragedy of Rock Hudson in the summer of 1985, like the discovery of cases of AIDS in children several years earlier, initiated an epidemic of fear that paralleled that medical epidemic. Regrettably, many studies have shown that the accuracy of information the public possesses is considerably less impressive than the fear many feel.

There is, of course, much that is truly frightening. While the extent of medical understanding of AIDS has grown rapidly since its first description, the initial uncertainties and speculations about it remain fresh in the popular mind. The amazing rate of development of scientific information about AIDS has been matched by exponential increases in the numbers of cases of the disease. Although the rate of rise of these numbers appears now to be slowing, still there will be twice as many cases of AIDS a little over a year from now as there are today. And AIDS itself is not the whole problem: two or three times as many people as have AIDS have a lesser form of the disorder, AIDS-Related Complex (ARC). Some people with ARC will progress to have AIDS; most, we think, will not — but the proportions remain uncertain. Furthermore, we now know that there are many other apparently healthy people who are infected with human T-lymphotropic virus, type III (HTLV-III), the virus that causes AIDS. Some of those people are infectious carriers, who can transmit the disorder; others are not. Most probably do not realize they have been exposed or that they can infect others. It is in some ways a paradox that these asymptomatic carriers are much more capable of spreading the infection than are patients with ARC or AIDS itself. The ultimate fate and the exact numbers of these infected-but-healthy Americans is unknown; our best information is that they outnumber patients with AIDS by factor of 100 to 1, and that the majority will remain healthy, but that some will progress to have ARC or AIDS.

Equally fearsome is the fact of the desperately sad outcome of full-blown AIDS; with few exceptions, the prognosis for people with the severe form of the disease is exceedingly bleak, and the months and years of their survival are commonly peppered with hospitalizations and tainted by debility. For some, though, the most devastating information is that describing the incubation period for AIDS; while the incubation period is generally less than three years, it is possible that five or more years may elapse between the time of exposure and the development of symptoms of AIDS itself. The fact that the antibody test turns positive after a matter of weeks is reassuring, but the wait for symptoms may be a long one for those who have not been tested. No wonder, then, that people are afraid: a new disease, a relatively short period of observation, rapidly increasing numbers of cases, a long clinical incubation period, healthy carriers, and a dreadful outlook.

Complicating these worries are some important attitudinal issues. AIDS has occurred primarily in two large groups of people who have traditionally evoked

discomfort or outright antagonism. In this country, about three-quarters of AIDS patients have been homosexual or bisexual males, and 17 percent have been intravenous drug users. Thus, a disease already frightful because of its particular clinical characteristics may seem all the more threatening and pernicious because of its demographic associations. This situation is not improved by the more recent observation that female prostitutes may carry and transmit AIDS. In the face of all these observations, it is vital to remember that AIDS is a biological event, not a moral comment; we must not let personal reactions of disgust or disapproval of homosexuality, prostitution, or drug use influence decision-making about AIDS or the people who have it. Neither can we afford to permit the fear or prejudice of others outside our institutions to direct our decision-making.

There have been few cases of AIDS itself among college and university students so far. For that matter, only a small proportion of AIDS cases have occurred in people who fall into the traditional college-age group. On the other hand, the incubation period, as noted earlier, may be quite long; what someone does now, in college, may not result in recognizable AIDS until long after commencement. Students are commonly experimental; those in college may act out differing elements of their sexuality, exercise inconsistent judgment in their selection of sexual partners, and toy with recreational drugs. They may not confine their sexual explorations to interactions with other students; they may have relationships with other college and university personnel and with citizens in the surrounding community, as well. AIDS is no longer a disease just located in major metropolitan areas; it has gradually spread away from our large cities and is now found in many small and medium sized communities. Nor is it any longer only a disease of gay men; heterosexual transmission is well documented.

There is, thus, no justification for complacency on the part of any institution in any area about any of its population. Small numbers of established cases thus far do not translate into a small problem, medically, ethically, educationally, or procedurally. That we will undoubtedly be seeing more students who actually have AIDS or ARC on our campuses is not, by itself, the point: of much greater general relevance are the facts that (1) we have in our colleges and universities a population who are on behavioral grounds at risk, and who need to be educated for their own protection, and that (2) those who are asymptotically infected and can transmit HTLV-III are generally not identified. The current climate is not likely to encourage those who are aware that their HTLV-III antibody test is positive to disclose this. Parents, faculty members, observers, and our communities will expect, nonetheless, that effective precautions are taken to guarantee that students are not subjected to unreasonable risks of getting AIDS from others.

What, then, must we do about AIDS? Answers derive from the best current medical information about the disease and its transmission, not from uneducated fear or prejudice. Critically important is an increasingly large body of in-

formation that clearly demonstrates that AIDS is not transmitted by any form of casual interpersonal contact. The causative virus is actually surprisingly fragile, and does not survive and multiply in the air, on inanimate objects, or on environmental surfaces. It does not swim across pools, or fly. Good research studies in households and schools have demonstrated convincingly and repeatedly that the risk of transmission of AIDS is exclusively that of intimate sexual contact and shared needles and that transmission in an ordinary academic, domestic, or work setting does not occur. We know that HTLV-III is present in the blood of most people with AIDS and ARC, and in some who are healthy carriers; thus, exposure to contaminated blood by sharing needles is important, and health care-related needlestick injuries create a very small risk. That many Americans continue to believe that AIDS can be acquired from a drinking glass, toilet seat, or one's casual companion undoubtedly reflects not just misinformation, but fear.

Current knowledge thus indicates that college and university students or employees with AIDS, ARC, or a positive HTLV-III antibody test do not pose a health risk to other students or employees in a usual academic or residential setting. The Public Health Service has stated that there is no risk created by living in the same house as an infected person; caring for an AIDS patient; eating food handled by an infected person; being coughed or sneezed on by an infected person; casual kissing; or swimming in a pool with an infected person. While the assurance implied in these confident statements is equivalent to that expressed in other medical matters, the degree of certainty and caution demanded by some is beyond the capabilities of science and beyond that considered reasonable in any other area. If we pursued the same "logic" some have applied to AIDS, we might, for example, admit that since there is some extremely small chance that airliners can crash into buildings, we will therefore forbid all airplanes from flying over any inhabited areas.

Intimate sexual contact, on the other hand, may transmit HTLV-III. Any form of genital or anal intercourse with an infected person creates risk; unprotected receptive anal intercourse is particularly dangerous. The risks associated with oral-anal contact are also high; oral-genital exposure is less risky but cannot be considered safe. The sharing of needles, which may expose people to contaminated blood, is dangerous for a multitude of reasons; the possibility of transmitting HTLV-III is one of the most important. Infections caused by HTLV-III are, then, *diseases of behavior*; people can choose to do, or not to do, the things which expose them to a risk of acquiring them. AIDS is thus unlike tuberculosis, or chicken pox, or the common cold — which are easily and casually transmitted between people without the need for certain behaviors that require decision-making. The risk is not that of the classroom, or the residence hall, or the roommate: it is in what is *done* in the classroom or residence hall, or with the roommate.

The primary response of colleges and universities to the AIDS epidemic, then, must be education. Because the disease is spread by certain chosen beha-

vivors, because there is no specific therapy in existence, and because a vaccine is not yet available, the most important goals for institutions will be those of increasing awareness and providing education to prevent further spread of the disease. Higher education must move aggressively and directly to controvert misinformation and counter mythology. We must speak forcefully about the need for safer sexual practices, and we must be willing to provide useful information about the techniques of risk reduction. Squeamishness about discussing some topics must not become apathy or resistance; effective education will require directness. Our educational programs must reach students at all levels, traditional and non-traditional, residential or commuter; they must be available for faculty and staff as well. Through education, we can perform the one major intervention currently possible in limiting the consequences of AIDS, which is *primary prevention*. Educational activities are of paramount importance in discharging the institution's responsibility to protect its student body and employees from unreasonable risks of transmission of the disease; since no actual safety risks are created in a normal academic, employment, or residential setting, the administration of effective AIDS education programs provides the best way for the institution to render enrollment or employment safe and healthful. It is time to stop worrying so much about "casual contact" and get on with the real business of educating people, reducing risk, and providing compassionate care for those with the disease.

What about policy matters? How detailed should an institution's procedures for dealing with AIDS be? The American College Health Association suggests a cautious approach. The issues related to balancing private rights and public health regarding AIDS are, thus far, incompletely resolved. In the interest of flexibility, sensitivity, the balancing of legitimate interests, and a simplicity of approach, the most appropriate policy is one of analyzing and responding to each case individually. Such a policy should include the appointment of a group or institutional office to manage the campus AIDS program, to allow for consistency in decision-making, and to assure effective communication. Colleges and universities will have to be careful in handling public information regarding AIDS issues; misquotations and contradictory statements can be very damaging to an otherwise successful effort.

This volume contains several documents which complement the recommendations and guidelines included in the American College Health Association's *General Statement on Institutional Response to AIDS*, issued in December, 1985. Each includes sufficient detail to stand alone, but they ideally will be read and considered together. Several address primarily issues of policy: administrative liaison/institutional policies, residential housing, and confidentiality of information. The statement on testing for antibody to HTLV-III and its accompanying Risk Assessment Form will help providers and patients make decisions. The statement on educational priorities provides assistance in formulating a program to address our responsibility to educate. Taken together with the *General Statement on Institutional Response to AIDS*, these documents offer

guidance in the management of a comprehensive and effective AIDS program.

Just as these materials suggest close communication between officers within an institution and effective liaison work with community agencies, the disciplines and representative groups of higher education must work together if colleges and universities as a whole are to respond effectively to AIDS. The work of the American College Health Association's Task Force on AIDS has been greatly assisted by our networking with the American Council on Education, the National Association of Student Personnel Administrators, the Association of College and University Housing Officers International, and the Association of Governing Boards of Universities and Colleges. Members of the Task Force have joined the deliberations of many other groups, and have spoken at scores of conventions and meetings. We have benefitted greatly from the assistance of the San Francisco AIDS Foundation, the Gay Men's Health Crisis in New York, AID-Atlanta, the Whitman-Walker Clinic in Washington, and the Charlottesville AIDS Resource Network.

In many ways, the work of this Task Force demonstrates the effectiveness of a committed group of volunteers operating with a very small budget. Our success would not have been possible without both the support of our institutions in committing the time of our members *and* the dedication that has led each of us to take an enormous amount of personal time for this work. As Chairman of the Task Force, I wish especially to acknowledge the strong institutional commitment made by the University of Virginia and the assistance and moral support of my colleagues in the Department of Student Health. Deserving of special acknowledgement are my family, who have tolerated the hours of word processing and the many nights away with cheerful aplomb, and my incredibly efficient and unruffled secretary, Mrs. Mary C. Anderson.

Chapter One

General Statement on Institutional Response to AIDS

December 2, 1985

The recommendations and guidelines included in this Statement augment and extend those of the Preliminary Statement on Disease Transmission issued by the American College Health Association (ACHA) on September 25, 1985. They are based on the best currently available medical information and on recommendations of the Public Health Service and the Centers for Disease Control. The American College Health Association acknowledges the valuable assistance of the American Council on Education in the development of guidelines pertaining to the legal issues and questions presented by AIDS.

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

Such educational programs will address the major intervention currently possible in limiting the consequences of AIDS, which is *primary prevention*. They may also be of paramount importance in discharging the institution's responsibility to protect its student body and staff from the transmission of AIDS. Since the current medical evidence indicates that no actual safety risks are created in a normal academic or employment setting, the administration of effective AIDS education and training programs provides the best way for institutions to render enrollment or employment safe and healthful. The AIDS epidemic raises issues

of liability that are of great concern to college and university administrators; the most effective means of addressing these issues at present is to educate students and employees about AIDS and to take reasonable precautions such as are suggested herein.

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

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

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

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

These facts, derived from the best epidemiologic data currently available,

are the basis for the following guidelines recommended by the American College Health Association.

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

appropriate to encourage new students to inform campus health authorities if they have AIDS, ARC, or positive HTLV-III antibody test in order that the institution can provide them proper medical care and education. This, like all other medical information, must be handled in a strictly confidential manner in accordance with the procedures and requirements in effect in the institution.

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

In general, it is recommended that no specific or detailed information concerning complaints or diagnosis be provided to faculty, administrators, or even parents, without the expressed written permission of the patient in

each case. This position with respect to health records is supported by amendment to the Family Education Rights and Privacy Act of 1974.

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

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

11. There is no medical necessity for institutions to advise others living in a dormitory of the presence in the dormitory of other students who have AIDS, ARC, or a positive HTLV-III antibody test. The responsibility to provide a safe living environment is best dealt with by educational programming, as discussed earlier in this statement. Similarly, college and university officials should make no attempt in any other setting to identify those students or employees who have AIDS, ARC, or a positive HTLV-III antibody test.
12. College and university health policy should encourage regular medical follow-up for those who have AIDS, ARC, or a positive HTLV-III antibody test. Special precautions to protect the health of immunologically compromised individuals should be considered during periods of prevalence of such contagious diseases as chicken pox and measles.
13. Those who are known to be immunologically compromised should be excused from institutional requirements for certain vaccinations, notably measles and rubella vaccines, as those vaccinations may lead to serious consequences in those with poorly functioning immune systems.
14. All colleges and universities should adopt safety guidelines as proposed by

the Public Health Service for the handling of blood and body fluids of persons with AIDS, ARC, or a positive HTLV-III antibody test. Those institutions which operate health care clinics and clinical laboratories providing services for students or employees should implement those Public Health Service guidelines and take measures to see that they are observed. In addition, the institution should provide educational programs about AIDS and the reduction of risk to health care providers for clinical personnel. The following articles in *Morbidity and Mortality Weekly Reports* provide detailed guidelines that should be generally followed:

- A. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staffs. MMWR 1982; 31:577-580.
 - B. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): Precautions for Health Care Workers and Allied Professionals. MMWR 1983; 32: 450-452.
 - C. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): MMWR 1985; 34: 533-534.
15. College and university health services should use disposable, one-user needles and other equipment whenever such equipment will puncture the skin or mucous membranes of patients. Health care officials should not rely on students or employees to identify themselves as having AIDS, ARC, or a positive HTLV-III antibody test, since many infected persons are unaware of their status; safety precautions must be used in all cases. If disposable equipment is not available, any needles or other implements that puncture skin or mucous membranes should be steam sterilized by autoclave before reuse or safely discarded. Extreme caution should be exercised particularly in disposing of needles.
 16. All colleges and universities should adopt safety guidelines for the handling of blood and body fluids of all students in other settings as well. Laboratories used in a teaching context, such as those required in biology courses, should be safe experiences. Given the fact that the existence and identity of those with AIDS, ARC, or a positive HTLV-III antibody test may not be known, procedures for the decontamination of environmental surfaces and objects soiled by blood or body fluids should be adopted and implemented. Laboratory courses requiring exposure to blood, such as finger pricks for blood typing or examination, should use disposable equipment and no lancets or other blood-letting devices should be re-used or shared. No student should be required to obtain or process the blood of others. The Public Health Service guidelines noted above include information about disinfection of environmental surfaces; a simple method they recommend is the cleaning of contaminated surfaces with a household bleach freshly diluted 1:10 in water.
 17. College and university health services must strictly observe public health reporting requirements for AIDS. Patients who meet criteria for the revised

surveillance definition of AIDS must be reported to the local public health authorities. The detailed surveillance definition is included in:

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

Chapter Two

Statement on Institutional Policies and Administrative Liaison

Working Group Chaired by
Howard M. Surface, M.P.H.
Paul A. Walters, Jr., M.D.

DEVELOPMENT OF INSTITUTIONAL POLICIES

Establishment of a Task Force: The American College Health Association believes that education and communication are the vital elements in the response of any college or university to AIDS-related issues. Effective communication demands the appointment of a Task Force of senior institutional officials for the purposes of establishing policies and procedures and overseeing the necessary educational efforts. The Task Force should include the Directors of Housing, Health Services, Counseling Center, Food Service, and Institutional Relations, as well as the Legal Counsel and senior Student Affairs officer. The Task Force should obtain for its own members detailed information about AIDS and should establish mechanisms for continuing education and the dissemination of new information. *The role of this Task Force is detailed further in this document, and in the Statements on Residential Housing, Confidentiality of Information, and Educational Priorities.*

The American College Health Association suggests that the Task Force avoid the adoption of written blanket policies concerning students or employees with AIDS or AIDS-related conditions. Instead, it suggests that certain guidelines be understood and that the written policy indicate that institutional officers will analyze and respond to each case as required by its particular facts. Insofar as possible, AIDS-related issues should be addressed through existing policies and procedures governing other medical matters. Some important policy guidelines are included in the General Statement on Institutional Response to AIDS.

This chapter addresses three major areas of responsibility of the Task Force: Risk Management, Liaison Activities, and Administrative Issues.

RISK MANAGEMENT

The Task Force should adopt general written guidelines in regard to the admission, matriculation, academic and social participation, and handling of

students and employees with AIDS, ARC, or a positive test for antibody to HTLV-III. ***Suggested policies are included in the General Statement on Institutional Response to AIDS.*** The Task Force should appoint an agency or official to analyze each case, using the best existing medical facts and advice. If the person assigned this role (perhaps called the "Case Manager") is not a health service physician, he or she must have easy access to a physician for consultation. The Case Manager should be a member of the Task Force and should be fully conversant with statutory and other requirements regarding confidentiality of information. A key part of the Case Manager's role will be the provision of consistency in the handling of questions that arise concerning the risks caused or experienced by a person with AIDS, ARC, or a positive test for antibody to HTLV-III. The identity of the Case Manager should be widely known; it is important that student affairs staff know how to refer problems for his or her consideration.

LIAISON ACTIVITIES

Since any college or university is part of a larger community, **it is important that each institution, through its Health Service, maintain effective relationships with local health care agencies, physicians, and hospitals.** Such relationships provide the opportunity for the institution to demonstrate its leadership in addressing the issues with which the AIDS crisis confronts each community. In many places, a college or university may fill a significant void in this way; in others, the institution provides valuable assistance to local authorities and health care providers by facilitating communication. The public will look to colleges and universities for cooperation in developing AIDS educational programs.

Certain specific guidelines are relevant to the important liaison relationships colleges and universities should develop:

- 1. The American College Health Association strongly recommends that each college and university share its educational efforts with local agencies. A separate Statement on Educational Priorities provides an extensive discussion of suggested educational programs, methodologies, and options.**

- 2. Each Health Service is urged to establish its own data repository to complement existing information collected by other agencies in the community. The data collected may be of importance in regional health planning and health education efforts as well. As is true of any other health care organization collecting statistical information regarding AIDS-related conditions, there is an important dual responsibility inherent in this kind of data collection: to strictly maintain absolute confidentiality in regard to individual students or employees while generating statistical data that can be shared with other appropriate agencies. The existence of these figures, however, should not be equated with the necessity to release them; decisions regarding the sharing of the information must be in accordance**

with institutional policies. There is an additional responsibility to comply with statutory requirements for reporting of cases of AIDS; in some areas, ARC or positive antibody tests for HTLV-III are (or may become) reportable as well. *The American College Health Association's Statement on Confidentiality of Information provides further detailed information about these issues.*

3. Public Relations: Colleges and universities are likely to receive inquiries regarding the institution's policies concerning AIDS and the numbers of students, faculty, or employees affected. Colleges and universities may also maintain accurate, current information about AIDS and AIDS-related issues which should be made readily available for the public good. The American College Health Association makes certain specific recommendations:

a. Appointment of a Spokesperson. The Task Force should appoint an agency or an individual to handle public information about AIDS-related issues. This role is best filled by a single individual, whose experience in dealing with the print and broadcast media creates a credible, forthright, and effective presence in facing difficult questions. A member of the public affairs staff will often best serve this purpose.

b. Public information. In consultation with the college or university legal counsel, the Task Force must work with the spokesperson to determine what information is appropriate for public dissemination. This process will entail a review of applicable statutes and policies regarding both public information and the confidentiality of medical records.

c. Participation by other offices. It is very likely that college and university housing officials, health officers, and counselors (among others) will be asked to comment about AIDS as an issue or about the institution's experience. It will be helpful to provide education for institutional managers concerning public affairs policy. The institution should not permit unauthorized personnel to represent its policies or experience in regard to AIDS. *See the Statement on Residential Housing for a discussion of these issues as they pertain specifically to residential life and housing officers.*

d. Forms of response. The Task Force should determine the format and character of responses to inquiries. The control gained by a written response is of great value. Formal training sessions in dealing with reporters are often helpful for officials who will be facing personal interviews.

ADMINISTRATIVE ISSUES

The following recommendations deal with certain administrative issues common to many institutions; they complement the suggestions in the *General Statement on Institutional Response to AIDS*.

1. College and University Employees: The Task Force should determine policies for institutional employees with AIDS, ARC, or a positive test for antibody to HTLV-III. In doing so, each institution should abide by the recommendations of the Centers for Disease Control and the Public Health Service. A detailed discussion is provided in the following article; any subsequent modifications or extensions of these recommendations should be noted.

SUMMARY: RECOMMENDATIONS FOR PREVENTING TRANSMISSION OF INFECTION WITH HUMAN T-LYMPHOTROPIC VIRUS TYPE III/LYMPHADENOPATHY ASSOCIATED VIRUS IN THE WORKPLACE. MORBIDITY AND MORTALITY WEEKLY REPORT 34: 681, 1985.

The special case of **food service workers** is discussed at length in those guidelines, which state that "food-service workers known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infection or illness for which any food-service worker should also be restricted."

Officials of institutions which employ **personal service workers** (those whose occupations require close personal contact with clients — hairdressers, barbers, estheticians, cosmetologists, manicurists, pedicurists, massage therapists, for example) must guarantee that these workers are educated about transmission of blood-borne infections, including HTLV-III and hepatitis B; that all such workers are licensed and comply with local and state health requirements; and that the guidelines of the Centers for Disease Control in regard to personal service work are strictly observed.

2. Athletics, including intramural sports. The key elements of an appropriate response to AIDS in college and university athletic programming are, again, education and communication. A good working relationship between athletic officials and other institutional officers is vital. The American College Health Association suggests the following approaches:

a. Education: Coaches and intramural directors should receive education about AIDS and should understand the institution's policies, especially in regard to public relations and the handling of confidential information. (*See discussion above.*)

b. Participation. Whether or not a varsity or intramural athlete is physically able to practice or compete should be a medical decision, not one made in the athletic department. Students with AIDS-related conditions may be perfectly capable of vigorous athletic activity; in some circumstances, however, competition would not be in the best interest of their health. An individual assessment by a Health Service physician is required.

College and university health officers should make all reasonable efforts to encourage students with AIDS, ARC, or a positive test for antibody to HTLV-III to so inform their health care provider, so as to guarantee better medical care. In the case of an athlete, this will enable

the health care provider to make appropriate recommendations in regard to athletic participation. *The success of any such effort depends on the maintenance of absolute confidentiality of the medical information involved; see the Statement on Confidentiality of Information for further discussion.*

Intercollegiate athletic associations may issue requirements or recommendations regarding athletes with AIDS, ARC, or a positive antibody test for HTLV-III. Those who wish to continue to participate may voluntarily choose to discuss their condition with the coach. It seems unlikely that athletic competition presents a sufficiently clear danger to another individual to warrant the unauthorized disclosure of confidential information by a health care provider to a coach.

Athletic departments should have in force procedures for handling injuries to student athletes and for dealing with spilled blood or body fluids. Health services can be helpful in providing guidance if these procedures do not exist.

c. Public relations. It is essential that policies established by the campus Task Force in regard to the release of information be strictly followed.

3. Cardiopulmonary Resuscitation. Colleges and universities commonly provide or sanction training in cardiopulmonary resuscitation (CPR). Institutional officials should guarantee that guidelines provided by the American Red Cross and the American Heart Association are followed strictly.

4. Health Care Workers and Students. In implementing programs to protect health care workers, health care professions students, and patients from the transmission of HTLV-III, institutional officials should consult with local health officers and legal counsel; any guidelines developed should be consistent with the detailed recommendations of the Centers for Disease Control (MMWR 34:681, 1985). Extensive discussion of these issues exists in the referenced material, and is beyond the scope of this document. *See specific recommendations in the General Statement on Institutional Response to AIDS, and in the three publications of the Centers for Disease Control referenced therein.*

5. Other Risk Areas. The Task Force should see that procedures for the safe handling of blood and body fluids are adopted and implemented in settings other than health centers and athletic departments, as well. Areas of concern include teaching laboratories in the biological sciences, for example. *See specific recommendations in the General Statement on Institutional Response to AIDS.* If the Task Force feels that any other institutional activity requires consideration as regards the risk of transmission of HTLV-III, it should seek expert medical and legal advice in structuring an appropriate policy.

Chapter Three

Statement on Housing Policies

Working Group Chaired by
J. Robert Wirag, H.S.D.

Education and **communication** form the basis of any institution's best approach to dealing with the complex and inter-related issues raised by AIDS. All members of the academic community must be kept informed about these issues. The institution must make every effort to develop policies and procedures that are based on the most credible body of scientific and legal knowledge at hand. As new information about AIDS and HTLV-III becomes available, institutional officers must reconsider policies and procedures accordingly.

Institutions providing on-campus living have a duty to support an environment free of unreasonable risks for its residents. Typically, this duty is discharged through an administrative unit (e.g., Residence Life Program) that manages a healthful living environment through facility maintenance, appropriate staffing, and sound programming. As a facilitating resource for the institution, Residence Life Programs work with many other campus units — such as Admissions, Food Services, Financial Aid, the Health Service, Counseling Center, Police Department, Judicial Affairs, Academic Affairs, and Public Relations. This type of cooperation is necessary if students' numerous academic, physical, emotional, and social concerns are to be dealt with effectively. The inter-relationships of the complex medical, social, ethical, and legal issues involving AIDS demand even greater cooperation among these various campus offices.

Institutional officials must communicate housing policies and procedures concerning AIDS widely. They must be readily accessible, clearly presented, openly discussed, and comfortably understood at all institutional levels. They must receive consistent support within the institution — particularly by the Residence Life staff, from the Residential Assistants' to the Director; to do otherwise will undoubtedly result in confusion and may expose individuals or the institution to unreasonable risk and consequent tort liability.

If the number of cases of AIDS continues to increase, it is likely that difficult decisions will confront greater numbers of housing officials. Those who have

not yet had to deal with a student with AIDS, ARC, or a positive antibody test for HTLV-III cannot afford to ignore the issues they will have to face. All must undertake systematic planning now to prepare for such an eventuality. Housing directors must consider "worst case" scenarios and "what if" exercises and agree with other campus officials on measures to manage effectively those decisions that will affect students with AIDS, ARC, or a positive antibody test for HTLV-III; other students; or the interests of the institution at large.

The campus housing policy must rest on the following facts:

(1) **The best currently available medical information is that HTLV-III is not transmitted by any form of casual contact. No evidence supports the existence of any risk to household contacts. There is no justification for excluding students with AIDS, ARC, or positive tests for HTLV-III from residential housing in order to protect others from casual transmission. On the other hand, immunocompromised students, whether they have an AIDS-related disorder or another illness may require special housing arrangements for their own protection.**

(2) **HTLV-III is transmitted by certain behaviors, primarily, intimate sexual contact and the sharing of needles contaminated with blood. Protection against these exposures requires education of all students and employees; it is not accomplished by excluding those with AIDS, ARC, or a positive antibody test for HTLV-III from residence halls.**

(3) **AIDS, ARC, and positive tests for HTLV-III antibody are conditions present in individuals, not in buildings.**

The most important feature of any AIDS-related housing policy is a *case-by-case evaluation* of any student known to have AIDS, ARC, or a positive antibody test for HTLV-III. Such an evaluation will appropriately consider the current medical situation of the student involved; it is likely that decisions will be reviewed later, depending on changes in the student's medical condition.

The American College Health Association suggests the following guidelines for housing and resident life programs in developing a comprehensive response to AIDS.

GUIDELINES FOR HOUSING AND RESIDENCE LIFE PROGRAMS

The following recommendations and guidelines recognize certain specific features of the close cooperation necessary among various units of the institution to guarantee an appropriate and consistent response to AIDS-related housing issues.

1. Identify a campus task force to serve the community as a working group to respond to AIDS-related concerns. This group might appropriately include Directors of the Health Service, Food Services, and Housing and representatives of the Personnel Office, among others. This group must weigh all pending decisions carefully to protect individual students,

other members of the college or university community, and local citizens, as well as the institution itself. It should determine the impact of applicable federal and state laws or judicial decisions before recommending policies that exclude or remove persons having AIDS, ARC, or a positive antibody test for HTLV-III. If students with AIDS or ARC are regarded as "handicapped" by their medical condition, institutional officers must consider the applicability of the Rehabilitation Act of 1973, which prohibits discrimination against "qualified handicapped individual(s)" in programs or activities conducted with federal financial assistance.

2. Identify principal individuals delegated the responsibility of coordinating AIDS education among faculty, staff, and students. These individuals should stay aware of new information about AIDS, be informed about policies at comparable institutions, and attempt to foster an objective and informed attitude about AIDS in the institution. Housing and Residence Life officers must work closely with these people to provide good educational programming for residence hall staff and residents, as well as for maintenance, clerical, and other housing support staff. Residence hall staff should be educated prior to the arrival of students each Fall. A good educational program does not stop after the initial presentations are over; periodic updates and reviews, with an opportunity for discussion, will promote effectiveness.

3. All Housing and Residence Life staff should be able to identify campus and community resources for referrals for counseling, medical testing and evaluation, and education.

4. Housing and Residence Life staff should understand the legal requirements and obligations concerning confidentiality of information. Only a careful explanation of the importance of unwavering adherence to these requirements and a willingness to take strong measures against those who violate them will enable campus officials to reassure students that individual privacy and medical confidentiality are respected and protected by institutional personnel. The Housing and Residence Life programs should establish procedures to deal with rumors about students alleged to have AIDS, and should limit participation in rumor-spreading by institutional staff by all reasonable means. *Please see the American College Health Association's Statement on Confidentiality of Information for further discussion.*

5. It is important to encourage students with AIDS, ARC, or a positive antibody test for HTLV-III to inform health officials of their condition to guarantee their best medical care. The Health Service should make arrangements at the earliest possible time to inform immunocompromised students of outbreaks of highly contagious diseases which pose a particular danger to them (e.g., chicken pox, measles); in order to reduce their exposure. The effective implementation of such a plan depends on close cooperation among the Housing Office, the Residence Life Program,

and the Health Service; only information essential to guarantee the protection of the students involved must be transmitted.

6. Housing and Residence Life officers should be prepared to respond to inquiries from parents about a known or suspected student with AIDS, ARC, or a positive antibody test for HTLV-III living in campus housing, and to questions from them or others about the institution's policy in this regard. Refer them to a single designated campus official (appointed by the task force; see #1) for response; do not allow several different staff members to deal with these concerns. *Further discussion is provided in the Statement on Institutional Policies and Administrative Liaison.*

7. Under no circumstances should Housing officials allow concern or suspicion about the health or sexuality of a student on the part of one or more other students or employees result in a demand that the suspected student be tested for HTLV-III antibody, relocated, isolated, ostracized, or excluded from campus housing.

RECOMMENDATIONS FOR A CAMPUS HOUSING POLICY

Recognizing that institutional circumstances vary, the American College Health Association suggests that campus officials consider the following options to protect healthy students; those with AIDS, ARC, or a positive antibody test for HTLV-III; and the institution itself.

1. To Protect the Student with AIDS, ARC, or a Positive Antibody Test for HTLV-III

a. Communicable Disease Alert. Develop an information-sharing network to inform all immunocompromised students about highly contagious diseases that may be of particular danger to them and to identify protective measures to reduce such risk after consultation with health officials. Be certain that no unnecessary compromise of confidential information occurs in the appropriate performance of this function.

b. Early identification. Through a variety of education strategies, encourage persons with AIDS, ARC, or a positive test for antibody to HTLV-III to inform a campus health care provider about their condition, with the understanding that such information will be regarded as protected, confidential medical information. Only the success of this effort will allow the effective dissemination of a communicable disease alert.

c. Cooperation and Support. Encourage the student with AIDS, ARC, or a positive antibody test for HTLV-III to discuss his or her situation with certain other campus officials, such as a Dean or a counselor in the Residence Life program, on a confidential basis in order that potential difficulties can be anticipated. It is important that all such students have someone to whom to turn for advice, support, and understanding. Colleges and universities may wish to publish a list of campus officials who have been properly prepared to

handle effectively the concerns of students at risk.

d. Restriction of Information. Do NOT inform other students in the residence hall or elsewhere of the presence of a student with an AIDS-related condition. Do NOT inform the roommate of such a student. Sharing that information only causes needless fear and anxiety and may result in unnecessary, painful, and isolating consequences for the affected student. It is NOT necessary for the protection of other students, because AIDS is not transmitted by ordinary casual residential contact.

e. Relocation. Depending on the individual medical and social circumstances involved, it may be appropriate to provide special housing arrangements for students with AIDS or ARC. Those who are immunocompromised should be offered the option of a separate (single) living quarters or of a room to accommodate a caretaker. Any discussion about relocating a student should involve careful consideration of the consequences of such a move — e.g., attention that may be drawn to the student's special circumstances by virtue of the relocation; ridicule or other abuse; the student's own feelings of being ostracized and excluded. Thus, such a relocation should be accomplished only after thorough discussion with the student involved, and only with his or her informed consent in advance.

2. To Protect Other Students and Employees From a Student with AIDS, ARC, or a Positive Test for Antibody to HTLV-III.

a. Medical Monitoring. Encourage the affected student to participate in a program of regular medical follow-up and monitoring of his or her condition by health care personnel familiar with AIDS-related problems.

b. Education of the Affected Student. Through the health care provider, assess the affected student's knowledge about the transmission of HTLV-III and the ways and means of preventing it. Provide, or arrange for, detailed education of the affected student and emphasize the need to behave in such a way to guarantee that no one is endangered.

c. Education of Other Students and Staff. Provide an effective and ongoing AIDS education program for all students and employees of the institution. Educational programs should reach Housing and Residence Life employees prior to the arrival of students in the Fall. Students living in campus housing should be educated shortly after their arrival.

d. Not Necessary: it is NOT necessary to notify other students or roommates of the presence in the residence hall of a student with AIDS, ARC, or a positive test for antibody to HTLV-III. It is NOT necessary to exclude such affected students from campus housing.

3. To Protect the Institution from Adverse Publicity, Loss of Students, or other Consequences Because of Knowledge or Rumor of Students with AIDS, ARC, or a Positive Test for Antibody to HTLV-III.

a. Early Identification, Medical Care, and Education: Encourage students with AIDS, ARC, or a positive test for antibody to HTLV-III to inform a campus health care provider about their condition. Provide, or ar-

range for, competent and frequent medical follow-up and for detailed education of the affected student(s) regarding the transmission of HTLV-III and the steps necessary to prevent it. Provide effective and ongoing educational programs for all other students and for institutional employees so they will be aware of preventive behaviors.

b. Policies and Procedures. Develop, through a task force, policies and procedures for dealing with students with AIDS, ARC, or a positive test for antibody to HTLV-III. Guarantee that such policies and procedures conform with applicable federal and state law. Be certain that they are well understood and consistently applied throughout the institution. Please see also the Statement on Institutional Policies and Administrative Liaison.

c. Confidentiality. College and university officials must guarantee that confidential medical information about students with AIDS, ARC, or a positive test for antibody to HTLV-III is protected. The inadvertent or malicious "leaking" of such information can cause extremely painful consequences for the affected student(s) and for the institution. All who might potentially deal with confidential medical information should clearly understand these facts. For further discussion, see the Statement on Confidentiality of Information.

d. Public Relations. The institution's task force should appoint a single official to respond to public inquiries. He or she should state the institution's policy forthrightly and clearly, but should absolutely refuse to provide any specific information about individual students or residence halls. *A detailed discussion of this and other public relations issues is included in the Statement on Institutional Policies and Administrative Liaison.*

Statement on Housing Policies has been approved and recommended by the Association of College and University Housing Officers-International.

Chapter Four

Statement on Educational Priorities and Methods

Working Group Chaired by
Anne Lomax, M.A.

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AIDS EDUCATION: A RESOURCE GUIDE

INTRODUCTION

This guide is an attempt to apply *wellness* philosophies to ourselves in addition to our students, i.e., to practice what we preach. *Part of wellness is staying in touch with our needs and asking for help before external pressures and stressors get out of hand.* Some of us are not sure where to start and feel overwhelmed by the responsibilities of AIDS education. Some of our colleagues have excellent working models already in place and are willing to share their experience with the rest of us.

AIDS is a reality and prevention through education is our responsibility. Now is the time to reach out, get help, and get going. This AIDS Education Resource Guide will help us:

1. **Share information** so we do not "reinvent the wheel" each time an AIDS education program is developed.

2. **Set priorities for AIDS education** programming to fit our specific financial and time limitations.

3. **Use our people power** to the best advantage.

4. **"Network,"** so that we are not working in isolation and can provide emotional support to each other.

5. **Develop regional speakers' bureaus** and lists of people who are already doing AIDS education, including ways to contact them.

6. **Know where to send for** written materials and brochures appropriate to our educational needs. The American College Health Association Task Force on AIDS has developed several low cost educational materials specifically designed to facilitate campus efforts to educate students, faculty, and staff. These materials are described herein near the end of this book.

FOCUS ON PREVENTION

Until a consistently effective treatment is found for individuals suffering from ARC and AIDS or until people can be immunized against the HTLV-III virus, preventing spread of the disease through changes in behavior is our strongest defense. As health educators we are familiar with disease prevention through wellness education; AIDS education is just that — wellness education for disease prevention. Knowing the model is the easy part; knowing how to talk about the topic is often more difficult.

Having accurate information is primary; being prepared to talk about sensitive topics like safe sex and reducing AIDS risks associated with drug use is equally crucial. The educating starts with ourselves and our staffs.

Some of us have training in talking about these sensitive topics and some of us are not sure how to approach them. Some of us have been doing AIDS education for five years and some of us are just beginning. Some of us are familiar with

successful educational strategies and some of us don't know where to start. Some of us are the only staff person in our health services and are responsible for medical services *and* educational outreach. Others of us work at larger campuses in health education units where responsibilities are shared among multiple staff members. Some of us have medical or nursing backgrounds, some have health education backgrounds, and some have an eclectic combination of education and professional experience.

Many of you reading this are not directly involved with health care, but the AIDS crisis has made it necessary that you become informed and involved. This guide is written for everyone searching for means to adequately and appropriately cope with the institutional and individual issues AIDS raises.

Networking is a valuable and cost-effective means to tackle and resolve difficult situations — especially through the American College Health Association. This resource guide is the result of just such networking.

Together we make up a group of people who are responsible for students and health education at our institutions. That you are reading this probably means that you have been given some responsibility in providing AIDS education to the students on your campus or to your campus community. *Through ACHA networking and this resource guide we can support each other in fulfilling this shared responsibility.*

LANGUAGE MATTERS

The language we use in AIDS education makes a difference. This applies to three general categories:

- 1) **Avoid using negative labels**, e.g. AIDS "victim."
- 2) **Know the general terminology** associated with AIDS, e.g. ARC = AIDS Related Complex.
- 3) **Know specific terminology associated with high risk behaviors**, e.g. rimming (oral/anal contact).

AVOID USE OF NEGATIVE LABELING

"AIDS victim" is a phrase we hear in the media, in everyday conversation, and in discussions by health professionals. **By using the term "victim" we create an unnecessary external stressor for people coping with ARC or AIDS.** In the June 3, 1985 *Sexuality Today Newsletter*, Kathi Knowles, Executive Director of the Health Information Network in Seattle, addresses this issue directly:

"While the word 'victim' may seem very innocent, it is laden with a number of psychological implications and sets up restrictions in people's minds. ...

"With any disease, there is a psychological component, which can vary

from slight to intense, depending upon a number of factors. These factors can include the patient's own current psychological functioning; their support systems already in place; where the disease affects the body, whether the disease is life-threatening; if there is loss of physical functioning from the person's normal state of function; and the amount of knowledge the individual has about the disease, knowledge about standard medical treatment for the disease and predicted outcome.

"Given these factors, the psychological impact of AIDS can be very intense. ... The word 'victim' has negative connotations, sets up a self-fulfilling prophecy of hopelessness and pity, and further saps the psychological strength and energy of the individual who is already coping with the above factors.

"One way mental health professionals can help with the 'positive attitude' concept is to choose another phrase to describe these people rather than 'victim'. One option might be 'person that contracts....' A consistent approach from both the medical and mental health community and the media concerning choice of words in describing these people might result in patients taking more responsibility for their health care and working more cooperatively with their health care providers."

An additional kind of negative labeling is used by some inaccurately to connect AIDS with a homosexual orientation. For example, the phrases that refer to AIDS as a "gay plague" or "faggot disease" imply that the causative virus (HTLV-III/LAV) somehow "knows" someone's sexual orientation and seeks out homosexual people; **that the virus is transmitted by certain high risk behaviors regardless of sexual orientation is not made clear.** As part of this negativism, further misunderstanding about homosexuality is perpetuated.

Negative labelling can be completely avoided by referring to those who have AIDS as "people with AIDS." This term is non-judgmental, does not assume any sexual orientation, and does not predict any outcome. A person with AIDS (or "P.W.A.") is thus identified, but not evaluated. This kind of sensitive terminology is an important element in a compassionate approach to people struggling with both a disease and a problem of others' attitudes.

GENERAL AIDS-RELATED TERMINOLOGY

Terms most often used in AIDS education are listed in a *glossary* located in the first section of **AIDS EDUCATION: THE CONTENT.**

SPECIFIC AIDS-RELATED TERMINOLOGY

Education for so-called high risk groups is often more specific than that for the general population. Some people may be more likely to engage in certain high-risk behaviors; often these behaviors have descriptive names which may not be familiar to the general public but which are well known and widely

used by sub-populations.

Student populations may not use the same descriptive terms as those used by non-student populations. *As educators we need to find a balance between the need to accurately caution students against high risk behaviors and to work within both our particular campus's political environment and the sensitivities of our students.* This may mean describing high risk behaviors in general terminology rather than sexually explicit terminology, e.g. putting any large objects in the anus is a high risk behavior. We have a challenge to be clear and direct about what behaviors are considered risky or unsafe and at the same time to use language which is acceptable to both students and administration. We may have to educate administrators about the need to be sufficiently explicit to make our efforts effective.

Identification of high risk behaviors and some of the associated terminologies are given in the content sections for risk groups. *Finding ways to accurately describe these behaviors in terms appropriate to our specific target populations is part of our responsibility. Similarly, finding written materials that address the educational needs of all our students, faculty, and staff requires sensitivity to the acceptability of certain types of language and images. We must, however, not let squeamishness about words or behaviors interfere with direct, effective identification of unsafe behavior and effective identification of risk-reducing alternatives.*

EDUCATIONAL APPROACHES: WHAT'S WORKING?

As educators, especially health educators, we have a responsibility to provide information on two levels: 1) to the student population, and 2) to the staff and student leaders who directly deliver services to the students, i.e. the "gatekeepers." Of these two categories, our efforts have the greater impact by providing education to the gatekeepers.

After providing AIDS education for the past year, health educators at the University of California, Berkeley found that it was effective to focus 50% of the resources on training gatekeepers. **Educating gatekeepers such as residence life staff, counselors, food service workers, administrators, health care workers, and any other staff in contact with students multiplies the outreach which health educators have.** It also assures that consistently accurate information is being provided at all levels; students come into contact with gatekeepers on a daily basis while AIDS education programs are situation specific. *Distribution of this book, AIDS on the College Campus, to all campus gatekeepers is highly recommended.*

Each of us has financial and time limitations on what we can accomplish. It is within these boundaries that we begin to look at what's possible; given x-amount of funds and y-number of staff members (people power) what can we do concerning AIDS education on our campuses?

This section provides some educational outreach approaches based on

People Power ♦

Funds ♦	A Low Funds Low People Power	B Low Funds Medium People Power	C Low Funds High People Power
	D Medium Funds Low People Power	E Medium Funds Medium People Power	F Medium Funds High People Power
	G High Funds Low People Power	H High Funds Medium People Power	I High Funds High People Power

funding and staffing differences. The suggestions are categorized from A–I, reflecting low, medium, and high levels of funding and people power. People power includes non-paid support staff, like peer educators. The chart above illustrates the possible combinations of funding and personnel we will be facing. Each subsequent list of suggestions builds on that of the previous (lower-lettered) category. If, for example, your evaluation is that you have medium funds and medium people power, you are in category E; you may profit from the ideas listed for A, B, and D as well.

A. Low Funds — Low People Power

If you are on your own with numerous other responsibilities and have little time and minimal funds:

1. The ACHA brochure, AIDS: WHAT EVERYONE SHOULD KNOW provides excellent coverage of the topic. The ACHA also publishes a risk reduction brochure, **SAFE SEX**, and distributes educational videotapes about AIDS. All are available from: American College Health Association, 15879 Crabbs Branch Way, Rockville, Maryland 20855. Phone (301) 963-1100

2. Arrange with campus or local radio stations to run **Public Service Announcements on AIDS information/referrals. PSA's are free and can be quickly written and taped.**

3. Contact your local and state Health Department; they probably have

limited copies of free materials, including pamphlets and posters, which they can send. These are usually up-dated periodically and therefore provide current information.

4. Have a large (permanent) poster in the waiting area or lounge of the Student Health Service. Many students have excellent poster writing skills; ask for a volunteer. Graphics art students are another resource. Include information about:

- What your health service offers
- Where written information is available
- HTLV-III Alternative Test Sites
- Locations and Phone numbers

5. Contact local and regional AIDS centers; these are located especially in large cities and metropolitan areas. Many will supply speakers; most provide written materials.

6. Share resources with community hospitals and other nearby colleges. Public health departments frequently will work with hospital and community groups to arrange programs. Cooperative efforts with other colleges and universities conserve everyone's resources.

B. Low Funds – Medium People Power

1. Work with your campus newspaper to develop an article or series of articles emphasizing AIDS prevention and highlighting the fact that the virus is not passed through casual contact. While it takes staff time to work with campus reporters, articles are free.

2. Coordinate a panel discussion or symposium open to the campus community covering all aspects of AIDS. This takes time to coordinate but there are qualified, well-informed speakers who will participate for free. Possible topics include:

- Epidemiology — HTLV-III, transmission, testing
- AIDS/ARC — symptoms, diagnosis, treatment
- Prevention — reducing risks, safe sex, "worried well"
- People at risk — vulnerable populations; risk behaviors
- Psycho-social aspects — individual, social, community
- Women and AIDS
- Legal Issues
- Research advances
- Discussion with people with AIDS/ARC

Contacts: (See Resource List for addresses)

Richard P. Keeling, M.D., University of Virginia
Margaret W. Bridwell, M.D., University of Maryland
Wayne Ericson, Ph.D., Illinois State University

Joy L. Greenway, M.D., University of Arizona
Cathy Kodoma, University of California, Berkeley
Anne Lomax, M.S.A., University of Delaware
Ida C. Murray, Cabrillo College, California
Carol J. Sudol, R.N., B.S.N., George Mason University
Howard M. Surface, M.P.H., University of North Carolina—Charlotte
Jo Ann Underwood, Virginia Polytechnic Institute
Paul Walters, M.D., Stanford University
J. Robert Wirag, H.S.D., University of Arkansas
H. Roland Zick, M.D., University of Colorado

C. Low Funds – High People Power

1. Offer an AIDS INFORMATION TELEPHONE SERVICE; one central number where information and referrals are available. This service also provides ongoing needs assessment to keep your finger on the pulse of student and campus concerns. For example, on the University of California, Berkeley campus where such a service has been offered for the past year, initial concerns reflected misinformation about casual contact and need for clinician referral for students considering themselves to be "at risk." Within six months, calls reflected more personal awareness that AIDS is not a "gay disease," with questions about "if I slept with someone who slept with someone who now has a positive antibody test, am I at risk?"

If you have qualified student volunteers already working with you, e.g. peer educators, student advisors, they can be trained to operate the phone service and the cost is minimal: a phone, referral notebook, log book, and trained, volunteer operators.

For more information about AIDS INFORMATION PHONE SERVICES in operations contact:

Cathy Kodoma
Student Health Service
Room 381, Cowell
University of California, Berkeley
Berkeley, CA 94720
415-642-7202

2. If you have peer educators working with you, include AIDS education in their initial and/or ongoing training. They can present AIDS programs or STD programs including AIDS in residence halls, commuter groups, classes, fraternities, sororities, etc. Starting the program with a quiz about AIDS is one way to get students involved and also to check how much they know. A sample quiz is included below.

Peer educators can also do programs on how to talk with partners about "safe sex." In addition, you may be able to work with your campus gay group to provide risk reduction information to their members. College lesbian/gay student groups have provided excellent AIDS education; don't be timid about tapping

those resources. The ACHA brochure on Safe Sex has been especially developed to be appropriate education for everyone.

Contacts: (See Resource List for addresses)

Cathy Kodama, University of California, Berkeley

Anne R. Lomax, University of Delaware

Peggy Brown Paviour, University of Virginia

Robin Sawyer, University of Maryland-College Park

SAMPLE QUIZ

EDUCATION ABOUT HTLV-III ANTIBODY TESTING

(True or False: Circle One)

1. True False Reported AIDS cases in the U.S. show an equal distribution nationwide.
2. True False The prevalence of HTLV-III antibody in the general population is higher than the prevalence of antibody to the herpes virus.
3. True False A positive HTLV-III antibody test is diagnostic for AIDS.
4. True False Persons who are HTLV-III positive should be referred to a physician for further evaluation
5. True False Members of high risk groups who are antibody negative for HTLV-III should not donate blood.
6. True False At least one study has determined that condoms can provide adequate protection against acquiring an HTLV-III infection.
7. True False Several investigators have shown that over half of those who are HTLV-III antibody positive will go on to develop AIDS.
8. True False Someone in a risk group for AIDS who is HTLV-III antibody negative does not need to take any special risk reduction measures.
9. True False Health care workers are at high risk for acquiring an HTLV-III infection from the patients that they serve.
10. True False The epidemiology of AIDS in Africa is the same as in the U.S.
11. True False Addicts who share needles run an increased risk for acquiring an HTLV-III infection.
12. True False Many cases of HTLV-III transmission via saliva have been documented.
13. The groups of people who have the highest risk of acquiring AIDS are:
a. _____ c. _____
b. _____ d. _____
14. Two ways that people can reduce the chances of acquiring an HTLV-III infection are:
a. _____ b. _____
15. The period of time from exposure to AIDS until onset of AIDS has been shown to vary from: _____ to _____ years

Developed by: James C. Welch, R.N.

HTLV-III, AIDS Education Coordinator

Department of Public Health, State of Delaware

D. Medium Funds – Low People Power

1. Have posters printed which visually show that AIDS is not transmitted through casual contact.

Contacts: (See Resource List for addresses)

Cathy Kodama, University of California, Berkeley

Frank Carter, M.B.A., University of Pittsburgh

Paul Walters, M.D., Stanford University

Your local or state health department

2. If you don't have much time for outreach, develop an in-house resource area on AIDS. Accumulate low cost brochures and duplicated articles (be careful of copyrights). Advertise that you have a resource center available for students doing papers on AIDS, interested people, etc. Purchase AIDS educational materials from the ACHA.

Contacts: (See Resource List for addresses)

Richard P. Keeling, M.D., University of Virginia

Chi Hughes, Whitman/Walker Clinic

Cathy Kodama, University of California, Berkeley

Anne R. Lomax, M.A., University of Delaware

Nancy Shaw, San Francisco AIDS Foundation

E. Medium Funds — Medium People Power

1. Work with campus student groups in developing and disseminating information about safe sex. You can pool people power and financial funding on a joint project that will help all of you get the information where it needs to be — where behavior changes need to happen.

GLSU (Gay and Lesbian Student Union) groups are a good place to start. Allied health student groups on campus are another good place, e.g. nursing, health education, life sciences, etc. Some of the best campus AIDS education programs have been organized and accomplished largely by student groups; many students welcome the opportunity for a volunteer project, and gay groups in particular are often eager to develop programs on AIDS.

Contacts:

ACHA, Rockville, Maryland

Richard P. Keeling, M.D., University of Virginia

Joanne Underwood, R.N., M.S., Virginia Polytechnic Institute

Cathy Kodama, University of California, Berkeley

2. Tap campus and community resources and develop specific information targeted at IV drug users. Include information on other drug use, emphasizing that most drug use weakens the body's immune system.

3. Offer on-campus rap groups where printed materials are distributed and different topics are discussed at different sessions. There can also be ongoing groups for the "worried well", for friends of people with AIDS/ARC, etc. (This

can also be a low funds/medium people power idea if little cost is put into materials.)

Contacts: (See Resource List for addresses)

Pamphlet: *When A Friend Has AIDS* available from many AIDS resource groups, including:

AID-Atlanta
AIDS Project Los Angeles
Gay Men's Health Crisis (New York)
HERO (Baltimore)
Metrolina AIDS Project (Charlotte)
NO AIDS Task Force (New Orleans)
San Francisco AIDS Foundation
United States Conference of Mayors
Whitman-Walker Clinic (Washington)

F. Medium Funds — High People Power

1. Organize an AIDS awareness day. Work with campus and community officials in providing an assortment of consciousness-raising opportunities, including panel discussions, condom promotions, workshops on how to talk about safe sex with a partner, the pro's and con's of having the HTLV-III antibody test, wellness-focused workshops on prevention, information on drugs (alcohol included), video showings, etc. Funds can be used to pay for travel expenses for outside speakers, printed handouts, food, and advertisements. Use people power to carry balloons, put up publicity, staff booths, and facilitate workshops. Student groups, including gay/lesbian organizations and peer educators, can contribute much to the planning and execution of these events.

The following educators represent institutions which have already conducted AIDS Awareness Days:

Angela Burks, M.S., Old Dominion University
John Dorman, M.D., Stanford University
Joy L. Greenway, M.D., University of Arizona
Richard P. Keeling, M.D., University of Virginia
Kathy Knipmann, M.P.H., Harvard University
Cathy Kodama, University of California, Berkeley
Howard Surface, M.P.H., University of North Carolina, Charlotte
Jo Ann Underwood, R.N., M.S., Virginia Polytechnic Institute

2. If one does not already exist, work to develop a campus task force on AIDS involving participants from a number of different disciplines and Student Affairs responsibilities. This serves to unite the campus on policy issues in addition to providing an ongoing focus for educational outreach.

Contact: (See Resource List for addresses)

John Dorman, M.D., Stanford University
Cathy Kodama, University of California, Berkeley

Richard P. Keeling, M.D., University of Virginia
Howard Surface, M.P.H., University of North Carolina-Charlotte
J. Robert Wirag, H.S.D., University of Arkansas

G. High Funds — Low People Power

1. Place ongoing AIDS awareness/education ads in the campus newspaper. Use factual blurbs which help dispel myths, raise consciousness, and promote safe sex.

2. Purchase available AIDS AV materials which can be used in programming to stretch your limited people power. The ACHA has excellent AV materials especially developed for college and university use.

Contacts: (See Resource List for addresses)

Stephen D. Blom, M.B.A., ACHA, Rockville, Maryland

Richard P. Keeling, M.D., University of Virginia

Frank Carter, University of Pittsburgh

3. If you have money but no people-help, you can train qualified students to run an AIDS telephone information/referral service and pay them (see C in this section).

4. Have phone stickers printed to advertise the number for above phone/information service.

5. Purchase some of the more expensive brochures; some will print your resources and referral numbers on the back.

6. Arrange for outside speakers to give talks on AIDS issues.

H. High Funds — Medium People Power

1. Buy space in the campus newspaper to run a questions and answers column on AIDS.

2. Advertise your services for doing on-campus educational workshops for student groups, faculty groups, classes, etc. Let it be known that you have the staff and materials to meet any campus needs for AIDS education and referrals.

3. Run "personals" in the campus newspapers on a regular basis; encourage students to know and talk with their sexual partners. These can be attention getting, entertaining, and educational.

Examples of personals created by peer educators at the University of Delaware:

AIDS cannot be acquired through casual contact. Learn more about the facts. Info available at the Student Health Service.

AIDS can happen if you are gay or straight — so get to know your partner before it's too late.

You have a responsibility concerning AIDS: **DON'T SPREAD MYTHS.**

Safe sex means using condoms; care about your partner.

Condoms go with everything except vaseline.

AIDS is transmitted in two ways: blood and semen.

4. Have a condom awareness booth and give out free condoms and condom information. For information on condom awareness programs contact:

David Mayer has organized several Condom Awareness Programs in California and is available for discussion and consultation. His phone number is 415-420-8838.

Debra B. Sivertson, R.N., N.P., University of Maryland, Baltimore County

Margaret Brown Paviour, University of Virginia

I. High Funds — High People Power

1. Develop a campus AIDS Resource Guide that can be made available to all students. It could include campus policy on AIDS; services available with phone numbers, locations, and hours; support groups; counseling; testing; information on health, wellness, risk reduction, safe sex. Could be a cooperative project among a number of different groups.

2. Develop AV materials to be used with specific outreach programs, e.g. video or slide/tape presentation.

3. Publish a health service newsletter focusing entirely on AIDS. Disseminate to entire university community.

Contact:

Doryn Davis-Chervin Dr. P.H.
Health Promotion Program
Cowell Student Health Center
Stanford University
Stanford, CA 94305

4. Address staff and personnel concerns about ARC/AIDS by encouraging members of the university community to call you even if they are uncertain where to direct their concerns. Provide training for staff and personnel "gatekeepers"; often policy development for personnel follows from this kind of education.

5. Continuing education can be offered to staff and personnel on AIDS education/awareness if you have the staff to do this.

6. Offer services to help train area college and university staff who are low on people power.

RESOURCE LIST: NAMES, ADDRESSES, AND PHONE NUMBERS

AIDS Action Council
729 Eight Street, S.E.
Suite 200
Washington, DC 20003
202-547-3101

AID-Atlanta
811 Cypress Street
Atlanta, GA 30308

AIDS Project Los Angeles
937 N. Cole Ave.
Los Angeles, CA 90038
213-871-2437

American College Health Association
Stephen D. Blom, M.B.A.
Executive Director
15879 Crabbs Branch Way
Rockville, MD 20855
301-963-1100

Margaret W. Bridwell, M.D.
Director, Student Health Center
University of Maryland
College Park, MD
301-454-4928

Angela Burks, M.S.
Health Educator
Old Dominion University
Student Health Service
Norfolk, VA 23508
804-440-3132

Susan Cowell, R.N., M.S., N.P.
Health Educator
Rochester Health Service
University of Rochester
Box 617, Medical Center
Rochester, NY 14642
716-275-5835

Doryn Davis-Chervin, Dr. P.H.
Associate Director
Stanford University
Cowell Student Health Center
Stanford, CA 94305
415-723-0821

John Dorman, M.D.
Stanford University
Student Health Service
Stanford, CA 94305
415-497-4834

Wayne Ericson, Ph.D.
Director, Student Health Service
Illinois State University
Normal, IL 61761
309-438-8655

Gay Men's Health Crisis
Box 274
132 West 24th Street
New York, NY 10011

Joy L. Greenway, M.D.
Physician
Building 63
Student Health Service
University of Arizona
Tucson, AZ 85721
602-621-6490

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

Chi Hughes
Director, Public Education & Minority
Clinic Outreach
AIDS Education Fund
Whitman/Walker Clinic
2335 18th Street, N.W.
Washington, DC 20009
202-332-7095

Michael Kane, M.D.
Student Health Service
Massachusetts Institute of Technology
Cambridge, MA
617-253-7825

Richard P. Keeling, M.D.
Chairperson, ACHA AIDS Task Force
Director, Student Health Service
Box 378, Medical Center
University of Virginia
Charlottesville, VA 22908
804-924-2670

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415-642-7202

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University of Delaware
Newark, DE 19716
302-451-8992

Jeff Martin, Ph.D.
Student Health Service
Kansas State University
Manhattan, KS 66502
913-539-4290

Metrolina AIDS Project
P.O. Box 32662
Charlotte, NC 28232
704-333-2437
704-364-AIDS

Ida C. Murray
Cabrillo College
Student Health Service
6500 Soquell Drive
Aphos, CA 95003
408-479-6439

National AIDS Network
Mr. Paul Kawata
Executive Director
729 Eight Street, S.E., Suite 300
Washington, D.C. 20003

NO AIDS Task Force
AIDS Information Center
906 Bourbon St.
New Orleans, LA 70116
504-529-3009

Peggy Brown Paviour
Health Educator, Student Health Service
University of Virginia
Charlottesville, VA 22908
804-924-5362

San Francisco AIDS Foundation
54 Tenth St.
San Francisco, CA 94103
415-863-2437

Sex Information and Education Council
of the U.S. (SIECUS)
80 Fifth Avenue, Suite 801-2
New York, NY 10011

Nancy S. Shaw, Ph.D.
Coordinator, Programs for Women
San Francisco AIDS Foundation
333 Valencia Street, Fourth Floor
San Francisco, CA 94107
415-864-4376

Debra B. Sivertson, R.N., N.P.
Director, Student Health Center
University of Maryland, Baltimore County
Catonsville, MD
301-455-2542

Carol J. Sudol, M.P.H.
Director, Student Health Center
George Mason University
4400 University Drive
Fairfax, VA 22030
703-323-2584

Howard M. Surface, M.P.H.
Director, Student Health Service
University of North Carolina Charlotte
Charlotte, NC 28223
704-597-4617

Joanne Underwood, R.N. M.S.
Student Health Service
Virginia Polytechnic Institute
Blacksburg, VA 24061
703-961-6444

United States Conference of Mayors
1620 Eye St., N.W.
Washington, DC 20006
202-293-7330

Paul Walters, M.D.
Director, Student Health Service
Stanford University
Standord, CA 94305
415-497-4834

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

J. Robert Wirag, H.S.D.
Director, Student Health Service
University of Arkansas
600 Razorback Road
Fayetteville, AR 72701
501-575-4451

H. Roland Zick, M.D.
Wardenburg Student Health Service
Campus Box 119
University of Colorado
Boulder, CO 80309
303-492-5661

AIDS EDUCATION: THE CONTENT

GLOSSARY

IMPORTANT TERMS IN AIDS EDUCATION

(Adapted with permission from a glossary published at Sanford University)

ACQUIRED

A condition which is not inherited or congenital.

AIDS

(Acquired Immune Deficiency Syndrome) — a serious condition characterized by a defect in natural immunity against disease. With this loss in immune response, the individual falls prey to a host of what are called "opportunistic infections." It is not highly contagious. It is specifically transmitted through sexual contact, by shared needles, or by direct infusion of infected blood or blood products.

ANTIBODY

Protein substance developed by the body to fight disease organisms. Not effective against virus which is inside cells. Antibodies to AIDS virus do not effectively inactivate the virus.

ARC

(AIDS Related Complex) — characterized by a prolonged (two weeks or more) history of fever, unexplained weight loss, swollen lymph nodes, and/or fungus infection of mouth and throat. It is not known what percentage of people with ARC or **LAS** (below) will go on to develop full-blown **AIDS**. The likelihood of such progression may be related to the presence of cofactors (below).

ARV

(AIDS related virus) — same as **HTLV-III**.

CARRIER

Virus-infected individuals with no symptoms. Most of these people are unaware that they are infected. These individuals represent a major potential source of new infection since they are fully capable of transmitting the virus to others.

COFACTORS

Other substances, microorganisms, or characteristics of individuals which may make them more susceptible to the AIDS virus. An important group of cofactors may be recreational drugs, especially **poppers** (below).

CONGENITAL IMMUNE DEFICIENCY

A situation present at birth in which an infant has an inadequacy in its natural ability to fight disease; can be genetically inherited or passed through the placental blood stream from the mother as is true for perinatal transmission of the **HTLV-III** virus.

DEFICIENCY

A breakdown or inability of certain parts of the immune system, making a person more susceptible to certain diseases to which the person would not ordinarily be subject.

ELISA

Enzyme linked immunosorbent assay; a testing method to detect antibodies to the HTLV-III virus.

FALSE NEGATIVE

A negative test in someone who in fact has been infected by the virus but for some reason has not developed the antibody.

FALSE POSITIVE

A positive test for HTLV-III antibody, usually a result of an artifact of the laboratory test, in someone who has not in fact been exposed to the virus. All persons with positive results should have the test repeated and/or confirmed by a more specific test.

HELPER-SUPPRESSOR RATIO

The ratio of **helper T-cells** to **suppressor T-cells**. In ARC, this ratio often is inverted because of an increase in suppressor cells; in AIDS, it inverts because of a decrease in helper cells. Normally there are 1.3-1.8 times more helper cells than suppressor cells, so the normal ratio is 1.3 to 1.8. This ratio varies a little from one testing laboratory to another.

HELPER-T CELL

The type of lymphocyte that **HTLV-III** infects. The helper T-cell is the managerial cell of the immune system.

HTLV-III

(**Human T-Lymphotropic Virus Type III**) — the virus that causes AIDS. Also called **LAV** (below).

IMMUNE SYSTEM

The body cells that recognize foreign agents or substances, neutralize them, and recall the experience later when confronted with the same challenge. The immune system provides protection against many infections and cancers.

INCUBATION PERIOD

The time between infection with the AIDS virus and the onset of symptoms seems to range from 6 months to 5 years or more. Not everyone exposed to the virus develops the disease; thus far, only a minority have.

KAPOSI'S SARCOMA (KS)

A type of cancer usually occurring on the surface of the skin or in the mouth. KS may also spread to other organs of the body. Before AIDS, usually found as a slowly progressing cancer in elderly men.

LAS

(**Lymphadenopathy Syndrome**) — disease of the lymph nodes — part of

ARC. Refers to a chronic enlargement of lymph nodes (glands), often associated with symptoms of **ARC**.

LYMPHOCYTE

A type of white blood cell. Lymphocytes include several subgroups; all work together to operate the immune system. One type, the **Helper T-Cell**, is the prime target for infection by **HTLV-III**.

LYMPHOMA

A cancer of the lymph nodes; certain type of lymphomas occur with unusual frequency in people with AIDS.

OPPORTUNISTIC INFECTIONS

Illnesses which would not be a threat to anyone whose immune system was functioning normally.

PNEUMOCYSTIS CARINII PNEUMONIA

(**PCP**) — a parasitic infection of the lungs. The most common opportunistic infection of AIDS patients. **PCP** has symptoms similar to any other form of severe pneumonia: cough, fever and difficulty breathing. This infection rarely if ever affects individuals with normal immunity.

POPPERS

Inhaled nitrate derivatives (amyl nitrite) which cause dilation of the blood vessels. They are used primarily during sexual experiences to heighten sensations of orgasm or when dancing. Their use seems to be a cofactor for the development of **ARC** or **AIDS**, especially **KS**.

POPULATIONS AT HIGHEST RISK

- 1) sexually active homosexual or bisexual men
- 2) present or past users of intravenous drugs
- 3) prostitutes, male or female
- 4) female partners of bisexual men or male drug users
- 5) heterosexual men and women with multiple or experimental partners

“SAFE SEX”

Relatively “safer sex” is condom-protected sex. Sexual practices involving tissue injury are extremely dangerous and should be avoided. Unprotected oral sex carries the potential of viral transmission. Safer sex is a healthful way to enjoy sexual intimacy without spreading AIDS or other sexually transmitted diseases.

STD

Sexually Transmitted Disease.

SYNDROME

A group of symptoms and diseases that together are characteristic of a specific condition.

THRUSH

A fungal infection of the mouth; common in people with **ARC** or **AIDS**.

TOXOPLASMOSIS

A parasitic infection that commonly involves the brain in people with AIDS.

VICTIM

A negative label with many psychological implications. We suggest against using this label with respect to AIDS and other STD's. Other more positive replacements include: "person who has contracted AIDS," "AIDS patient," "person with AIDS."

VIRUS

Minute, parasitic organism which depends on nutrients inside cells for its metabolic and reproductive needs. These organisms cause a variety of infectious diseases and stimulate host antibodies. Unlike bacteria, unable to survive long on its own. Not affected by common antibiotics.

WESTERN BLOT

A test for antibodies to the HTLV-III virus that is more specific and accurate than the **ELISA** test.

AIDS EDUCATION: GENERAL INFORMATION

As health educators, we need to have a good working knowledge of each of the following:

What is AIDS?

What is ARC?

What are the symptoms?

What is HTLV-III/LAV?

What is the HTLV-III antibody test?

How is AIDS transmitted?

Who is at risk for getting AIDS?

How can people reduce risks?

What if you have AIDS, ARC, or a positive antibody test?

What if someone you know has AIDS, ARC, or a positive antibody test?

Basic information on each of the above questions is included in the ACHA brochure, AIDS: WHAT EVERYONE SHOULD KNOW.

AIDS EDUCATION: SAFE SEX

Safe sex is a concept which encourages a behavioral focus on sexual activity aimed at *preventing* transmission of HTLV-III. It applies to men and women regardless of sexual orientation.

Safe sex is something positive people can do that can make a difference in slowing the spread of AIDS. It is a wellness approach which makes each of us responsible for our own and our partner's sexual health. In many ways, the safe sex concept asks for people to change some ideas and behaviors relating to sexual expression.

The changes are not necessarily easy to make. It is one thing to promote the use of condoms or encourage people to know and talk with their sexual partners; it is another thing to know how to do these things when they count. As health educators, our responsibility includes promoting safe sex behaviors *and* facilitating people in learning *how* to integrate these behaviors in their lives.

The ACHA has developed a brochure entitled "Safe Sex" which is an up-to-date discussion of facts everyone should know about safer sex, and about practices which carry risk of sexually transmitted diseases, including AIDS. It has been written in plain, non-medical language.

PRACTICING SAFE SEX

Involves using safe forms of sexual expression and avoiding unsafe sexual behaviors. Includes reducing the number of sexual partners one has and avoiding anonymous sex. Knowing one's partner to the point of knowing his/her sexual history and wellness is important.

From our current knowledge about AIDS, we can differentiate sexual practices based on likelihood of transmission into three categories: safe, possibly safe, and unsafe. These apply to men and women regardless of sexual orientation.

SAFE

- Mutual masturbation
- Light kissing
- Body massage
- Hugging
- Body-to-body rubbing (frottage)
- Light S&M (sadism and masochism) activities (without bruising or bleeding)
- Using one's own sex toys
- Showering together
- Fantasies — verbal or visual

POSSIBLY SAFE

- Deeper kissing
- Anal intercourse with condoms
- Vaginal intercourse with condoms
- Fellatio interruptus (oral sex stopping before climax)
- Cunnilingus (oral/vaginal contact)
- Urine contact ("water sports") on intact skin

UNSAFE

- Anal intercourse without condoms
- Vaginal intercourse without condoms

Manual/anal intercourse (fisting)
Oral/anal contact (rimming)
Shared sex toys

AIDS EDUCATION: RISK GROUPS

The following is used with permission from the American College Health Association and is taken from the brochure entitled AIDS: WHAT EVERYONE SHOULD KNOW.

"70-75% of people with AIDs have been homosexual or bisexual men; 17% have been intravenous (IV) drug abusers. A significant percentage of the homosexual/bisexual group also have used IV drugs. Others at high risk have included hemophiliacs (who receive products made from the blood of many donors) and blood transfusion recipients. The availability of the antibody test for HTLV-III is having a significant impact in reducing the number of cases transmitted by blood or blood derivatives.

Some people who don't belong to any of these established risk groups have gotten AIDS; most have been sexual partners of those in one of the risk groups. AIDS can be transmitted sexually between men and women; some female prostitutes carry the virus, since they have multiple sexual partners and commonly are intravenous drug abusers. AIDS may also be transmitted from mother to infant before or at birth. Although the number of cases occurring in those outside known risk groups is small, all students, gay or straight, should be informed and know how to protect themselves."

In many ways, it is more meaningful to think in terms of high-risk activities than of high-risk groups. There is nothing *inevitable* about being gay in terms of AIDS risk; whether one is gay or straight, certain *activities* are risky. For example, unsafe sexual intercourse with an unknown partner creates risk for anyone. On the other hand, safe sex *reduces* risk for anyone — gay or straight.

GAY/BISEXUAL MEN AND AIDS

As health educators we need to be aware of:

- 1) the psychological/behavioral/wellness implications of AIDS for gay and bisexual men
- 2) the fact that people can mix fear of AIDS with fear of homosexuality (homophobia).

The HTLV-III virus can be transmitted to anyone regardless of sexual orientation or preference; AIDS is not a "gay disease." AIDS is the extreme manifestation of a viral infection which has a challenging epidemiology and which has two confirmed modes of transmission, via blood and semen.

Gay or bisexual men are at risk only if they have had more than one male part-

ner since 1977. Being gay does not put one at risk; being male and having more than one male sexual partner in this time period does put one at risk. It also puts any partners at risk whether they are male or female.

Men who do test positive on the HTLV-III antibody test or develop ARC or AIDS often find it extremely difficult to know how to tell their partners. As educators we can model ways for partners to risk being honest; the same issue is true for individuals who contact herpes and struggle with how to tell their partners. This modeling can be done through role playing situations and by giving people permission to be anxious about their partner's reactions *and still risk telling them*.

This situation holds for gay men and their male partners and for bisexual men and their male and female partners. Bisexual men who are married are often not "out" to their wives and experience tremendous guilt on many levels if they receive a positive antibody test. In order to share this crucial health concern with their wives they must also risk being honest about their sexual orientation.

Telling a partner can be an extremely stressful experience; working up the courage to do so can also be stressful. Extending this period of uncertainty and anxiety keeps the stress response triggered which further weakens the person's resistance and well-being. Stress management is vital here; support for getting through this time in a person's life is extremely important.

Being homosexual in our culture has its own related stressors. For students who may be "coming out" for the first time, making peace with their sexual orientation is often a jarring experience; fear and misunderstanding about homosexuality is widespread in our society and coming to grips with one's true sexual self is often a frightening process. Add to this a recognition that one's potential partners may be at risk for AIDS and the process becomes even more threatening and overwhelming.

Gay men in the process of "coming out" may find it extremely difficult to discuss or practice safe sex with a partner; this is analogous to young women who find it difficult to think about or talk about using contraception during their first experiences of heterosexual intercourse. People often take health risks in these situations because they are under emotional overloads; "one time cannot make a difference" is a common attitude. Unfortunately, unprotected intercourse, whether homosexual or heterosexual, is a risk. The well-used Planned Parenthood adage "HOPE IS NOT A METHOD" is applicable to both avoiding AIDS as well as to avoiding pregnancy.

In our role as health educators we can promote safe sex practices clearly and matter-of-factly. We can encourage condom usage and personal responsibility for protecting oneself and others. **And we can help people learn how to talk openly with their partners and take proper precautions before they share sexual intimacy.**

GAY/BISEXUAL MEN AND AIDS: What Is Known

Any male who has had more than one male sexual partner since 1977 is consi-

dered at risk for possibly having contracted the HTLV-III virus.

Men who have not had any sexual contacts during this time period or partners who have been mutually monogamous since 1977 are not considered at risk provided they are not I.V. drug users who have shared needles.

The direct exchange of semen and/or blood during sexual activity is a known way that the HTLV-III virus can be passed from one partner to another.

Anal intercourse allows for direct exchange of semen and blood; tiny capillaries in the rectal mucosa can break and small tears can occur in the rectal lining.

The receptive partner seems to be at greater risk for later developing AIDS. Anal intercourse without use of condoms is very risky; condoms can act as a barrier against exchange of bodily fluids.

Proper use of condoms can reduce the risk of transmission of viruses, bacteria, and other infections; spermicidal jellies and creams can kill viruses and can be put on the penis before the condom to provide back-up in case the condom breaks.

Use only synthetic condoms; natural skin condoms are not good barriers.

Use only water-based lubricants with condoms; oil-based lubricants like Crisco and Vaseline can cause condoms to break.

Manual/anal intercourse (fisting) also causes tearing of the rectal mucosa and bleeding; blood can be exchanged if cuts or open sores are on the partner's hand or arm. This practice has been proven to be directly correlated with AIDS and is considered very risky.

Fisting can also weaken the receptive partner's general health resistance and overall well-being because bacterial and viral infections can directly penetrate into the bowel and bloodstream. In addition, the body must also spend extra energy healing the torn tissue.

Oral/anal contact (rimming) is also risky due to the possible swallowing of blood in fecal matter or direct contact with blood through bleeding hemorrhoids.

Fecal matter also transmits a variety of bacterial infections which can further weaken a person's overall health.

Sharing dildoes, vibrators, or other sex toys may transmit body fluids carrying the HTLV-III virus.

The following behaviors are also considered safe: mutual masturbation ("jacking off") as long as there are no cuts in the skin that semen could get into, body massage, hugging, body-to-body rubbing, showering together, using one's own sex toys, light S&M activities (without bruising or bleeding), fantasies, and any other shared intimacy that does not involve the exchange of bodily fluids.

Drugs add risk in three ways:

- 1) I.V. drug use may lead to sharing needles, which may transfer contaminated blood from an infected person to someone else.

- 2) Alcohol, speed, marijuana, and poppers (nitrite inhalants) may damage

the body's immune system, making it more difficult to fight off disease and infection. Poppers may be a "cofactor" for the development of ARC or AIDS.

3) Drugs also impair judgment making it more difficult to make "safe sex" decisions.

GAY/BISEXUAL MEN AND AIDS: What Is Unknown or Unclear

Deep tongue kissing is considered possibly safe if both partners have no open sores or cuts on their lips, tongues, or mouths. To date there are no reported cases of the HTLV-III virus being transmitted through deep kissing; however, avoiding deep kissing may be a good idea except with a special partner with whom you may feel safe.

It is unclear as to what risks are related to urine contact (water sports); if the urine contact is on unbroken skin there is little risk. However, the risk of urine entering the body as a transmitter of HTLV-III is not known.

Fellatio may be safe if semen does not enter the mouth. The active partner is at risk here; partners need to agree ahead of time that the passive partner will not ejaculate in the other person's mouth. An additional factor is the existence of a pre-ejaculate fluid from the Cowper's gland which precedes ejaculation prior to the awareness that ejaculation is imminent. This requires stopping fellatio well in advance of any sensation that climax is about to occur.

I.V. DRUG USERS AND AIDS: What is Known

Among I.V. drug users the sharing of needles is the main way the HTLV-III virus is passed.

Even if needles (works) are not shared immediately, blood in the syringe's core does not dry up right away and will be inserted into the next user's bloodstream.

Health risks are associated with any use of drugs by injection; not using needles is the only way to avoid these risks. However, people continuing to inject drugs can follow these measures to help reduce their risk contracting the HTLV-III virus, ARC, or AIDS.

- 1) When needles are shared with others, so are diseases; the greatest risk reduction is in not sharing needles.
- 2) Needles should be washed with alcohol after each use and then left to soak in alcohol until the next use.
- 3) Skin should always be cleansed with alcohol before injecting.

I.V. DRUG USERS AND AIDS: What is Unknown or Unclear

I.V. drug use is responsible for a higher percentage of cases among black

people; given socio-economic realities in our culture it is unclear how to reduce this risk.

Many of the people counted in the AIDS categories of gay males or prostitutes may also be drug users. What was the risk behavior?

Use of recreational drugs, such as alcohol, speed, poppers, etc. act in immunosuppressive ways to further weaken the body and in some instances may be cofactors in AIDS development.

WOMEN AND AIDS: What Is Known

I.V. drug use is the most common way women have developed AIDS.

The second largest category of women who have acquired AIDS are sexual partners of men in risk groups.

Sexually active women with multiple or experimental male partners may be infected with HTLV-III from a man who is unaware that he was infected by a previous male or female partner.

The HTLV-III virus may be passed via semen entering the rectum or vagina (and on into the uterus).

A woman with AIDS, ARC, or a positive test for antibody to HTLV-III may be able to transmit the virus to her male sexual partners through vaginal sex. In the United States, transmission by this route has been rare, but it does occur.

Rectal tissue can tear during anal intercourse allowing for direct semen/blood contact. Receptive anal sex is as risky for heterosexual women as for the homosexual men, if the male partner is infected with HTLV-III.

The uterine lining (endometrium) is blood-rich tissue and can come into direct contact with semen as sperm move through on their way to the Fallopian tubes.

No cases have been proven to have been transmitted via kissing.

There are currently no reported cases of AIDS among lesbians.

Mothers with positive tests for antibody to HTLV-III, ARC, or AIDS can pass on the HTLV-III virus during pregnancy so that the newborn child can be infected. To avoid perinatal transmission women at risk for HTLV-III infection should defer pregnancy. Any such woman considering pregnancy should get detailed, competent counseling *in advance*.

Diagnosis of AIDS in infants and children is clouded by the difficulty of distinguishing congenital immune deficiency from acquired immune deficiency.

Children have also contracted the HTLV-III virus through blood transfusions.

Although there have currently been few verified cases of artificial insemination being the cause of transmission to women or their babies, sperm donors should be screened.

Women represent a higher percentage of total AIDS cases in Africa (50%) than in the U.S. (7%).

WOMEN AND AIDS: What Is Unknown or Unclear

It is not clearly understood how the HTLV-III virus is transmitted during heterosexual vaginal intercourse.

It seems more likely that the HTLV-III virus is passed through semen to blood contact rather than through semen to vaginal secretions contact. Therefore there seems to be a greater risk for male/female genital intercourse during menstruation.

Caution should be exercised about cunnilingus during menstruation in the event that the HTLV-III virus could be passed via menstrual blood and received through cuts or sores in the tongue or mouth.

NATIONAL RESOURCES FOR STATISTICAL UPDATES

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

Public Health Service
HOTLINE: (general information)
1-800-342-2437
HOTLINE: (specific questions)
1-800-447-AIDS

AIDS Action Council
Federation of AIDS-Related
Organizations
1115½ Independence Avenue, SE
Washington, DC 20003
202-547-3101

National Institute of Allergy and
Infectious Diseases
Office of Research Reporting and
Public Response
301-496-5717

American Association of Physicians
for Human Rights
P.O. Box 14366
San Francisco, CA 94114
415-558-9353 or 415-673-3189

National Coalition of Gay STD
Services
P.O. Box 239
Milwaukee, WI 53201
414-277-7671

National Hemophilia Foundation
Soho Building
110 Greene St., Room 406
New York, NY 10012
212-219-8180

National Gay Task Force
80 Fifth Avenue, Suite 1601
New York, NY 10011
212-741-5800 or 1-800-221-7044

Chapter Five

Statement on HTLV-III Antibody Testing

Working Group Chaired by
Richard P. Keeling, M.D.

LIMITATIONS OF THE TEST

The American College Health Association recognizes that there are important limitations to the clinical application of the currently available enzyme-linked immunosorbent assay (ELISA) test for antibodies to HTLV-III, the agent thought to cause the Acquired Immunodeficiency Syndrome (AIDS). Interpretation of test results is complicated by the following problems:

1. False Positive Tests. False positive tests occur in a small percentage of people whose blood does not in fact contain antibodies to HTLV-III and who are not infected with the organism. Some of these people have cross-reacting antibodies; in other circumstances, technical problems cause the test to be falsely positive. Repeat ELISA testing may be negative, but may also remain positive. People with false positive ELISA tests have negative confirmatory tests done by the Western blot method. In general, false positive ELISA tests are weakly, as opposed to strongly, reactive. Some technical problems are specific to individual test kits and procedures.

2. False Negative Tests. There are rare false negative tests in some people who actually have been infected by HTLV-III, and whose blood does in fact contain antibody. In some cases, even people who have symptomatic immune deficiency and/or recoverable virus in blood and other body fluids have a negative HTLV-III antibody test.

3. Insensitive Tests. Negative tests may occur in people who are in fact infected, but whose antibody response has not yet occurred; this situation is *regularly* encountered in the first 6-8 weeks after infection. It may also occur for up to 6 months after infection when antibody formation is delayed or inadequate.

4. Need for Confirmatory Tests. Positive ELISA tests require confirmation by a more specific procedure, the Western blot test, in clinical situations.

5. Lack of Clinical Correlates. The absence of any specific clinical correlates to a positive test result is a major shortcoming and a common source of

misunderstanding. People with confirmed positive tests may have:

a. Asymptomatic infection, currently marked only by a positive antibody test. Current evidence is that a majority of these people are infectious (can transmit the virus); some are not. Some may progress to have AIDS-related complex (ARC) or AIDS itself, and others will stay healthy for years. No feature of the ELISA or Western Blot test distinguishes among these possibilities, and presently available data do not allow for accurate predictions or the outcome for any given patient.

b. Thrombocytopenia (low platelet count) with or without evidence of a hemostatic defect (tendency to bruise or bleed easily). Some of these people will progress to develop AIDS; others will stay clinically stable for long periods of time. Most clinicians consider this a form of AIDS-related complex.

c. Full-Blown AIDS manifest by major opportunistic infection; premature, unusual cancers, or both.

6. Errors in Interpretation. Some misinterpret the results of the test. A positive test result is sometimes misunderstood as evidence of the existence of AIDS itself or of the inevitability of development of AIDS. In some contexts, a positive test has been used as a marker for homosexuality or drug use. Positive test results, whether or not they are confirmed, have been regarded as reason for termination of employment, refusal of insurance coverage, and exclusion from school.

7. Application as a Screening Test. The ELISA test, when applied as a screening device to a population in which the prevalence of HTLV-III infection is low, is known to be significantly less reliable in correctly identifying seropositive people (those with HTLV-III antibodies). Such populations include, for example, unselected entering college and university students, health sciences students, and institutional employees. In blood banking experience, only a minority of initially ELISA-positive donors remain positive on repeat testing; only a minority of repeat ELISA-positive blood donors are positive by Western blot.

INDICATIONS FOR TESTING

The American College Health Association further recognizes that the tests for antibody to HTLV-III were developed and are licensed as procedures to screen donated blood, and it wholeheartedly supports their utilization for that purpose. ACHA encourages all citizens to abide by the request of the American Red Cross and the Public Health Service that persons in certain defined high risk groups voluntarily exclude themselves as blood donors. Such groups include:

1. Anyone who demonstrates the signs or symptoms of AIDS.
2. Males who have had sex with more than one male since 1977.
3. Males whose male sexual partner has had sex with more than one male

since 1977.

4. Past or present abusers of intravenous drugs.
5. Hemophiliacs.
6. Sexual partners (male and female) of persons in these groups.

Under no circumstances should individuals use blood donation as a way to be tested for HTLV-III antibodies. The occurrence of even a small percentage of false negative tests and the existence of infectious virus in people who have been quite recently infected and still have no serum antibody demand that individuals in risk groups not even consider donating blood.

There is absolutely no risk of transmission of HTLV-III to the donor in the process of blood donation.

Despite the limitations of the tests, they may provide important, useful information in certain circumstances. Although all people in AIDS risk groups should *not* engage in any activities that could transmit AIDS, whether or not they are tested for antibody to HTLV-III, the tests may be effective as an adjunct to risk assessment, behavioral counseling, and health education. The following are common situations in which testing is considered:

1. Given the likelihood that people with positive tests are infectious, **a confirmed positive test may provide greater motivation for alterations in behavior than the simple possibility or probability of infection** as assessed by a patient and his/her health care provider. A negative test, though no guarantee against future infection, may motivate some individuals to stay healthy and uninfected through changes in sexual behavior. This, however, is distinctly an individual matter. There is no proof that testing is any better than good education for changing behavior. In addition, it must be kept in mind that the test only reflects the situation at one moment in time, and that people who have been very recently infected will have a negative test only for the time being.

2. **In certain clinical circumstances, the test is an important adjunct to the evaluation of an illness**, especially when the symptoms and signs suggest AIDS or an AIDS-related disorder. With refinements in treatment, early intervention during an asymptomatic or AIDS-related complex stage may be more clinically beneficial than treatment of AIDS.

3. Some people are so worried about possible exposure to HTLV-III that the concern itself becomes a distraction, provides great stress, and compromises their normal activity. Assuming that the potential exposure occurred at least 2-3 months prior to the intended time of testing, **the test may relieve anxiety, if negative, or bring more useful counseling approaches, if confirmed positive. On the other hand, the anxiety caused by a positive test may well be worse than uncertainty.**

4. Those involved in a new relationship may desire testing to protect the health of both partners; in certain circumstances, the test, performed on both partners, may be helpful.

5. **Women in high risk groups who are or intend to become pregnant may want to be tested in order to make more informed decisions about**

existing or future pregnancies.

6. Male hemophiliacs **may desire testing to avoid transmission to sexual partners.**

CONFIDENTIALITY OF INFORMATION

In most jurisdictions, only cases of AIDS meeting the criteria of the revised surveillance definition of the Centers for Disease Control (see MMWR 1985; 34:373-375) are reportable to local health authorities. There are, however, some states in which the fact of a positive HTLV-III antibody test, with or without evidence of ARC or AIDS must be reported.

Even where test results are not reportable by law, they commonly become part of the medical record of the person tested. Such information is protected from disclosure without consent of the tested individual by a number of statutes, and thus is "confidential." However, access to the information may be secured by potential employers, insurers, and others who produce an authorization signed by the persons tested. The results then become open to the interpretation of the agency or individual securing consent for their release.

Truly anonymous testing is available in some areas. In these testing programs, there is no use of the name of the person being tested (or any other identifying data, such as a Social Security number), and no named record is generated. Thus, no accidental or malicious compromise of confidential data can occur.

The American College Health Association's Statement on confidentiality of information provides a detailed discussion of these issues.

USING THESE FACTS AND OBSERVATIONS, THE AMERICAN COLLEGE HEALTH ASSOCIATION MAKES THE FOLLOWING RECOMMENDATIONS IN REGARD TO TESTING FOR ANTIBODY TO HTLV-III:

1. Colleges and universities should establish a high level Task Force to **manage the institution's response to AIDS-related issues** (see Statement on Institutional Policies and Administrative Liaison). This group will direct the provision of AIDS information and education; it should see that accurate, timely information about HTLV-III antibody testing is included in the educational program.

2. The American College Health Association recommends that any individual requesting testing for antibody to HTLV-III be provided accurate, timely information on which he or she can base a rational, personal decision about taking the test. **The issues involved in such decisions are too complex and personal to allow for blanket recommendations that any group should or should not be tested.**

3. No student or employee should be tested, or referred for testing, for HTLV-III antibody unless: **the testing is confidential or anonymous, positive**

ELISA results are confirmed by additional, more specific testing; counseling is provided before and after the test; and informed consent is obtained.

4. All persons desiring HTLV-III antibody tests require counseling both before and after the tests are done. No one should have the test done unless pre-test counseling has been provided; no one should be given test results without the ready availability of post-test counseling. All institutional agencies providing counseling services should cooperate to assure that accurate, up-to-date, and consistent information is provided to all seeking it. If such counseling is not available within the institution, there must be arrangements for it to be provided elsewhere.

5. Those who counsel or advise students or employees about HTLV-III antibody testing must themselves be thoroughly familiar with the medical, psychological, and social implications and the technical limitations of the tests, and well educated concerning AIDS.

6. College and university health officers should be aware of the procedures and qualifications of local and regional sources of testing for HTLV-III antibody.

7. Test results should never be provided by telephone, both to guarantee confidentiality and to facilitate post-test counseling.

8. Care providers must be aware that a variety of psychological reactions to either confirmed positive or negative test results can be expected. It is impossible to overstate the importance of sound knowledge, a non-judgmental approach, and a compassionate, unhurried attitude on the part of the care provider.

9. Adequate pre-test and post-test counseling requires:

- a. the allotment of sufficient time**
- b. a private setting**
- c. guaranteed confidentiality or anonymity**
- d. encouragement to the patient to ask questions, state fears, and verbalize reactions**
- e. the availability of follow-up counseling, when appropriate and indicated**
- f. consideration of referral of those with confirmed positive tests to a peer support group, if one exists or can be formed**

10. Information provided during counseling sessions should include:

- a. assessment of risk for AIDS and assistance in developing a sufficient body of information to allow for an enlightened decision.**
- b. the technical and clinical capabilities and limitations of the test, and its cost**
- c. the significance of positive and negative results**
- d. the local procedures for handling confidential medical information**
- e. the range of psychological impact and reaction to the test**
- f. alternatives to testing: behavior modification without testing**
- g. the best current information about the transmission of AIDS;**

behavioral guidelines for avoiding transmission

- h. the possibility that confusing or conflicting information will be presented by other sources, especially the media
- i. resources for further information
- j. arrangements for local medical and psychological follow-up
- k. assistance with developing personal strategies for managing this new information (e.g., vis-a-vis family, friends, lovers, etc).

11. The disposition and handling of test results and other confidential information are addressed in a separate statement written by the ACHA Task Force on AIDS. Briefly, this information is protected by statutory standards; unauthorized disclosure to *anyone* creates liability. Whether the counseling sessions, the fact that the test was done, or the test results themselves should be recorded in the medical record are difficult issues. ACHA suggests that, given the potential for misuse of this information, care providers weigh carefully the importance of entering such records, except in circumstances of the medical evaluation of *specific symptoms and/or signs suggesting HTLV-III infection*. At the very least, patients must be informed in advance about exactly what information will be entered in the medical record and might therefore be available to others. Please see the Statement on Confidentiality of Information for further discussion.

12. The American College Health Association strongly discourages the use of any test for HTLV-III antibodies as a mandatory "screening" procedure in any setting except blood donation. Especially, there should be no screening of:

- a. entering students, before or after admission
- b. any group of current students or employees
- c. those identified by supposition or admission as being at high risk
- d. health sciences students
- e. food service employees, whether students or not

13. All health care providers should be aware that test procedures, interpretations, and reporting requirements may change over time; it is important to be familiar with current information and to stay in touch with developments in the field.

RISK ASSESSMENT FORM

Working Group Chaired by
Nancy S. Shaw, Ph.D.
Leland G. Wessell, M.D.

The following Risk Assessment Form is both a clinical and an educational tool, designed to assist clients and health care providers in understanding the behavioral factors that influence an individual's risk of AIDS.

The clinician can use the score that results from a client's careful and honest answers in teaching risk reduction and in following its success. The higher the score, the greater the risk; decreasing scores over time denote risk reduction.

This Risk Assessment may help clinician and client reach a decision as to whether to do the test for antibody to HTLV-III. It educates about behaviors that may lead to exposure to the virus; since it is **not** retained in the medical record but rather goes home with the client, it may provide that education again after the visit with the clinician has ended. The periodic use of this form to assess risk by individual clients may provide a tangible motivational tool for risk reduction.

As is true of any tool, this form can be misused. Because of the very sensitive nature of the information it requests, it must NEVER be included in medical records. The American College Health Association suggests that it be obtained in quantity and given to each client whose risk is assessed. Each individual participating in this risk assessment should be told in advance that he or she will keep the form and that no information transmitted to the care provider verbally will be included in the record, either. **The importance of this Risk Assessment Form is in education, not in record-keeping.**

Additional copies of the Risk Assessment Form may be obtained from the American College Health Association.

CONFIDENTIAL — NOT A PERMANENT PART OF THE MEDICAL RECORD

Many factors must be considered in assessing your level of wellness. Among these are: 1) your risk of acquiring or transmitting any Sexually Transmitted Disease (S.T.D.) and 2) the use of psychoactive chemicals during sexual activity which can increase your risk of acquiring an STD. STDs' considered here include, but are not limited to, gonorrhea, syphilis, chlamydia, Hepatitis B, Giardiasis, and AIDS. The first two questions are biographical in nature and are not part of the risk assessment score, but are intended to guide your provider in making the best possible appraisal of your health. The remaining eight are part of the scored behavioral risk assessment. Please be honest in responding to the following questions — we assure you that this document will be handled with the utmost confidentiality by you and your health care provider only. Please feel free to discuss the results with your provider. You may retain the survey for your own reference. It will not be placed in your medical record.

There are 10 questions listed below. Please check the answer that best describes your preferences or activities.

- A) How long have you been sexually active? _____
- B) Your most recent consistent sexual partner experience
male _____ female _____ both male and female _____
- 1) How many partners have you had *per month* in the last year?
3 _____ 10 or more
2 _____ 4-10
1 _____ 0-3
- 2) How many partners *per month* in the year previous?
3 _____ 10 or more
2 _____ 4-10
1 _____ 0-3
- 3) The kinds of sexual contacts I have are:
3 _____ one time anonymous "tricks", groups, or prostitutes
2 _____ multiple times with the same partner(s)
1 _____ exclusive to my lover or spouse
- 4) I have sexual encounters or contacts most frequently
3 _____ in baths, bookstores, parks, "massage parlors", "spas",
public restrooms
2 _____ in bars, autos, parties
1 _____ in my or my partner's home
- 5) The frequency I use drugs to enhance my sexual encounters.
3 _____ frequently
2 _____ occasionally
1 _____ rarely/never

Please circle drugs used: poppers (amyl or butyl nitrites), alcohol, marijuana, hallucinogens (LSD, mushrooms), PCP, amphetamines, barbiturates, Quaaludes or _____ (please fill in others)

- 6) The frequency with which I *inject* myself with any of the above drugs is:
- 3 _____ often
 2 _____ occasionally
 1 _____ never
- 7) I have sexual encounters most frequently in:
- 3 _____ New York, LA, San Francisco, Miami, Washington DC,
 _____ Houston, Newark NJ, Atlanta
 2 _____ other large urban areas (Boston, Philadelphia, St. Louis,
 _____ Seattle, etc.)
 1 _____ small cities, towns, rural areas
- 8) Those kinds of sexual activities I practice most frequently are (please circle specific activities):
- 3 _____ unprotected vaginal or anal intercourse, oral-anal contact (rimming), direct fecal or urine contact (scat or water sports), or manual-anal (fisting).
 2 _____ "protected" vaginal or anal intercourse (use of condoms and spermicides), oral-genital contact (fellatio or cunnilingus)
 1 _____ masturbation, body rubbing, kissing

Add up the numbers from each question (1 to 8) and see the key below to determine your level of risk.

My score is _____.

KEY:

17 or more: you are at high risk for developing STD's, including AIDS, and for possibly developing dependence on psychoactive substances. You should visit your provider every one to three months for a medical assessment and consider counseling for drug use.

12-16 points: you are at medium risk for developing problems and are encouraged to see your provider every three to six months.

11 or less: you are at low risk for problems and are encouraged to see your provider every six to twelve months.

This scoring system was designed to: 1) increase your awareness of STD's and the risk factors associated with acquiring or transmitting STD's 2) stimulate self-evaluation of your sexual lifestyle and 3) encourage your taking responsibility for your health and the health of your sexual contacts. You should see your provider immediately if you have questions or develop any symptoms of illness.

Chapter Six

Statement on Confidentiality of Information

Working Group Chaired by
Joy L. Greenway, M.D.

The American College Health Association recognizes that information in medical, educational, or employee records concerning the existence of AIDS, ARC, or a positive HTLV-III antibody test in a student, faculty, or staff member is currently highly sensitive, commonly misunderstood, and potentially misused. If college and university officers are to provide effective, up-to-date preventive education and deliver first quality medical and psychological services, they must remain a trusted and sought-after source of accurate information and provide consistent guidance on the issues with which AIDS challenges their institutions. They can best accomplish this if the information shared with them by students, employees, faculty, parents, and other medical services regarding an individual's concern with AIDS-related issues is absolutely and securely confidential.

Confidential information regarding AIDS, ARC, or a positive HTLV-III antibody test is and should be handled as are other confidential materials using existing protective policies and practices whenever possible. Each institution must assure that such mechanisms are consistently in place to protect the confidentiality of *all* medical records and to prevent the misuse of *any* confidential information.

The American College Health Association offers the following suggestions for institutions to consider in regard to establishing and maintaining appropriate procedures for the handling of confidential information.

1. The American College Health Association proposes that guidelines for handling confidential medical information about students or employees with AIDS, ARC, or a positive HTLV-III antibody test clearly follow the general standards included in *RECOMMENDED STANDARDS AND PRACTICES FOR A COLLEGE HEALTH PROGRAM*, Fourth Edition, 1984.

In general, it is recommended that no specific or detailed information concerning complaints or diagnosis can be provided to faculty,

administrators, or even parents, without the expressed written permission of the patient in each case.

No person, group, agency, insurer, employer, or institution should ordinarily be provided any medical information without the prior specific written consent of the patient. Confidential medical information is protected by statutes, and any unauthorized disclosure of it may create liability.

2. The duty of physicians and other health care providers to protect the confidentiality of information is superseded by the necessity to protect others (implying a duty to warn) only in circumstances involving a clear risk to others. **The American College Health Association does not believe that the best current medical information about AIDS justifies or requires warning others of the presence of someone with AIDS, ARC, or a positive HTLV-III antibody test in the institution.** In particular, given the absence of any evidence of transmission of HTLV-III by casual interpersonal contact, there is no need or justification for warning roommates, others in a residence hall, others in the academic workplace, administrative officers, or instructors of the presence of such an individual. Please see the Statement on Housing Policies for further discussion in regard to housing issues.

4. **The officers of each institution, acting through a high level Task Force, should consider in advance the desirability of having plans for handling requests for disclosure of confidential information about students or employees with AIDS, ARC, or a positive HTLV-III antibody test through legal processes.** This process will require both familiarity with the statutory requirements in the area and consultation with the institution's legal counsel. No health officer or other institutional official should respond to requests for the involuntary release of confidential information without prior consultation with the college or university attorney. Please see the American College Health Association's Statement on Institutional Policies and Administrative Liaison for information on the establishment and structure of the institution's Task Force.

4. **The Task Force should be familiar with and guarantee institutional compliance with federal and state laws, regulations, and policies that protect the confidentiality of medical and educational records and with the requirements for timely reporting of certain test results or medical conditions to local health authorities.** These requirements currently vary with location; in addition, it is possible for legislative action in any jurisdiction to alter them from time to time. It is thus necessary for each institution to be familiar with current information and stay in touch with developments and proposals in these areas.

5. College and university faculty or staff members must not enter information that a student or employee has AIDS, ARC, or a positive HTLV-III antibody test into non-medical, educational records without the knowledge

and consent of the student or employee involved. **The Family Education Rights and Privacy Act of 1974 applies to any "educational" records which include such information. Any recording of information about AIDS, ARC, or a positive HTLV-III antibody test might be considered "in violation of the privacy" of students or staff and "inappropriate" for inclusion within the educational record. If such information is felt to qualify for inclusion in the educational record, it could not be disclosed without the prior, written consent of the student or employee involved.**

6. All health center, counseling center, residence life, housing office, and other student affairs personnel must be made aware of the necessity for protection of confidential information and of the procedures in place for the maintenance of secure confidential records. It is particularly important that those who do not ordinarily have a one-to-one care-giving relationship with patients or clients receive such information, as they are less likely to be accustomed to protecting confidential material. The importance of the careful handling of information about AIDS-related problems should be emphasized.

7. The number of people in the institution who are aware of the existence and/or identity of students or employees who have AIDS, ARC, or a positive HTLV-III antibody test should be kept to a minimum, both to protect the confidentiality and privacy of the individuals involved, and to avoid the generation of unnecessary fear and anxiety among other students and staff. The Task Force should establish in its policies the guarantee that no institutional officer will be asked, as a requirement of his or her position, to compromise the confidentiality of information about students or employees with AIDS, ARC, or a positive HTLV-III antibody test.

8. The American College Health Association suggests that, if at all possible, college and university counseling and health services not allow current students to handle the health records of other current students. If there is no alternative, at least the students handling medical records must be educated about the importance of the protection of confidential information in general and about the special sensitivity of information about students with AIDS, ARC, or a positive HTLV-III antibody test.

9. Each institution's Task Force should be prepared to deal swiftly, effectively, and efficiently with any purposeful or accidental breach of the security of confidential information. In the case of health and psychological records, intentional and malicious misuse of confidential information warrants severe action. The options available to institutional officers will vary with the institution, depending on personnel policies.

10. Given the possibility of unintended or accidental compromise of the confidentiality of information, health officers and counselors should weigh carefully the importance of including specific information regarding the existence of AIDS, ARC, or a positive HTLV-III antibody test in the

medical or counseling records. **Each facility should develop its own written policy on the recording of this information in consultation with the Task Force and the legal counsel, and all care givers should follow the policy consistently.** Variation in individual practice within the facility may lead to confusion, misunderstandings, and unnecessary discomfort for patients and care givers. Given the fact that absolute security over filed information may be impossible to achieve, some institutions may choose to exclude specific information about AIDS, ARC, or a positive HTLV-III antibody test from the *regular* medical or counseling record. *If this policy is chosen, the institution is obligated to develop an alternative means of guaranteeing that health care personnel exposed to blood or body fluids from such individuals are able to identify those patients and specimens so they can take appropriate precautions to avoid accidental transmission of HTLV-III.* See #16 below.

11. **Students and staff seeking guidance on AIDS-related issues and problems should be informed in advance about what information will be entered in their medical or educational records as a result of the facility's stated policies.** Health care providers, counselors, and other institutional officials should be prepared to explain the institution's policies and procedures in regard to the protection of confidential information. **The American College Health Association strongly suggests that each college or university take a firm position in support of the careful protection of confidential information and that it state that position forthrightly.**

12. **Health care providers and counselors should consider their method of recording counseling in regard to AIDS or testing for antibody to HTLV-III.** Such entries in the record should be designed not to draw added attention. Many facilities have an active policy concerning the entry of information about counseling for pregnancy, pregnancy termination, or sexually transmitted diseases; it may be appropriate to adopt such policies to include AIDS-related counseling as well.

13. **Informed consent should ordinarily be obtained before the ordering of testing for antibody to HTLV-III. If written consent is obtained, this document should be placed in secure files in the health service. Similarly, when the results of testing for antibody to HTLV-III are recorded, they should be placed in secure files.** Access to such secure files should be strictly controlled according to health service policies.

14. **When the evaluation of specific symptoms or signs suggesting infection with HTLV-III is undertaken, medical records must include accurate, complete, and accessible information to guarantee a high quality of care for the individual concerned.** It is not in the best interest of the student or employee involved nor of the institution's program of risk reduction for health care providers to omit this important information from the record.

15. Tests for antibody to HTLV-III, if conducted through the health service laboratory, should be ordered in a manner designed to protect the identity of the patient. The American College Health Association suggests that facilities develop specific methods, such as the use of an identifying code number rather than a name or Social Security number, to assure the maintenance of confidentiality within their own operation. There is clearly no need for most staff members to be aware that any particular student or employee is being or has been tested for antibody to HTLV-III.

16. Each health care facility, acting in concert with the Task Force, should consider policies and procedures for the protection of health care personnel from exposure to blood or other body fluids of patients known to have AIDS, ARC, or a positive HTLV-III antibody test. While maintaining the security of confidential information, health services must find ways accurately to identify persons and specimens that pose a hazard for medical personnel. The American College Health Association suggests the following possible procedures and encourages institutions to consider others:

A. All patients with AIDS, ARC, or a positive HTLV-III antibody test should receive education about the risks undertaken by the nurses, physicians, laboratory technicians, opticians, and dentists who care for them. **When seeking medical, dental, or eye care these individuals should advise the care provider that he or she should take precautions to avoid transfer of body fluids; although a positive test does not always equate with infectiousness, the practitioner can then take appropriate precautions to protect himself and others.**

B. It is useful to suggest to those with AIDS, ARC, or a positive HTLV-III antibody test that they tell nurses, laboratory technicians, or others who will be utilizing needles for intravenous lines, anesthesia, or venipuncture that they should **"observe body fluid precautions."** This does not require more specific disclosure, but allows the caregiver to protect himself or herself. This is especially important when the student or employee is being seen in some facility other than his/her usual one, where the need to take precautions may not be recognized.

C. **Within the college or university health care facility itself, officials should consider establishing a system of labelling and coding laboratory request slips, pathology specimens, and medical records so as to inform clinical personnel of the need to exercise appropriate body fluid precautions.** This coded warning need not be specific, and may well already exist in the case of hepatitis B. If policies and procedures for the handling of information and specimens related to hepatitis B exist, they may likely be easily adapted to cover AIDS-related issues as well.

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ORDER FORM

The following items are offered to help you educate students, faculty, staff and others at your institution. To order, fill in totals, print or type your mailing address and return the form to ACHA. Please allow 2-3 weeks for processing of orders.

1. ***"THE AIDS DILEMMA: HIGHER EDUCATION'S RESPONSE"***

(Available May 1986.) 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.

(Qty. Ordered:) _____ Videotape (Prices below)

Specify: () Beta ½ in. or () VHS ½ in. or
() U-Matic ¾ in. (Add \$20 for ¾ in. tape)

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Member
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\$75 ea.

NASPA
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Members
\$75 ea.

All others
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"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 your campus.

(Qty. Ordered:) _____ **ACHA Special Report** (Prices below)

	ACHA Member	
	<u>Institutions</u>	<u>All Others</u>
1-4	\$5.00	\$7.50
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10 plus	3.50	5.00

ORDER FORM

"Safe Sex" — (ACHA Health Information Series)

An attractive four-color brochure with an up-to-date discussion of facts everyone should know about safer sex and about practices which carry risk of sexually transmitted disease, including AIDS. Presented in plain, non-medical language.

(Qty. ordered:) _____ **Safe Sex** (See prices below)

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"AIDS — What Everyone Should Know" — (ACHA Health Information Series)

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 the best available information. Suitable for campus-wide distribution.

(Qty. Ordered:) _____ **AIDS — What Everyone Should Know**
(See prices below)

	<u>ACHA Institutions</u>	<u>All Others</u>
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500-999	.12	.17
1,000-19,999	.10	.15
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(301) 963-1100

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15879 Crabbs Branch Way
Rockville, Maryland 20855
301-963-1100

A series of approximately 12 horizontal stripes, alternating between dark green and light cream, spanning the width of the page at the bottom.

AIDS on the College Campus

ACHA Special Report

Richard P. Keeling, M.D.
Director, Department of Student Health
Associate Professor of Internal Medicine
University of Virginia
Editor

Produced by the
Task Force on AIDS
of the
American College Health Association
with program support from TIAA-CREF

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behavioral guidelines for avoiding transmission

- h. the possibility that confusing or conflicting information will be presented by other sources, especially the media
- i. resources for further information
- j. arrangements for local medical and psychological follow-up
- k. assistance with developing personal strategies for managing this new information (e.g., vis-a-vis family, friends, lovers, etc).

11. The disposition and handling of test results and other confidential information are addressed in a separate statement written by the ACHA Task Force on AIDS. Briefly, this information is protected by statutory standards; unauthorized disclosure to *anyone* creates liability. **Whether the counseling sessions, the fact that the test was done, or the test results themselves should be recorded in the medical record are difficult issues.** ACHA suggests that, given the potential for misuse of this information, care providers weigh carefully the importance of entering such records, except in circumstances of the medical evaluation of *specific symptoms and/or signs suggesting HTLV-III infection*. At the very least, patients must be informed in advance about exactly what information will be entered in the medical record and might therefore be available to others. Please see the Statement on Confidentiality of Information for further discussion.

12. The American College Health Association strongly discourages the use of any test for HTLV-III antibodies as a mandatory "screening" procedure in any setting except blood donation. **Especially, there should be no screening of:**

- a. entering students, before or after admission
- b. any group of current students or employees
- c. those identified by supposition or admission as being at high risk
- d. health sciences students
- e. food service employees, whether students or not

13. All health care providers should be aware that test procedures, interpretations, and reporting requirements may change over time; **it is important to be familiar with current information and to stay in touch with developments in the field.**

RISK ASSESSMENT FORM

Working Group Chaired by
Nancy S. Shaw, Ph.D.
Leland G. Wessell, M.D.

The following Risk Assessment Form is both a clinical and an educational tool, designed to assist clients and health care providers in understanding the behavioral factors that influence an individual's risk of AIDS. The clinician can use the score that results from a client's careful and honest answers in teaching risk reduction and in following its success. The higher the score, the greater the risk; decreasing scores over time denote risk reduction.

This Risk Assessment may help clinician and client reach a decision as to whether to do the test for antibody to HTLV-III. It educates about behaviors that may lead to exposure to the virus; since it is **not** retained in the medical record but rather goes home with the client, it may provide that education again after the visit with the clinician has ended. The periodic use of this form to assess risk by individual clients may provide a tangible motivational tool for risk reduction.

As is true of any tool, this form can be misused. Because of the very sensitive nature of the information it requests, it must NEVER be included in medical records. The American College Health Association suggests that it be obtained in quantity and given to each client whose risk is assessed. Each individual participating in this risk assessment should be told in advance that he or she will keep the form and that no information transmitted to the care provider verbally will be included in the record, either. **The importance of this Risk Assessment Form is in education, not in record-keeping.**

Additional copies of the Risk Assessment Form may be obtained from the American College Health Association.

CONFIDENTIAL — NOT A PERMANENT PART OF THE MEDICAL RECORD

Many factors must be considered in assessing your level of wellness. Among these are: 1) your risk of acquiring or transmitting any Sexually Transmitted Disease (S.T.D.) and 2) the use of psychoactive chemicals during sexual activity which can increase your risk of acquiring an STD. STDs' considered here include, but are not limited to, gonorrhea, syphilis, chlamydia, Hepatitis B, Giardiasis, and AIDS. The first two questions are biographical in nature and are not part of the risk assessment score, but are intended to guide your provider in making the best possible appraisal of your health. The remaining eight are part of the scored behavioral risk assessment. Please be honest in responding to the following questions — we assure you that this document will be handled with the utmost confidentiality by you and your health care provider only. Please feel free to discuss the results with your provider. You may retain the survey for your own reference. It will not be placed in your medical record.

There are 10 questions listed below. Please check the answer that best describes your preferences or activities.

- A) How long have you been sexually active? _____
- B) Your most recent consistent sexual partner experience
male _____ female _____ both male and female _____
- 1) How many partners have you had *per month* in the last year?
3 _____ 10 or more
2 _____ 4-10
1 _____ 0-3
- 2) How many partners *per month* in the year previous?
3 _____ 10 or more
2 _____ 4-10
1 _____ 0-3
- 3) The kinds of sexual contacts I have are:
3 _____ one time anonymous "tricks", groups, or prostitutes
2 _____ multiple times with the same partner(s)
1 _____ exclusive to my lover or spouse
- 4) I have sexual encounters or contacts most frequently
3 _____ in baths, bookstores, parks, "massage parlors", "spas", public restrooms
2 _____ in bars, autos, parties
1 _____ in my or my partner's home
- 5) The frequency I use drugs to enhance my sexual encounters.
3 _____ frequently
2 _____ occasionally
1 _____ rarely/never
- Please circle drugs used: poppers (amyl or butyl nitrites), alcohol, marijuana, hallucinogens (LSD, mushrooms), PCP, amphetamines, barbiturates, Quaaludes or _____ (please fill in others)

- 6) The frequency with which I *inject* myself with any of the above drugs is:
3 _____ often
2 _____ occasionally
1 _____ never
- 7) I have sexual encounters most frequently in:
3 _____ New York, LA, San Francisco, Miami, Washington DC, Houston, Newark NJ, Atlanta
2 _____ other large urban areas (Boston, Philadelphia, St. Louis, Seattle, etc.)
1 _____ small cities, towns, rural areas
- 8) Those kinds of sexual activities I practice most frequently are (please circle specific activities):
3 _____ unprotected vaginal or anal intercourse, oral-anal contact (rimming), direct fecal or urine contact (scat or water sports), or manual-anal (fisting).
2 _____ "protected" vaginal or anal intercourse (use of condoms and spermicides), oral-genital contact (fellatio or cunnilingus)
1 _____ masturbation, body rubbing, kissing

Add up the numbers from each question (1 to 8) and see the key below to determine your level of risk.

My score is _____.

KEY:

17 or more: you are at high risk for developing STD's, including AIDS, and for possibly developing dependence on psychoactive substances. You should visit your provider every one to three months for a medical assessment and consider counseling for drug use.

12-16 points: you are at medium risk for developing problems and are encouraged to see your provider every three to six months.

11 or less: you are at low risk for problems and are encouraged to see your provider every six to twelve months.

This scoring system was designed to: 1) increase your awareness of STD's and the risk factors associated with acquiring or transmitting STD's 2) stimulate self-evaluation of your sexual lifestyle and 3) encourage your taking responsibility for your health and the health of your sexual contacts. You should see your provider immediately if you have questions or develop any symptoms of illness.

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