University College

Resource Materials for AIDS Presentations

1992-1993
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AIDS PRESENTATION OUTLINE
UNIVERSITY COLLEGE
1992-93*

Introduction

Basic Assumptions

1. AIDS is not a gay disease, i.e., the virus does not know if you are black or white, male or female, gay or straight; it looks for a window of opportunity. It's not WHO you are, but WHAT you do.

2. Recent estimates suggest that approximately 1.5 million people are HIV+ and 90% of those people are not aware of their HIV status.

3. A recent study by the American College Health Association and Center for Disease Control shows that 1 out of 500 college students is HIV+.

4. You are more dangerous to someone with AIDS than they are to you.

5. Three basic ways of getting the virus:
   1. By having sex with an infected person
   2. By sharing needles and syringes with an infected person (including Steroid use!!!)
   3. During pregnancy, birth, or breast feeding from infected mother to child.

6. We cannot cure it, but we can stop it.

Show film "Changing the Rules."

Answer any questions

Distribute brochures and evaluations

* The film "Changing the Rules" is now more than five years old and statistics are very outdated though this is still the best media presentation around. If you use the tape be sure to correct the statistics (see resource materials)
Some of you may feel comfortable giving the AIDS presentation without the video. If this is the case, be sure to cover the following points while also incorporating the basic assumptions from the previous outline.

I. Identify and define the basic terms
   A. Human immunodeficiency virus (HIV)
   B. Acquired immunodeficiency syndrome (AIDS); a result of HIV infection

II. HIV Infection
   A. Initial exposure
   B. Flu-like symptoms may appear
   C. HIV antibodies develop, usually 6-12 weeks later (window period)
   D. Infected person does not feel sick, sometimes for 5-10 years (incubation)
   E. Infected person develops symptomatic HIV infection
   F. Person develops AIDS
   G. Continuum of possible illnesses
      1. None
      2. Fever
      3. Fatigue
      4. Diarrhea
      5. Skin rashes
      6. Night sweats
      7. Loss of appetite
      8. Swollen lymph nodes
      9. Significant weight loss
      10. Lack of resistance to infection
      11. Furry white spots in the mouth
      12. Dry cough/shortness of breath
      13. Memory or movement difficulties
      14. Pneumonia

III. Transmission
   A. Cannot get HIV from just being around someone with HIV
   B. HIV is not spread through casual contact
C. Documented cases of HIV transmitted by these fluids from an infected person

1. Blood
2. Semen
3. Vaginal fluid
4. Breast milk (few cases reported)

D. HIV usually transmitted through

1. By having sex with an infected person
2. By sharing needles and syringes with an infected person.
3. During pregnancy, birth, or breast feeding, from infected mother to child.

IV. Prevention

A. No risk sexual activities include

1. No sex
2. Masturbation
3. Sex only with an uninfected monogamous partner who does not share needles and syringes.

B. Risky Sexual Activities Include:

1. Contact with partner’s blood, semen, or vaginal fluid unless you know for sure that your partner does not have HIV. Examples include:
   a. unprotected oral, anal, and vaginal sex
   b. oral-anal contact
   c. mutual masturbation in which skin is not intact

C. Using condoms greatly lowers your risk of HIV infection.

D. Use a latex condom and nonoxynol-9 every time from start to finish

E. Drugs and alcohol may cloud your judgment.

1. They may make you more likely to have sex and share needles or syringes.
V. Testing

A. Negative antibody test means:
   1. You are not infected with HIV or
   2. You have been recently infected with HIV and can infect others, but the test did not detect antibodies.
   3. Consider being retested in another 3-6 months because of "window period."

B. A positive antibody test means:
   1. You are infected with HIV
   2. You will always have HIV
   3. You can infect others
   4. Antibody tests for HIV are more than 99% accurate.

C. Free and Anonymous testing available at Columbus Health Department
### Acquired Immunodeficiency Syndrome (AIDS)
#### Data for Ohio and the United States

**U.S. Data through June 30, 1992**

**Ohio Data through September 30, 1992**

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<th>Ohio Total (%)</th>
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<td>621</td>
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<td>Subtotal</td>
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<td>3443</td>
<td>1903</td>
<td>609</td>
<td>613</td>
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| **PEDIATRIC (<13 yrs.)** | | | | | | | |
| Hemophilia           | 179 (5)        | 9 (17)         | 9 (29)       | 0 (0)     | 0 (0)    | 0 (0)    | 0 (0)    |
| Mother w/ HIV risk: | 3315 (85)      | 39 (75)        | 20 (65)      | 10 (91)   | 7 (88)   | 2 (100)  |          |
| Mother w/ IDU       | 1561 (1)       | 9 (1)          | 6 (1)        | 1 (2)     |          |          | 0 (0)    |
| Mother sex w/ IDU   | 673 (10)       | 7 (2)          | 2 (1)        |          |          |          | 0 (0)    |
| Other risk history  | 1061 (20)      | 7 (7)          | 4 (2)        |          |          |          | 2 (2)    |
| Blood transfusion   | 300 (6)        | 3 (6)          | 2 (6)        | 1 (9)    | 0 (0)    | 0 (0)    | 0 (0)    |
| Undetermined        | 104 (3)        | 1 (2)          | 0 (0)        | 0 (0)    | 1 (3)    | 0 (0)    | 0 (0)    |
| Subtotal            | 3398           | 52 (17)        | 31 (11)      | 8 (2)    |          |          |          |
| **TOTAL**           | 230179         | 3495           | 1934         | 620      | 621      | 320      |          |

*Note: All rates in this report use 1980 Census figures, are cumulative since 1981 and are calculated per 100,000 population. U.S. figures reflect confirmed cases of AIDS in U.S. residents reported to CDC. Ohio figures reflect confirmed reported cases of AIDS in persons stating Ohio residence at time of initial diagnosis.*
### COUNTIES OF RESIDENCE AT AIDS DIAGNOSIS
Ohio, through September 30, 1992

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<tr>
<th>County</th>
<th>Total</th>
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<th>Dead</th>
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NOTE: 86 of Ohio's 88 counties are represented here.

*All rates on this report use 1980 U.S. Census figures, are cumulative since 1981, and are calculated per 100,000 population.

### ONSET CASES FATAL %FATAL
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### CUMULATIVE AIDS CASES BY RESIDENCE AT DIAGNOSIS

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<th>U.S. fatalities</th>
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Peter Somani, M.D., Ph.D.
Director of Health

Ohio Department of Health
AIDS Activities Unit
(614) 466-5480
The Second 100,000 Cases of AIDS—U.S., June 1981-December 1991

The following caseload report appeared at pages 28-29 of the January 17, 1992, Morbidity and Mortality Weekly Report (MMWR), which is published by the U.S. Centers for Disease Control (CDC). For further information, contact MMWR offices at CDC in Atlanta, Georgia at (404) 639-2104.

The Second 100,000 Cases of Acquired Immunodeficiency Syndrome—United States, June 1981—December 1991

The first cases of acquired immunodeficiency syndrome (AIDS) were reported in June 1981 (1). From 1981 through December 1987, 50,000 AIDS cases had been reported to CDC, and by August 1989, 100,000 cases had been reported (2). From September 1989 through November 1991, state and territorial health departments reported 100,000 additional cases. By December 31, 1991, a cumulative total of 206,392 cases had been reported (Figure 1), and the cumulative number of reported deaths associated with AIDS was 133,232. This report presents characteristics of the first and second 100,000 persons with AIDS.

Overall, most reported AIDS cases occurred among homosexual/bisexual men (i.e., men who reported sexual contact with other men) (59%) and injecting-drug users (IDUs) (22%). Of the first 100,000 reported AIDS cases, 61% occurred among homosexual/bisexual men with no history of IDU, and 20%, among female or heterosexual male IDUs. In comparison, of the second 100,000 reported cases, 55% occurred among homosexual/bisexual men with no history of IDU, and 24% occurred among female or heterosexual male IDUs.

The second 100,000 cases reflect an increasing proportion of persons with AIDS who have been reported to have had heterosexual exposure to persons at risk for human immunodeficiency virus (HIV) infection. Of the first 100,000 persons with AIDS, 5% were attributed to heterosexual transmission, compared with 7% among the second 100,000—a 44% increase. Of all AIDS cases among women, 34% were attributed to heterosexual transmission, and women accounted for 61% of all cases attributed to heterosexual transmission. Of the first 100,000 persons with AIDS, 9% were women, compared with 12% of the second 100,000 persons. The first 100,000


*Cases reported through December 1991.
persons with AIDS included 1683 children, of whom 81% were born to mothers with or at risk for HIV infection; the second 100,000 persons with AIDS included 1702 children, of whom 87% were born to mothers with or at risk for HIV infection.

A disproportionate number of AIDS cases continue to be reported among blacks and Hispanics. Of the first 100,000 reported cases, 27% occurred among blacks and 15% among Hispanics; of the second 100,000 reported cases, these proportions increased to 31% and 17% for blacks and Hispanics, respectively.

The proportion of AIDS cases related to transfusions as a mode of exposure declined in both adults (2.5% to 1.9%) and children (11% to 5.6%) from the first to the second 100,000 cases.

Reported by: Surveillance Br, Div of HIV/AIDS, National Center for Infectious Diseases, CDC.

Editorial Note: The cumulative total of more than 200,000 reported AIDS cases emphasizes the rapidly increasing magnitude of the HIV epidemic in the United States. The first 100,000 cases were reported during an 8-year period, whereas the second 100,000 cases were reported during a 2-year period.

The number and proportion of AIDS cases associated with heterosexual transmission of HIV has been increasing steadily. Factors associated with an increased risk for heterosexual transmission include multiple sex partners and the presence of other sexually transmitted diseases. In the United States, men and women who have unprotected sexual contact, particularly with partners known to have risks for HIV infection, are at increased risk for HIV infection. A recent analysis of expected trends in AIDS cases in the United States suggests that by 1995, the infection rate among nondrug-using heterosexual men and women may be associated with a doubling of AIDS cases acquired through heterosexual transmission (3).

Of the estimated 1 million HIV-infected persons in the United States, approximately 20% have developed AIDS. Approximately half of all persons who have been diagnosed with HIV infection and who have evidence of severe immunosuppression (i.e., CD4+ counts <200 cells/μL) meet the current AIDS surveillance case definition (4). Approximately 125,000 persons who do not have an AIDS-defining illness are estimated to have a CD4+ lymphocyte count <200 cells/μL (CDC, unpublished data). CDC has proposed expanding the AIDS surveillance case definition to facilitate more complete reporting of all persons with severe HIV-related immunosuppression and who are at the highest risk for developing serious illnesses or death* (5).

References
2. CDC. First 100,000 cases of acquired immunodeficiency syndrome—United States. MMWR 1989;38:561-3.

*The draft document is available for review from the National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231. Written comments on this draft document should be sent to the same address by February 14, 1992.
AIDS FALLACIES

Terms that contribute to misunderstanding about HIV

The following terms are widely used by AIDS activists, health professionals, political leaders, and the media. The terms are medically misinformed and socially misleading. Although convenient to use, they contribute to public misunderstanding about the HIV epidemic. They also distort and diminish the experiences of people living within the HIV spectrum, their families and friends. The Taskforce recommends that these terms not be used, for reasons outlined below.

AIDS Virus: Popular term for Human Immunodeficiency Virus (HIV), the virus that can damage the immune system and cause a variety of illnesses, among them the cancers and infections known as AIDS. HIV infection is NOT the same as a diagnosis of AIDS. Not all persons infected with HIV will necessarily develop AIDS. At the present time, researchers estimate that 75 to 80 percent of those infected will develop some form of immune deficiency over 16 years. “AIDS virus” ignores these important facts, and collapses the distinction between HIV infection and AIDS. It also encourages a public association with other, casually transmitted viruses (such as the flu virus)—in spite of everything one says about transmission. AIDS organizations originally adopted the term to avoid the confusion created by the many different and constantly changing names for the virus (HTLV-3, LAV, ARV). In 1986, an international scientific committee selected the term HIV, thereby eliminating any justification for “AIDS virus.” The preferred terms are HIV, the virus, or the virus that can lead to AIDS.

AIDS Carrier: Technically correct term, in that a person infected with HIV “carries” it in his or her body and can infect others. But the historical usage of this term conjures up images of contagion and plague. In popular usage, it confuses infectious viruses (like HIV) with contagious ones. It reinforces the misconception that persons with HIV-related conditions threaten public health through everyday activity. (An “AIDS Carrier” becomes a Typhoid Mary of AIDS.) In reality, of course, it is the person with HIV, ARC or AIDS who is most vulnerable. The preferred terms are person with HIV, infected person or HIV-antibody positive individual.

AIDS Test: Perhaps the most misused term in the HIV epidemic. The AIDS test is actually a test for the antibody produced in response to infection with HIV. Most researchers believe that a negative antibody test means HIV infection. But “AIDS test” reinforces the equation of virus infection and AIDS. (Many people believe that the test provides an AIDS diagnosis.) Aside from its absolute inaccuracy, the notion of an “AIDS test” also powers misguided demands for universal, mandatory “AIDS testing” of various groups. The preferred term is HIV Antibody Test.

Risk Group: A term used to describe a population group where high-risk behaviors (unsafe sex, sharing needles) are or have been prevalent. Public health researchers use it for tracing the history, and predicting the future spread, of an epidemic. In the public mind, however, “risk group” slides into the idea that simple membership in such a group puts one at risk for HIV infection. It contributes to AIDS-phobic reactions against groups disproportionately affected by AIDS: gay men, Black and Hispanic people, hemophiliacs. There is no such thing as a risk group, there are only risk behaviors. Risk behavior or risk practice are the preferred terms.

AIDS Victim: In widespread use, the term seems at first glance sympathetic to persons within the HIV spectrum. Literally “victim” means someone who suffers as a result of incident or accident. While it seems neutral, however, the term also connotes passivity, fatalism and negativism. For these reasons, people with AIDS have rejected the name “AIDS victim” as well as “AIDS patient.” At the second AIDS forum in Denver in 1983, men and women with AIDS explained their opposition to the terms: “We condemn attempts to label us ‘victims,’ which implies defeat, and we are only occasionally ‘patients,’ which implies passivity, helplessness, and dependence on the care of others.” At Denver these men and women chose the name person (or people) with AIDS. In Washington, D.C., in 1987, people with AIDS expanded the name to people living with AIDS. These are the preferred terms. They are often shortened to the acronym PWA.
From: AIDS on the College Campus
A Special Report of the American College Health Association, 1989, Editor, Richard P. Keeling, M.D.

Working with Students Who are Concerned about Others

The stigmatization, secrecy, silence, and controversy surrounding HIV infection and AIDS complicate the reactions of students who feel concern or grief about a significant person in their lives who is HIV-infected. Underlying the many conflicts these concerned students feel are the basic issues of dealing with chronically or terminally ill relatives and friends. The addition of the specific problems of AIDS commonly isolates concerned students and weakens their confidence in support networks. A student who might otherwise seek comfort and understanding from her friends in dealing with her brother’s serious illness may feel fearful in doing so when the brother’s illness is AIDS.

Some students worry about casual transmission of HIV from the infected person. Others do not understand HIV, or AIDS, or the significance of antibody test results. Thus, a therapist’s first responsibility is education. A referral to a health educator or health care provider may provide answers, and a number of good informational brochures and pamphlets are available for reference. Some worried students simply want to know how to help; a discussion of some of the major adjustments and needs of people with HIV infection may meet this need.

An earlier section of this chapter emphasizes that students concerned about casual contagion often have other psychological needs as well. In the specific case of a student worried about someone else, these psychological needs may center on the past history and dynamics of the student’s relationship with the other person. As is true of people dealing with another’s terminal illness in other settings, students may need to ventilate anger or frustration about their relationship with the sick person. There are commonly unresolved issues, and students feel disappointed at the prospect of leaving them incompletely addressed. Guilt is frequent. When the person with AIDS progresses through the stages of illness, the concerned student needs help in working through the stages of grief. AIDS makes the process of developing an accepting view of the dying or lost person more difficult. Therapists must often address major issues of self-concept, mortality, illness, “fault” in suffering, and family roles as students come to terms with their loss. Once again, support groups are helpful.

CLINICAL MANAGEMENT OF HIV INFECTION

Richard P. Keeling, M.D.

INTRODUCTION

HIV infection is an active medical problem demanding active clinical management. Clinicians cannot responsibly choose a purely passive, “wait and see what happens” approach in caring for asymptomatic seropositive individuals, nor for people with early symptoms of HIV disease. This chapter includes recommendations for evaluating and managing asymptomatic and slightly symptomatic seropositive people in college and university health services; it is not intended as a text about AIDS itself. The major clinical responsibility in college health centers will be to manage asymptomatic infected individuals as effectively as possible. Many other texts and review articles provide details of the management of full-blown AIDS.

This chapter provides no final answers; there are still debates about the details of the “standard of care” for seropositive people. Additional therapies, diagnostic procedures, and psychological interventions may become available in coming months and years; all clinicians should be aware of new approaches and treatments as they develop. The guidelines suggested herein may be revised and augmented as knowledge improves.

NATURAL HISTORY OF HIV INFECTION

Prognosis of HIV Infection

HIV infection is not static. Once exposure results in infection, antibodies to HIV develop and a series of increasingly predictable clinical consequences ensues. Mathematical models, based on relatively safe actuarial assumptions and the first seven to eight years of collected experience with large cohorts of people with HIV infection, now suggest that the overwhelming majority of sero-
positive people will gradually progress to symptomatic stages and, eventually, to AIDS itself. It is premature to say that literally everyone with HIV infection will eventually have AIDS, and we hope that the combination of new therapies and self-directed management by seropositive people will prevent that from happening. Nonetheless, a realistic assessment of currently available data is that we should routinely expect the outcome of HIV infection to be AIDS. Since a "cure" for AIDS itself is not yet at hand, we must do all we can to preserve the health and immune competency of infected people for as long as possible.

**Incubation Period/Latency Phase**

The major variable in prognosis appears to be time: that is, the nature of the eventual outcome of HIV infection seems predictable, but the speed with which it happens varies extensively. The incubation period, or latent phase, of HIV infection averages at least eight, and possibly more than nine years, but has a range of only a few months to more than 14 years. The best existing data suggest that most people develop AIDS in the time period of 6 to 11 years after HIV infection. Within a considerable range of variation, these predictions hold true for people infected by sexual transmission or by contaminated blood products. In any individual person's life, it is difficult to make accurate or helpful predictions; the exact date of exposure and first infection may not be known, and there seem to be many factors that influence the speed with which HIV infection proceeds.

During the latent phase, clinical evidence of HIV infection is absent or scant. HIV antibodies persist on ELISA and confirmatory testing procedures (Western blot and immunofluorescent antibody), but, typically, HIV p24 antigen tests are negative. Immunologic tests during latency demonstrate progressively falling helper lymphocyte (T, or CD4) counts; all other things being equal, the helper count seems to fall about 10 to 15 percent (or, about 90 to 100 cells X 10^9/l) per year. Incomplete or absent skin reactions on delayed hypersensitivity testing occur as helper cell counts fall. Serum levels of beta-2 microglobulin rise slowly during latency as a function of lymphocyte turnover. These changes may occur in phases separated by fairly stable plateaus.

Infected individuals are also infectious to others, but the degree of infectiousness seems to vary extensively from person to person and from time to time. During the latent phase, infectivity seems lower than during acute HIV infection or after the development of symptomatic disease. There is no clinically available method for assessing infectivity at this time. Seropositive individuals must assume that they are able to transmit HIV.

**Cofactors Influencing Progression of Infection**

**Factors at the Time of Infection**

Since the length of the incubation period varies so extensively, it is logical to assume that there are other factors (usually called cofactors) which influence the rate of progression of HIV infection. Some such factors may be determined by the means of transmission of the virus and the state of the immune system at the time of infection. For example, infants, whose immune systems are immature and unstable, typically become ill more quickly than children and adolescents. The incubation period also may be shorter in adults who are older than 30 at the time of original infection. Someone infected with HIV through blood transfusion develops AIDS more quickly if the transfusion was given to treat a significant underlying medical problem than if the transfusion was for trauma.

**Cofactors after Infection**

Other influences come into play after infection is established. In general, non-drug-using gay men have longer incubation periods after exposure to HIV than do their drug-using peers, for
example. There are multiple immunosuppressive events and infections in the lives of most people who share needles with others, and those factors all collaborate to promote replication of HIV. HIV seems not to be reproduced continuously but, rather, at intervals; periods of replication seem to be stimulated by events which activate the immune system in general, and helper T cells in particular.

Certain events and conditions, then, seem to accelerate HIV infection during the latency phase, whereas others may limit or retard it. Our knowledge of these factors is descriptive, inferential, and superficial, in most cases. Increasingly sophisticated studies in the new field of psychoimmunoneurology support the hypothesis that high stress and hopelessness, for example, promote the more rapid development of illness. Loneliness and social isolation have a negative influence. Infection with other organisms, especially other sexually transmissible agents, may also facilitate the progression of HIV infection. Re-exposure to HIV itself apparently is a negative cofactor; accordingly, seropositive individuals should still protect themselves from HIV. Exposure to chemicals or drugs that suppress immune function are negative factors: alcohol, recreational drugs, and some prescription pharmaceuticals seem associated with faster progression. The magnitude of the effect of alcohol and drugs will obviously vary with the specific agent, frequency of use, intensity of exposure, and route of administration. Our current level of knowledge does not, however, allow us to specify exactly what is a safe level of alcohol consumption for a seropositive person. Many clinicians caring for seropositive people feel that tobacco use, especially cigarette smoking, is harmful to immune function.  

Other factors seem to slow down the progress of HIV. Many are predictable as opposites of the negative cofactors discussed above. Stress reduction, positive self-concepts, a sense of control over the future, a commitment to life, and spiritual peace all seem to be beneficial. People who pursue medical care as a partnership with a sense of independence and self-determination seem to stay healthier longer. The support of others as well as sharing the experience of HIV infection seem beneficial. Some previous experience with overcoming and surviving major life traumas and losses seems to correlate with longer survival in HIV infection. Regular aerobic exercise may modulate immune function in helpful ways through the release of neurochemical mediators that influence lymphocytes. Adequate sleep and reasonable nutrition (including the maintenance of ideal lean body mass and the avoidance of specific deficiencies of micronutrients) seem important.

CLINICAL PHASES OF HIV INFECTION

The natural history of HIV infection includes four general phases:

1. Acute HIV Infection
2. Asymptomatic Seropositivity
3. Symptomatic HIV Disease without AIDS
4. Full-Blown AIDS

A number of complex classification systems for HIV disease have been developed. While they may be of use in comparing individuals in research studies and in epidemiological investigations, it is not yet clear that any of the currently available classification schemes has prognostic significance. An approach that looks more descriptively at the general phases of infection seems more useful and applicable for the purpose of clinicians in college and university health centers.

Acute HIV Infection

There may be absolutely no clinical correlate of original HIV infection, but a mononucleosis-like illness occurs in the days to weeks after initial infection with HIV in one-third to one-half of people. Fatigue, arthralgias, low-grade fever, variable adenopathy, and mild pharyngitis are common features. Notable components of
the illness in a minority of people are a variable maculopapular rash and significant neurological features (encephalitis, seizures, disorientation). Blood tests show initial lymphopenia, followed by mild lymphocytosis with atypical lymphocytes present. Slide tests for mononucleosis and differential heterophile tests are negative. Acute HIV disease is generally self-limited, terminating spontaneously after ten days to three weeks.

Since the currently available HIV antibody assays do not turn positive for several weeks after infection, routine HIV antibody testing during this acute illness is unrevealing. Acute HIV infection can be diagnosed only in retrospect by demonstrating seroconversion to HIV after exposure to virus. Acute HIV disease should be suspected in students who are at risk for HIV infection and present with mononucleosis-like illnesses and negative mononucleosis slide tests.

A special note about acute HIV disease for health care workers: during this acute illness, infected persons have significant HIV viremia and are infectious. Their HIV antibody tests are negative. This disparity — HIV infectiousness with a negative antibody test — is a fundamental reason for using universal precautions in handling the blood and body fluids of all students.

**Asymptomatic Seropositivity**

**Immunological Features**

Asymptomatic seropositivity is a phase of relative and deceptive clinical quiescence during which viral replication continues. Immunologic markers demonstrate gradual deterioration, the speed and intensity of which may be influenced by a number of cofactors, as discussed above. There is no specific helper T cell number that defines this phase of HIV disease; asymptomatic individuals have helper T cell counts from <100 to >1000 cells X 10^9/l. In most laboratories, the lower threshold of normal helper cell counts is 400 cells X 10^9/l; therefore, many asymptomatic seropositive people have normal counts. The helper/suppressor cell ratio, normally >1.0, is usually abnormal, though, because of an increase in the number and percentage of suppressor T cells (T<sub>8</sub> cells). There are many influences on lymphocyte subpopulations and their enumeration; day-to-day and diurnal variations occur, and stress, exercise, and other illnesses all affect the counts. Helper T cell counts are not, therefore, effectively used as the sole indicator of prognosis. Some people with helper cell counts <20 X 10^9/l have remained asymptomatic for long periods of time, whereas others with counts over 200 X 10^9/l have developed opportunistic infections. A succession of helper T cell counts tells much more than any single value. Helper T cell testing is best done in conjunction with clinical assessment and the use of other laboratory indicators, such as the HIV antigen and beta-2 microglobulin levels.

**p24 Antigen Testing**

The HIV p24 antigen is typically absent in the serum during most of the asymptomatic phase. Present during acute HIV disease, the antigen usually disappears as the acute illness resolves. HIV antigen reappears much later, usually years later, as symptoms of HIV disease begin to occur. A positive p24 antigen test during asymptomatic seropositivity has been a very negative prognostic indicator, suggesting high risk for progression to AIDS in the short or intermediate term. The p24 antigen test is not yet universally available. Antigen testing by itself should not be used to define prognosis; it is one indicator that is most helpful when used in conjunction with other markers.

**Beta-2 Microglobulin**

Beta-2 microglobulin is a fraction of the major histocompatibility complex (IIA) 1 antigen. It appears to be released into the serum in higher quantities when lymphocyte turnover is more rapid — as, for example, during infection and destruction of lymphocytes by HIV. Unlike p24 antigen, beta-2 microglobulin is normally present in the serum of asymptomatic seropositive people at low levels (in most laboratories, < 1.7 mg/l). Levels of beta-2 microglobulin rise during acute HIV infection, drop after resolution of the acute illness, and then rise very slowly during the phase of asymptomatic seropositivity. By the time AIDS is diagnosed, most people have beta-2 microglobulin levels exceeding 5.0 mg/l. Most asymptomatic people with beta-2 microglobulin levels greater than 5.0 mg/l will probably develop AIDS in the short term. When combined with HIV
antigen testing and helper T cell counts, the beta-2 microglobulin level can be of great assistance in understanding someone's place along the continuum of HIV infection.

The boundary between "asymptomatic seropositivity" and "symptomatic HIV disease" is sometimes hard to draw. The earliest symptoms related to HIV are subtle, protein, and shifting; sensations and problems come and go and may be difficult to distinguish from ordinary variations in healthy people. Some symptoms may represent HIV disease, a complicating infection, an unrelated illness, the psychological reactions to having HIV infection, or other factors. Fatigue, for example, seems common in seropositive people — but, in any individual case, it may be impossible to decide what exactly is responsible for the tiredness. Similarly, weight loss is frequent: but is that the weight loss of HIV disease, or depression, or a complicating illness? People considered to have asymptomatic seropositivity may have signs, if not symptoms: lymph nodes, for example, may be detected periodically. The shading of asymptomatic seropositivity into symptomatic HIV disease is slow and subtle. The nomenclature involved is not so important; understanding the general course of events is more helpful.

Clinical Events
A host of minor clinical events may occur periodically during this phase, especially after significant reductions in helper cell counts have occurred. These problems often come and go, seeming to respond to therapy, but recurring easily. Taken in isolation, a single episode may cause neither student nor clinician much concern. Over time, however, a pattern of events may emerge. Typically, the minor clinical problems of otherwise asymptomatic seropositive people are unusual in some way: more intense, more serious, or somehow different in pattern from what one expects in most people. Clinicians must stay alert for these differences in intensity, frequency, and pattern.

Some typical minor clinical problems of seropositive people include:

1. seborrheic dermatitis, especially on the face, and most particularly in the nasolabial folds; often comes and goes

2. itchy folliculitis, especially on the extremities, trunk and axillae. Clinically, this is a fairly nonspecific folliculitis that seems to appear and fade at unpredictable intervals. While some people tolerate it well, others complain bitterly of nocturnal itching and excoriate the lesions severely.

3. recurrent genital herpes. The recurrences may be more frequent and severe in seropositive people.

4. molluscum contagiosum, especially outside the groin; molluscum on the face and neck is fairly common in HIV disease.

5. genital warts (Human Papillomavirus [HPV] infection) may be more difficult to treat effectively in seropositive persons. Detailed studies are not yet available, and clinicians are accustomed to frustration in dealing with HPV disease — but, still, it seems that the problems are all the greater in seropositive individuals.

6. tinea infections. Obviously, many students have athlete's foot and tinea cruris. As is the case with the other problems noted in this section, what happens with tinea in HIV disease is a matter of pattern differences: more frequent, more severe, less responsive to therapy, more likely to recur.

7. dental abscesses, perhaps because oral defences against infectious agents are impaired fairly early in the course of HIV infection.

8. severe aphthous stomatitis. Multiple, very painful shallow ulcers may occur in waves, causing not only discomfort but also difficulty in eating and drinking.
9. angular cheilitis; may raise the question of vitamin or other micronutrient deficiencies.

While these minor clinical manifestations do not seem to have independent prognostic significance (that is to say, people with positive tests and some of these symptoms have no apparent difference in outcome from seropositive people with no symptoms at all), three other illnesses are strongly associated with the eventual development of AIDS in a definable time frame. The following three illnesses clearly indicate the beginning of symptomatic HIV infection:

1. herpes zoster, a long-term predictor of AIDS (usually within three to six years). Shingles may be quite severe in seropositive people. It often is very frightening and painful. Seropositive individuals with shingles commonly feel concerned not only about the immediate discomforts of the illness, but also the implication that their immunologic function is worsening; appropriate management may include psychological evaluation and counseling or psychotherapy. Since shingles is a dramatic illness, it may draw attention to previously unrecognized seropositivity. Although shingles certainly occurs in young people who do not have HIV infection or other problems in immune function, students with shingles should have a detailed history to identify any possible risk of HIV infection. The clinical management of shingles in seropositive individuals is similar to that used in other people, but with special attention to surveillance for dissemination of varicella virus to sites outside the original dermatome.

2. hairy leukoplakia, an intermediate-term predictor of AIDS (one to two years) among seropositive people. Hairy leukoplakia typically involves the sides of the tongue; it produces a filiform, whitish lesion that remits and recurs. Current research suggests that Epstein Barr Virus (EBV) causes hairy leukoplakia; in some cases, acyclovir therapy has produced improvement. Hairy leukoplakia may interfere with taste sensation and food enjoyment, problems which complicate the nutritional management of seropositive people.

3. oral candidiasis (thrush), predicts AIDS within nine to eighteen months in most seropositive people. Thrush is rarely the first indicator of seropositivity. Thrush has less prognostic significance when it occurs during antibiotic therapy for other infections, because broad spectrum antibiotics may sufficiently disturb the microbiological flora of the mouth to allow an overgrowth of candida. Antibiotic-related thrush also occurs rarely in individuals with normal immune function. Nonetheless, seropositive people not on antibiotics will be understandably upset if thrush occurs. Thrush may be difficult to manage with oral lozenges of antifungal agents; not uncommonly, daily ketoconazole is required.

Symptomatic HIV Infection without AIDS

The transition into symptomatic HIV disease is most clearly marked by chronic, relapsing and remitting lymphadenopathy; constitutional symptoms, including fevers, night sweats, anorexia, weight loss; worsening immunologic parameters; and more pressing clinical signs, such as psychoneurological disease, hairy leukoplakia, and thrush. During this phase of illness, once called "AIDS-related complex," or ARC, most individuals feel significantly ill for significant portions of time. There are often good days and bad days, but, in general, people with symptomatic HIV disease feel limitations in work, recreation, and social life.

Immunologic Trends

The immunologic trends noted in asymptomatic seropositivity continue as symptoms define the existence of HIV disease.

Absolute lymphocyte counts are reduced. Helper T cell counts are almost always < 400 X 10^3/l. Helper/suppressor ratios are usually very low, typically <0.3. HIV p24 antigen may reappear in the serum, and beta-2 microglobulin levels usually exceed 3 mg/l. As time goes on, hemocrit may fall slightly.

Major Clinical Syndromes

Lymph node enlargement is a common early sign; it may be the first clinical event suggesting underlying seropositivity. Most often, lymph nodes are enlarged in multiple sites. Enlarged nodes tend to be somewhat asymmetrical but tend to enlarge more or less in
the same proportions. Needle or surgical biopsy of enlarged nodes is rarely helpful in known seropositive persons with generalized lymphadenopathy. There are often significant infections in biopsy sites and delays in wound healing. A node found to be much larger (and growing much faster) than others raises suspicion of lymphoma, Kaposi's sarcoma, or other malignancy. Isolated, disproportionately enlarged lymph nodes are more appropriately biopsied.4

Constitutional symptoms are common. Losses of appetite and weight may proceed in parallel, but many times a person reports intact appetite in spite of obvious decline in body mass. Low-grade fevers without obvious precipitating cause are frequent; nonetheless, fever always demands a diligent search for possible etiologies, including unusual and covert infections. Night sweats bother many seropositive people; sometimes, sweating is severe and requires several changes of bedclothes in the same evening. As is true of fever, night sweats should prompt investigation for infection. The combination of night sweats, weight loss, and cough should specifically suggest tuberculosis, which is more common in seropositive people because of reactivation of previous infection in the setting of increasing immune deficiency.

Neurological and psychological manifestations of HIV infection may appear during this phase. The spectrum of possible manifestations is broad. Commonly reported in college and university students are Bell's palsy; mild cognitive defects with learning disabilities; radicular pain; memory defects; and alterations in mood with organicity on psychological testing. More threatening manifestations of HIV infection in the central nervous system may occur much more rarely: seizures, myelopathies, disorientation.

Uncertainty and stress are great during this period of HIV infection, however, and clinicians must try to discern what components of a total clinical picture represent actual neurologic HIV infection, and which are reactive elements of anxiety or depression. Many therapists and clinicians agree that they see the greatest HIV-

4The support of an experienced hematopathologist is important. The lymph node histopathology of HIV disease is sometimes subtle.

related stress among people with symptomatic disease without AIDS; the uncertainties and threats seem horribly real, and situations can change very quickly. The chapter on psychological issues and interventions provides more detail about these concerns.

Isolated thrombocytopenia in HIV disease is clinically similar to idiopathic thrombocytopenic purpura (ITP), but steroid therapy is hazardous, since it may precipitate opportunistic infections or Kaposi's sarcoma.

Diarrhea is common, refractory to treatment, hard to manage, and very troubling to people with HIV disease. Although clinicians should search for infectious etiologies, a clear cause may not be determined. Symptomatic management, reasonable nutritional guidelines, and surveillance for treatable pathogens are all important in handling this complication.

Full-Blown AIDS

Opportunistic infections, Kaposi's sarcoma, lymphomas, wasting syndromes, and psychoneurological disorders meeting the surveillance definition of the Centers for Disease Control allow the diagnosis of AIDS itself. Severely impaired immunological function is documented on a variety of clinical tests.

AIDS does not develop in anyone overnight. The severe immunological deficiency state that characterizes AIDS arises by slow evolution. Nonetheless, some people have had few symptoms, little medical care, and no sense of personal risk (or, much denial); it is, therefore, possible for a person to find out he or she has HIV infection and AIDS at the same time when some catastrophic opportunistic infection occurs or the lesions of Kaposi's sarcoma become obvious. More often, people who fear AIDS and also fear the knowledge of HIV infection have deferred being tested and finally come to a sad realization of infection when AIDS itself develops.

A discussion of the management of AIDS is beyond the scope of this chapter. We hope that, through partnerships in management among students, clinicians, therapists, nutritionists, and significant others, most infected people will remain relatively healthy for longer periods. Once AIDS itself does occur, management
becomes a complex process of treating complicating infections or cancers while administering antiviral therapy and supporting general health and immune function. Other texts more than adequately explicate this phase of management. Our decision to exclude that

AIDS is a primary care disease, and clinicians in college health will manage it well.

information from this text is purely a matter of making this book manageable in size and scope. It should not imply that AIDS is not to be managed by primary care clinicians in college and university health centers. On the contrary: AIDS is a primary care disease, and clinicians in college health will manage it well.
they are not in the “high risk group,” believe they are inherently safe no matter what they do.

“High risk behavior” is both more accurate and helpful than “high risk group.” “High risk behavior” emphasizes that it is not who you are, but what you do that places you at risk. The only true “high risk group” is hemophiliacs—who, because of need for blood products, have a high rate of seropositivity. They have higher risk not because of what they do, but because of their biological make-up.

Value-Neutral Words. Some words concerning sexual behavior and needle use are used differently by different people. “Monogamy,” “promiscuity,” “abstinence,” “addict,” and “prostitution” are examples. It is dangerous to assume that all audiences define these terms the same way we do. If we use them, we should define what we mean by them. In many cases, it is best not to use them at all, since they may make some listeners defensive and unable to hear our messages. Instead of “monogamy,” we can say “two people who have sex only with each other.” Instead of “promiscuity,” we can say “multiple partners.” Instead of “drug addict,” “drug user.” “Abstinence” is a powerful word, but a confusing one; some people mean not having physical intimacy, but others mean only not having intercourse. In using “abstinence,” we must be both clear and non-judgmental.
2. False Negative Tests. False negative tests are of two kinds. Extremely rarely, there is a technical problem or error that causes the test to be negative even when antibody to HIV is present. More commonly, the test is correctly negative, because antibody is not present, but "falsely" negative in the sense that the person tested actually has HIV infection. The latter situation occurs when the test is performed before antibody to HIV has become detectable, when an antibody response does not develop, or rarely, late in the course of AIDS when antibody levels fall. Thus, in some cases, people who have either symptomatic immune deficiency or recoverable HIV in blood and other body fluids, or both, have a negative HIV antibody test.

Antibodies to HIV are regularly not detectable during the first few weeks after infection. In the great majority of people, antibody is detected beginning 6-14 weeks after infection. Tests done six months after the most recent possible exposure to HIV do, in general, produce reliable information. Very clearly, though, some people infected with HIV do not form antibody for more than six months, and periods of 14 to 40 or more months are documented. It seems that delays in antibody detection longer than a few months are quite rare, so the likelihood of an infected individual still having a negative test many months after exposure is small. If there is any doubt about the accuracy of a negative test result, the test must be repeated 30-90 days later.

The problem of negative tests caused by absent or low titer antibodies obviously cannot be completely solved by better antibody test procedures. Antigen tests, which detect a fragment of the virus itself, may be positive in the days and weeks before seroconversion. The most common virus antigen tested for is p24. Antigen tests are not yet widely available, but as they are perfected, they will become important screening and diagnostic tools. Other newly developed tests that detect HIV identify portions of the viral genome; for example, the polymerase chain reaction (PCR) procedure has found evidence of infection with HIV in people whose antibody tests are still negative. Figure 1 summarizes important features of the timetable of antibody responses to HIV.

3. Lack of Specific 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 (called "asymptomatic seropositivity"). Current evidence is that a great majority of these people are infectious (can transmit the virus); some may not be. For practical purposes, every individual with a confirmed positive test is considered infectious, since there is no commercially available test to define who is and who is not. Some seropositive people may progress to have AIDS-related complex (ARC) or progressive generalized lymphadenopathy (PGL, also called chronic lymphadenopathy syndrome, or CLAS), and others may stay healthy for years. Although earlier data suggested that many asymptomatic seropositive people would remain healthy for many years
and that only a minority would develop full-blown AIDS, it now seems likely that most seropositive people will have significant illness. Projections vary, but in most actuarial computations more than half of seropositive people develop AIDS within seven to nine years after infection, and an additional large percentage develop ARC. Pessimistic mathematical models estimate that virtually all seropositive individuals will eventually be diagnosed with AIDS at an average time of eight years after infection. Nonetheless, it is unlikely for HIV infection to have a monolithic outcome. It is premature, probably inaccurate, hopeless, and hurtful to tell seropositive persons that their death from AIDS is inevitable. New treatments and interventions may drastically alter the prognosis in the many years before currently asymptomatic seropositive persons develop AIDS.

No feature of the ELISA, WB, or IFA tests distinguishes among these prognostic possibilities, and currently available data do not allow for accurate predictions of 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). Most clinicians consider HIV-related thrombocytopenia to fall in the category of AIDS-related complex.

c. AIDS-related complex

d. Progressive generalized lymphadenopathy

e. Full-blown AIDS manifest by major opportunistic infection; premature, unusual cancers; wasting; or neuropsychiatric disease.

| Table 1. |

<table>
<thead>
<tr>
<th>A Negative Test Means:</th>
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<tr>
<td>No antibody to HIV was found.</td>
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Which means:
1. Person was not infected, or
2. Test was done before antibody was produced, or while antibody levels were too low to be detected.

<table>
<thead>
<tr>
<th>A Confirmed Positive Test Means:</th>
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<tbody>
<tr>
<td>Antibody to HIV was found.</td>
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Which means:
1. Person is infected with HIV, and
2. Person can probably transmit HIV to others.
5. Application as a Screening Test. The ELISA test, when applied as a screening device to a population in which the prevalence of HIV infection is low, is known to be significantly less reliable in correctly identifying seropositive people than when it is used to test populations with a high prevalence of infection. Low prevalence populations include, for example, unselected entering college and university students, health science 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. It is likely that mass screening programs will produce more false positives than true positives and they will miss a significant number of recently infected people.

INDICATIONS FOR HIV ANTIBODY TESTING

A. Screening blood supplies

The American College Health Association recognizes that tests for antibody to HIV were developed and are licensed as procedures to screen blood and blood products, and it wholeheartedly supports their utilization for that purpose. ACHA encourages all citizens to abide by the request of the American Red Cross, the American Association of Blood Banks, 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 users of intravenous drugs.
5. Hemophiliacs.
6. Sexual partners (male and female) of persons in these groups.
7. People who have multiple sex partners or a history of multiple sex partners (homosexual and/or heterosexual) over the past 10 years.
8. People who immigrated to the USA after 1977 from countries with a high incidence of AIDS, such as Haiti, Zambia, Burundi, Rwanda, Uganda, Tanzania, Kenya, Angola, Zaire, Zimbabwe, and Malawi.

Under no circumstances should individuals use blood donation as a way to be tested for HIV 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 who may have had any behavioral risk of HIV infection not donate blood as a means to determine their HIV antibody status. Alternate testing sites allow HIV antibody testing without blood donation.

There is absolutely no risk of transmission of HIV to the donor in the process of blood or blood product donation.

B. Screening donors of organs for transplantation or semen for artificial insemination

C. Clinical use to identify HIV-infected individuals

Despite the limitations of HIV antibody tests, they may provide important, useful clinical information in certain circumstances. Although all people who have any behavioral risk of HIV infection should avoid activities that could transmit HIV, whether or not they are tested for antibody to HIV, the antibody tests may be effective as an adjunct to risk assessment, behavioral counseling, and health education. In addition, the development of therapies that may halt the progression of HIV infection and prevent seropositive people from becoming symptomatic suggests that there is a benefit to knowing whether HIV infection is present. Although specific treatments to limit the later consequences of HIV remain unproven, there is substantial reason to believe that early intervention is important and that certain health-promotion strategies, medical assessments, pharmaceuticals, immunizations, and self-directed therapies will be helpful. ACHA thus encourages persons who suspect they may have been exposed to and infected by HIV to be tested for antibody, as long as testing can be made safe as specified below; ACHA further urges seropositive people to seek further medical and immunological evaluation from well-prepared, sensitive, holistic health care professionals.
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 estimated probability of infection as assessed by a patient and his/her health care provider. A negative test, though no indication of immunity nor guarantee against future infection, may motivate some individuals to stay healthy and uninfected through changes in behavior. This, however, is distinctly an individual matter. There is no clear proof that testing is any better than good education for changing behavior. In addition, it is very important to remember 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.

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. Testing is appropriate in these circumstances as an adjunct to differential diagnosis. With refinements in treatment, early intervention during an asymptomatic or AIDS-related complex stage may be more clinically beneficial than treatment of AIDS; accordingly, symptoms and signs that may suggest early HIV infection should be thoroughly evaluated. Clinicians may refer to the chapter on clinical evaluation of seropositive people for details.

3. Some people are so worried about possible exposure to HIV that the concern becomes a distraction, causes great stress, and compromises normal activity. Assuming that the potential exposure occurred at least 4-6 months prior to the intended time of testing, the test may relieve anxiety, if negative, or bring more useful counseling approaches, if confirmed positive.

4. Persons involved in a new sexual relationship may desire testing to protect the health of both partners; in certain circumstances, the test, performed on both partners, may be helpful. Clinicians should be cognizant of false negative tests and counsel both partners about the possibility of new infection should there be other sexual partners outside the primary relationship.

5. Women with any behavioral risk of HIV infection 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. Hemophiliacs who have received blood products (including plasma, factor concentrates, and cryoprecipitate) may desire testing. Hemophiliacs with positive tests may use this knowledge to avoid transmission of HIV to sexual partners and to promote their own health.

7. People who received blood or blood products by transfusion between 1978 and mid-1985 may wish to be tested, depending on (a) the possibility of infection as assessed by clinicians and (b) their likelihood of transmitting HIV to others by their current behavior.
SAFER SEX

* HOW TO USE A CONDOM
* HOW TO USE A DENTAL DAM
How to Use a Condom

Prepared by the editors of *Medical Aspects of Human Sexuality* in collaboration with Reed Adams, PhD, Emanuel Fliegelman, DO, and Alan Greco, PhD.

Sexual abstinence is the only sure way to prevent pregnancy and sexually transmitted diseases, including AIDS. If you do decide to have sex, correct use of a condom will help you to protect yourself and your partner against these risks. This guide tells you how to use a condom for maximum protection.

How to Buy Condoms

<table>
<thead>
<tr>
<th>Do</th>
<th>Don’t</th>
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<tbody>
<tr>
<td><em>Do</em> buy a supply of latex, reservoir (nipple)-end, lubricated type condoms. They’re available in different colors, textures, and sometimes in two different sizes. A good quality condom is the most important feature for safer sex.</td>
<td><em>Don’t</em> buy condoms made of any material other than latex. (Only latex prevents passage of harmful germs.)</td>
</tr>
<tr>
<td><em>Do</em> check expiration date on outer package.</td>
<td><em>Don’t</em> buy old (outdated) condoms.</td>
</tr>
<tr>
<td><em>Do</em> check name of lubricant: it should contain nonoxynol-9, which provides a chemical barrier against sexually transmitted diseases.</td>
<td><em>Don’t</em> store condoms in hot glove compartment of car. Heat can damage the condom.</td>
</tr>
<tr>
<td><em>Do</em> store in a cool dry place.</td>
<td><em>Don’t</em> carry in hip wallet for long periods of time—this shortens shelf life.</td>
</tr>
<tr>
<td><em>Do</em> carry a condom with you at all times.</td>
<td><em>Don’t</em> be shy about buying condoms—40% are sold to women.</td>
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How to Put the Condom On

<table>
<thead>
<tr>
<th>Do</th>
<th>Don’t</th>
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<tr>
<td><em>Do</em> remove rolled condom from package.</td>
<td><em>Don’t</em> unroll condom; instead, carefully roll on all the way toward the base of the penis.</td>
</tr>
<tr>
<td><em>Do</em> roll condom down penis as soon as it is hard, before you start to make love (foreplay).</td>
<td><em>Don’t</em> put condom on only when you are ready to enter your partner—it may be too late. Drops of semen may ooze from the uncovered penis before ejaculation, and may infect or impregnate your partner.</td>
</tr>
<tr>
<td><em>Do</em> leave ¼–½ inch extra space at tip of condom to catch the ejaculate if the condom has no nipple.</td>
<td><em>Don’t</em> twist, bite, or prick condom with a pin—this will damage it and allow fluid to leak out, possibly infecting your partner.</td>
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</tbody>
</table>

Reed Adams is Adjunct Professor of Sociology, The Johnson C. Smith University, Charlotte, N.C.
Emanuel Fliegelman is Professor of Obstetrics and Gynecology, Philadelphia College of Osteopathic Medicine, and Director, Human Sexuality Program, Osteopathic Medical Center of Philadelphia.
Alan Greco is a clinical psychologist in private practice in Winter Park, FL.
How to Take the Condom Off

Do hold the condom at the rim: remove soon after ejaculation.
Do keep used condom away from partner's genitals and other areas of the body as well.
Don't let penis go soft inside partner—condom may drop off, and protection is lost.
Don't tug to pull condom off—it may tear.
Don't allow semen to spill on your hands or body. Wash hands or body parts if contact occurs. Wrap condom in tissue and dispose of safely.
Don't allow semen to come in contact with a skin break, cut, or open wound.

Special Points to Remember

- If you buy un lubricated condoms, you may need to buy a lubricant. Use only water-soluble lubricants such as spermicidal jelly or water.
- Don't use oil-based lubricants such as petroleum jelly or vegetable oil with latex condoms, since they can damage the condoms.
- Never use a condom more than once.
- Correct use of condoms increases comfort, and promotes a sense of security in having safer sex.

How to talk about condoms with a resistant, defensive, or manipulative partner

<table>
<thead>
<tr>
<th>If the partner says:</th>
<th>You can say:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I'm on the Pill. you don't need a condom.&quot;</td>
<td>&quot;I'd like to use it anyway. We'll both be protected from infections we may not realize we have.&quot;</td>
</tr>
<tr>
<td>&quot;I know I'm clean (disease-free): I haven't had sex with anyone in X months.&quot;</td>
<td>&quot;Thanks for telling me. As far as I know, I'm disease-free, too. But I'd still like to use a condom since either of us could have an infection and not know it.&quot;</td>
</tr>
<tr>
<td>&quot;I'm a virgin.&quot;</td>
<td>&quot;I'm not. This way we'll both be protected.&quot;</td>
</tr>
<tr>
<td>&quot;I can't feel a thing when I wear a condom: it's like wearing a raincoat in the shower.&quot;</td>
<td>&quot;Even if you lose some sensation, you'll still have plenty left.&quot;</td>
</tr>
<tr>
<td>&quot;I'll lose my erection by the time I stop and put it on.&quot;</td>
<td>&quot;I'll help you put it on—that'll help you keep it.&quot;</td>
</tr>
<tr>
<td>&quot;By the time you put it on, I'm out of the mood.&quot;</td>
<td>&quot;Maybe so, but we feel strongly enough for each other to stay in the mood.&quot;</td>
</tr>
<tr>
<td>&quot;It destroys the romantic atmosphere.&quot;</td>
<td>&quot;It doesn't have to be that way.&quot;</td>
</tr>
<tr>
<td>&quot;Condoms are unnatural, a total turnoff.&quot;</td>
<td>&quot;Please let's try to work this out—an infection isn't so great either. So let's give the condom a try. Or maybe we can look for alternatives.&quot;</td>
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<table>
<thead>
<tr>
<th>If the partner says:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>&quot;What kinds of alternatives?&quot;</td>
<td>&quot;Maybe we'll just pet, or postpone sex for a while.&quot;</td>
</tr>
<tr>
<td>&quot;This is an insult! Do you think I'm some sort of disease-ridden slut (gigolo)?&quot;</td>
<td>&quot;I didn't say or imply that. I care for you, but in my opinion, it's best to use a condom.&quot;</td>
</tr>
<tr>
<td>&quot;None of my other boyfriends uses a condom. A real man isn't afraid.&quot;</td>
<td>&quot;Please don't compare me to them. A real man cares about the woman he dates, himself, and about their relationship.&quot;</td>
</tr>
<tr>
<td>&quot;I love you! Would I give you an infection?&quot;</td>
<td>&quot;Not intentionally. But many people don't know they're infected. That's why this is best for both of us right now.&quot;</td>
</tr>
<tr>
<td>&quot;Just this once.&quot;</td>
<td>&quot;Once is all it takes.&quot;</td>
</tr>
<tr>
<td>&quot;I don't have a condom with me.&quot;</td>
<td>&quot;I do.&quot; or &quot;Then let's satisfy each other without intercourse.&quot;</td>
</tr>
<tr>
<td>&quot;You carry a condom around with you? You were planning to seduce me!&quot;</td>
<td>&quot;I always carry one with me because I care about myself. I have one with me tonight because I care about us both.&quot;</td>
</tr>
<tr>
<td>&quot;I won't have sex with you if you're going to use a condom.&quot;</td>
<td>&quot;So let's put it off until we can agree.&quot; or &quot;OK, then let's try some other things besides intercourse.&quot;</td>
</tr>
</tbody>
</table>

Adapted from the article "Cutting the Risks for STDs" by Alan Grieco, PhD, which appeared in the March 1987 issue of Medical Aspects of Human Sexuality.
Here are some guidelines for safer woman-to-woman sex:

- Stock up on latex condoms or dams.

  What are dams?
  Dams are six-inch square pieces of synthetic latex rubber. They can be used to prevent the spread of HIV during oral sex. You can make your own dam by cutting an unrolled latex condom to the center and opening it up.

  Where can I buy condoms or dams?
  Condoms are available at pharmacies. Medical supply stores sell latex dams, often in assorted flavors. Erotica shops frequently carry latex dams, too. Call the numbers listed at the end of this brochure for more information.

  Can they be used right out of the package?
  No. Condoms and dams are sometimes lightly covered with talcum powder. Before use, rinse the powder off and then air- or towel-dry.

  How do I use them?
  Spread a water-based lubricant with non-oxyynol-9 on the vaginal area. Then cover the entire vagina with the cut condom (or dam) and hold it carefully in place with your fingers. Stimulate your partner with your tongue and mouth, making sure the latex remains between you and your partner.

  Always keep the same side against your mouth, reserving the other side for your partner. Do not stretch the barrier too far; it might snap out of your hands, leaving your mouth unprotected.

  Is there another way to hold a condom or dam in place?
  Yes. Some erotica shops sell special "hands-free" harnesses. Do not sew or pin them inside your partner's panties; this might put a hole in the protection making it useless.

  Is any kind of rubber or plastic OK?
  No. Plastics such as those used for garbage bags or household wraps, have not been tested for HIV penetration. Many of these materials also contain toxic chemicals. Latex condoms, that have been scientifically tested, are effective barriers against HIV. Similar studies on latex dams have not been conducted.

  Are there other uses for condoms or dams?
  Use condoms on shared sex toys in addition to using them as dams. If you plan to have sex with a man, be sure he uses condoms. Always keep them on hand in case your partner is unprepared, and do not be embarrassed to use them.

  Use a condom or dam when you have oral sex (rimming) with your partner's ass.

  Can they be reused?
  No. Always use a new dam (or cut condom) each time you have oral sex with your partner's ass or vagina. Then throw it away.

- Keep a supply of latex gloves and condoms.

  When are latex gloves used?
  Put on a pair of latex gloves to masturbate your partner, penetrate your partner's ass...
Ohio Department of Health/AIDS Activities Unit

Some Facts About Women
HIV Infection and AIDS

1. Females are 11% of all reported AIDS cases in the United States.
2. More than 70% of women with AIDS in the United States are African-American and/or Latina.
3. More than 50% of women with AIDS in the United States have used injection drugs.
4. In parts of the Caribbean and Africa women make up almost half of all the reported AIDS cases. Most of those infected were put at risk by unprotected heterosexual behavior.
5. One-third of the women in the United States with AIDS were exposed via heterosexual contact.
6. In Ohio 6% of all AIDS cases are female.
7. HIV positive pregnant women have about a 30% chance of having an HIV positive child who will go on to have AIDS.
8. HIV infected mothers can pass HIV through breast milk, and should bottle feed their infants.
9. Women have been HIV infected through artificial insemination.
10. While HIV can be heterosexually transmitted from both women to men and from men to women, it appears that men infect women more easily.
11. Female-to-female sexual transmission of HIV has occurred, though most HIV infected lesbians have used injection drugs.
12. Condoms and a spermicidal lubricant, when used correctly and every time, can protect against transmission of HIV during oral, vaginal and anal intercourse.
13. Early signs of HIV infection in women may include serious vaginal yeast infections, pelvic inflammatory disease, missed menstrual periods, irregular menstrual bleeding and uterine or cervical cancers.
14. Women are at risk for HIV infection if: 1) you share needles or "works" during injection drug use; and/or 2) you have unprotected sexual intercourse (vaginal, anal or oral) with an infected person.
15. HIV infection and AIDS is a growing problem for women in the United States.
OHIO DEPARTMENT OF HEALTH/AIDS ACTIVITIES UNIT

WOMEN & AIDS FACT SHEET

Women of Color and HIV* Infection

*NOTE: HIV (Human Immunodeficiency Virus) is the infection that causes AIDS.

HIV infection and AIDS is a growing problem for women in the United States. Females currently account for 10% of the total AIDS cases reported. African American and Latina women are disproportionately represented among those diagnosed with HIV disease.

DID YOU KNOW?

1. The World Health Organization estimates that worldwide 500,000 cases of AIDS have occurred among women and children. Most of these individuals are women and children of color.

2. Almost 75% of women who have AIDS are women of color.

3. More than 50% of women with AIDS have used IV (intravenous) drugs. This is the most common avenue of infection for women of color.

4. One out of three female AIDS cases were acquired through heterosexual sex. This is the second most common avenue of infection for women of color.

5. HIV infected pregnant women can pass their infection on to their unborn children.

6. Heterosexual contact with men who also have sex with other men can place a woman at risk for HIV infection.

7. Alcohol and other drugs, like crack cocaine, place women at risk for HIV because of lowered inhibitions and the possibilities of behavior like trading sex for drugs.

8. Consistent and correct use of latex condoms during sexual intercourse can reduce the risk of HIV infection.

9. The presence of other Sexually Transmitted Diseases, like herpes or syphilis, can make an individual more easily infected with HIV if exposed.

10. Women of color can and must take action to protect themselves from HIV infection and AIDS.

For information concerning resources, call:

The Ohio AIDS Hotline: 1-800-332-AIDS (2437) (OHIO ONLY)
Spanish Language: 1-800-344-SIDA (7932)
Hearing Impaired: 1-800-DEAF-TTY

For printed material, contact:

National AIDS Information Clearinghouse
P. O. Box 6003
Rockville, MD 20850
1-800-458-5231
OHIO DEPARTMENT OF HEALTH/AIDS ACTIVITIES UNIT

WOMEN & AIDS FACT SHEET

HIV Infection and Pregnancy

In the United States, AIDS is a growing problem for women of child bearing age. Females now account for 10% of all AIDS cases. HIV positive mothers can pass the virus on to their fetuses. Currently the majority of women with AIDS have histories of intravenous (IV) drug use and this complicates the counseling, care and treatment issues associated with pregnancy.

DID YOU KNOW?

1. The World Health Organization estimates that 2 million women of child bearing age are infected with HIV worldwide.
2. HIV positive pregnant women pass maternal antibodies (including HIV antibody) to their newborns, and though approximately 70% of these infants will develop non-infected immune systems, another 30% will go on to develop HIV disease.
3. Many HIV positive women are often unaware of their own infections until their infants become ill.
4. Counter to earlier medical reports, pregnancy does not appear to accelerate the course of a woman’s HIV disease.
5. HIV positive women are advised not to breast feed their babies.
6. The anti-viral drug AZT (zidovudine) has not been approved for use with pregnant HIV positive women, though data are currently being collected to assess both the drug’s usefulness and its effects on the fetus.
7. More than half of women with AIDS have used IV drugs. IV drug using mothers experience higher rates of premature delivery and other pregnancy complications.
8. HIV positive pregnant women may be excluded from clinical drug treatment trials. Call 1-800-TRIALS-A for more information concerning specific options available in your area.
9. Women using artificial insemination from a donor whose semen has not been screened for HIV have become infected. It is important to know your donor’s risk history and HIV antibody status.
10. Almost 80% of babies with AIDS have been born to women of color.

If you would like a bibliography on HIV and pregnancy related topics, and/or more information concerning women and AIDS, contact:

Phyllis Gorman-ODH/AIDS Activities Unit-P. O. Box 118
Columbus, OH 43266-0118 (614)466-5480

or

The Ohio AIDS Hotline: 1-800-332-AIDS (OHIO ONLY)
Ohio Department of Health/AIDS Activities Unit

WOMEN & AIDS FACT SHEET

Clinical Manifestations of HIV Infection in Women

*Note: HIV (Human Immunodeficiency Virus) is the infection that causes AIDS.

As we move into a second decade of the HIV epidemic, more information is becoming available concerning the clinical manifestations of HIV infection in women. Continued research is necessary but below is a summary of some of the latest available research.

Did you know?

1. Within both the United States and internationally, women represent the most rapidly expanding group acquiring new HIV infections.
2. Kaposi's Sarcoma (KS), common among HIV infected gay and bisexual men, rarely occurs among women.
3. Early manifestations of HIV infection in women are usually gynecological complications.
4. The Centers for Disease Control's (CDC) AIDS case definition does not include any of the gynecological symptoms which are known to occur with frequency and severity in women with AIDS.
5. In a 1990 CDC study, 65% of HIV infected women died without fitting the CDC definition of AIDS.
6. Women are much more likely than men to have opportunistic infections missed or misdiagnosed because HIV infection is not suspected.
7. Women who are diagnosed as AIDS cases tend to die sooner after their diagnosis than men, and are much more likely to die within the same month that they are diagnosed.
8. All women, regardless of class, color, ethnic origin, pregnancy status, sexual or drug using history and/or sexual identity, deserve proper access to sensitive medical service.
10. Because of the association between HIV infection, HPV (Human Papilloma Virus) and cervical cancer, HIV infected women should have pap smears every six months.

For more information or for referrals to resources in your area, call:

THE OHIO AIDS HOTLINE: 1-800-332-AIDS(2437)

For more information concerning AIDS clinical trials, call:

AIDS Clinical Trials Information Service--800-TRIALS-A

For AIDS publications, posters and pamphlets, call:

National AIDS Information Clearing House--800-458-5231
LOSING THE BATTLE

MYSTERIOUS NON-HIV CASES EMERGE

THE SEARCH FOR A CURE STALLS

INFECTION AMONG WOMEN GROWS
WARS ARE USUALLY LAUNCHED with the promise of a quick victory, with trumpets primed never to sound retreat. And the campaign against AIDS was no exception. Soon after researchers announced in the mid-1980s that they had discovered the virus that causes AIDS, U.S. health officials confidently crowed that a vaccine would be ready in two years. The most frightening scourge of the late 20th century would succumb to a swift counterattack of human ingenuity and high technology.

But no one was making any victory speeches last week in Amsterdam, where more than 11,000 scientists and other experts gathered for the Eighth International AIDS Conference. The mood was somber, reflecting a decade of frustration, failure and mounting tragedy. After billions of dollars of scattershot albeit intensive research and halfhearted prevention efforts, humanity may not be any closer to conquering AIDS than when the quest began.

There is no vaccine, no cure and not even an indisputably effective treatment. While AIDS education has slowed the epidemic in developed countries, the disease continues to spread rapidly in many poorer nations. The World Health Organization says at least 30 million people around the world could be infected with the AIDS virus by the year 2000. Other experts think the number could reach 110 million.

Despite dogged detective work by the world's best researchers, AIDS (acquired immunodeficiency syndrome) remains one of the most mysterious maladies ever to confront medical science. The more researchers learn about the disease, the more questions they have. Human immunodeficiency virus (HIV), proclaimed to be the cause of AIDS, has proved to be a fiendishly fast-moving target, able to mutate its structure to elude detection, drugs and vaccines. No one knows for sure how HIV destroys the human immune system, and puzzled experts have debated whether the virus is the only culprit at work.
Bewilderment reached a new level in Amsterdam, where scientists reported cases of people who have an AIDS-like condition but have not been found to be infected with HIV. That frightening revelation raised the possibility that a new AIDS virus is emerging. Another theory, suggested by France’s Dr. Luc Montagnier, who first discovered HIV, is that the strange cases were caused by one or more mutant forms of HIV that were altered too radically to be detected by standard blood tests.

Hardly any of the news at the conference was good. As groups of protesters staged daily demonstrations demanding more action against the epidemic, Dr. Jonas Salk suggested that vaccine researchers were on the wrong track, and the actress Elizabeth Taylor blasted President Bush for not doing enough about AIDS. Delegates heard reports on the surging costs of treatment, warnings about the threat of AIDS-associated infections such as multidrug-resistant tuberculosis, and alarming projections that AIDS will become more of a heterosexual disease. The infection rate among women is rising and will pass the rate in men by the year 2000.

Strange new cases that do not seem to be caused by the known HIV viruses. Drug treatments that no longer look so promising. New complications in the search for a vaccine. Suddenly, the AIDS outlook has become bleaker: more heterosexual transmission, more cases among women and a rising death toll well into the next century.

"We’re dealing with something that’s expanding out of control," said Dr. June Osborn, chair of America’s National Commission on AIDS. Dr. Anthony Fauci, director of the U.S. National Institute of Allergy and Infectious Diseases, noted that "the science is going as fast as it has with any disease," but he admitted that "the advances over the last several years are clouded and dwarfed by the size of the growing epidemic." Mark Harrington, a member of the New York City-based Treatment Action Group, summed up the situation more simply and grimly: "It's clear we're losing the battle. We have one class of drugs that slows AIDS down by two or three years, and then people go on and die."

THE MYSTERY OF NON-HIV CASES
The biggest surprise in Amsterdam was the talk about a new kind of AIDS. Dr. Jeffrey Laurence of the New York Hospital-Cornell Medical Center described five instances of people who suffer from an AIDS-like illness and yet bear no trace of HIV anywhere in their body. When a similar
case was reported at last year's AIDS conference in Florence, it was dismissed as a fluke. This year several scientists in the audience stood up to tell of other cases of non-AIDS AIDS, bringing the total to about 30—a number that is small but impossible to ignore.

Is a deadly new microbe on the loose? Speaking in the U.S. last week, Dr. Sudhir Gupta of the University of California at Irvine claimed to have found one in patients with AIDS-like symptoms. But there is no proof yet that the virus caused the symptoms. It is possible that the patients don't have AIDS but have some other problem with their immune system that mimics the disease. "It's just very premature to talk, because we don't know if it's real," says Fauci. "We should know something in a matter of months."

Even if there turns out to be a new virus, people should have no reason to panic or refuse blood transfusions. Researchers think they can isolate the pathogen within months and develop a blood test. In the meantime, this unusual type of AIDS, whatever causes it, is very rare. Said Laurence: "Every major AIDS researcher is here in one place in one room, and still we're talking about only a handful of cases."

The bad news, if a new virus does exist, is that AIDS will become even harder to prevent once cure. Pharmaceutical manufacturers have already been hampered by HIV's ability as a quick-change artist. Only last year a group of promising anti-AIDS drugs had to be shelved because HIV adapted too easily to the medication. And drugs that prove effective against all forms of HIV will not necessarily knock out an entirely novel virus.

HIV is a formidable enough opponent, mainly because researchers still don't understand the method to its madness. Like all viruses, HIV is simply a strand of genetic material (in this case the nucleic acid RNA) surrounded by a protein coat. A virus lacks the tools to reproduce unless it invades a living cell and takes over the host's molecular machinery. The intruder can then produce many copies of itself, eventually killing the cell. One of HIV's favorite targets is the CD4 T-cell, an important player in the human immune system.

But there the understanding runs out. Why does HIV lie dormant in human cells, usually for years, before producing a full-blown case of AIDS? What triggers the deadly phase of the infection? How does the virus go about destroying the immune system? Even at the height of the disease, HIV particles are found in no more than 1 in 100 CD4 T-cells. And yet the cells that do not harbor the virus die off almost as fast as those that do. Some researchers think that HIV must somehow provoke immune-system cells to destroy themselves.

One prominent theory is that the virus needs an assistant assailant—a "co-factor," in scientific jargon. But the search for co-factors has been inconclusive. Although the presence of genital sores from syphilis or other venereal diseases makes transmission of the AIDS virus easier, neither the sores nor the microbes that cause them are necessary for HIV to spread. Researchers have also investigated the possibility that cytomegalovirus, a common form of herpes virus, might be the elusive co-factor, but eventually they ruled it out. "It has to be something that's not too obvious," says Dr. Kent Sepkowitz at the New York Hospital-Cornell University Medical Center. "Otherwise, we would have figured it out a long time ago."

Montagnier believes that the co-factor might be a mycoplasma—a primitive bacterium-like organism. The possible role played by this microbe may help explain one of the mysteries surrounding the origin of AIDS. Studies of blood samples preserved from decades ago show that HIV was present in Africa long before AIDS appeared. What caused the once harmless virus to turn deadly? Montagnier thinks it was a strain of mycoplasma that until recent years was confined to America. Somehow, somewhere, according to his theory, HIV and the mycoplasma got together in a group of humans, and that was the start of the AIDS epidemic.

POWERLESS DRUGS, ELUSIVE VACCINES

If HIV were an ordinary virus, designing drugs to kill it might not seem like an impossible mission. "But it is a much more difficult virus than anyone anticipated," says Myron Essex, head of the Harvard AIDS Institute. "It has more fancy genes to determine how it replicates. It has positive and negative controls that interact with cellular controls, which allows
it to crank up rapidly or remain silent for a long time. It's a very, very unusual virus."

Most important, HIV can easily disguise itself by altering the proteins in its outer coat. When that happens, the job of finding and attacking the virus becomes harder. Even AZT, the most effective drug against HIV, is nowhere near as potent as doctors or patients hoped it would be.

**FIRST APPROVED FOR USE IN THE U.S.** Five years ago, AZT prevented one of the viral genes from making an enzyme, called reverse transcriptase, that is critical to HIV's reproduction. This action prolongs life by postponing some of the symptoms of AIDS. But in patient after patient, HIV eventually mutates into a form that is less vulnerable to AZT. As a result, the drug's benefits generally run out within 18 months.

The only other anti-HIV drugs approved in the U.S.—n1 and noc—are variations on the AZT theme. Researchers have begun examining other types, however. One variety targets the gene that codes for another enzyme, protease, that is crucial to the manufacturing of viral proteins. The researcher looks promising, but a breakthrough is not expected anytime soon.

The same adaptability that makes HIV so troublesome to drug designers threatens to stymie vaccine development as well. Researchers are not at all confident that they can devise a simple series of shots that would give a person lifetime protection against HIV. To do that, a vaccine would have to ward off all of HIV's current strains as well as any future mutants.

Neutralizing HIV is especially tough because its coat is laced with sugar molecules that shield it from the human immune system. Some viruses, such as the one that causes polio, have no sugar in their protein coat. Others, like flu viruses, have only a little. It is no coincidence that the most effective vaccines have been made to fight these kinds of viruses. Never before have scientists tried to devise a vaccine against a pathogen as well protected as HIV.

Undaunted, researchers are testing about a dozen experimental vaccines. After the trials have been thoroughly evaluated, the most promising prototypes will be chosen—probably in the next two years—for testing to determine if they can stimulate the immune system to produce antibodies capable of blocking HIV infection. The trouble is that scientists can only guess at what constitutes an effective collection of HIV antibodies. No one has ever survived the disease to provide researchers with any clues. Even if the experiments go well, a preventive vaccine will probably not be available before the end of this century.

In the view of Dr. Robert Redfield of the Walter Reed Army Institute of Research in Washington and his colleagues are trying to develop a vaccine that helps people who are already infected. By injecting a slightly modified form of the virus' protein coat, the Army researchers hope to kick-start the patients' immune systems into mounting an effective counter-attack. Redfield thinks that his version of the viral coat may share enough characteristics with all the known mutant strains of HIV to overcome the variability problem. Said Redfield, a rare, unabashed optimist at the Amsterdam meeting: "I believe HIV is very simple, very straightforward, and it's going to be solved."

**THE EVOLVING EPIDEMIC**

One of the most baffling enigmas of AIDS is the fact that the disease spread primarily among homosexual and bisexual men and intravenous drug abusers in the U.S. and Europe but became a largely heterosexual infection in Africa. Researchers announced last week that they may have an answer. Based on a study of the newly emerging epidemic in Thailand, they concluded that HIV has shown predilections for different human host cells in different parts of the world.

Using biochemical tools that were not available at the beginning of the epidemics in Africa and the Americas, molecular biologist Chin-Yih Ou and his colleagues at the U.S. Centers for Disease Control found two distinct epidemics caused by somewhat different strains of HIV in the northeastern Thai city of Chiang Mai. Both epidemics started no more than four years ago, but one occurred mostly in intravenous drug abusers and the other started in female prostitutes. There was little overlap between the two groups.

The scientists discovered that the prostitutes were more often infected by a strain resembling those types found in Africa. Apparently, it preferred the moist mucosal tissue of the genital organs, making heterosexual transmission easier. The other variety, found in the drug abusers, appeared similar to strains detected in the U.S. and Europe. It thrived on immune cells in the bloodstream. As a result, transmission occurred through the exchange of contaminated blood, as might occur during the sharing of needles or in abrasive anal sex.

The rise of two or more dissimilar types of HIV could explain why AIDS did not explode among heterosexuals in the U.S. and Europe, yet spread rapidly among men and women in Africa and parts of Asia. HIV has still not evolved in the Indus coat. Others, like flu viruses, have only a
The Master Detective, Still on the Case

The French scientist who isolated the original AIDS virus is hotly pursuing yet another microscopic culprit

The mood of despair in Amsterdam last week was not shared by the small, stocky Frenchman who is one of the leading pioneers of AIDS research. By rights, Dr. Luc Montagnier ought to be alarmed by the suggestion that AIDS might occur without the HIV virus. After all, it was his team at the Pasteur Institute nine years ago that first isolated the infectious agent known as HIV.

But Montagnier knows his virus. He knows firsthand that it alters its genetic code as often as Madonna changes her persona, and thus could easily hide from a blood test. And when perplexed scientists turned to him for answers to the unsettling questions raised in Amsterdam, he delivered his views with the stoic self-assurance that has become his trademark.

No, "contrary to what American researchers think," he was not persuaded by the evidence that there must be a new virus. No, he did not believe the HIV-free infections supported the dubious theory that HIV is innocent of causing AIDS. And yes, he is still optimistic that effective vaccines will be found, probably before the year 2000. He, for one, does not plan to be working on AIDS for the rest of his career. But then, who knows? "Dogmatism is a deadly sin in science," says Montagnier.

In a field that is filled with prickly egos, the 50-year-old Parisian is a rarity: an unassuming professional who has faced controversy and emerged with his reputation enhanced. His Old World charm served him well in the difficult years from 1983 to 1987, when he was locked in a battle with Robert Gallo of the U.S. National Cancer Institute for the glory and the rewards that came with the discovery of the AIDS virus. Gallo, one of the world's most famous-and ambitious-scientists, probably did not know that the virus he isolated was a contaminant that came from a sample sent to him by Montagnier's lab. But Gallo grabbed the spotlight and tried to deny the significance of the French achievement—until the facts came out and Montagnier got the credit he deserved. A pained smile plays over Montagnier's face as he recalls the years of bitter charges and countercharges.

"The whole scientific community followed Gallo," he says. "We knew we were right, even if we were the only people in the world to know it."

An accountant's son who excelled in Greek and Latin in college during the German occupation, Montagnier is no stranger to adversity. He faced it again in 1990, when he supported a controversial theory that mycoplasma, a bacterium-like organism, is the trigger that turns a slow-growing population of AIDS viruses into mass killers. According to Montagnier, the explosion of the sexual activity in the U.S. during the 1970s fostered the spread of a hasty, drug-resistant strain of mycoplasma. Once, meanwhile, lay dormant in Africa. The AIDS epidemic began, Montagnier speculates, when the two microbes got together, perhaps in Haiti.

The Pasteur Institute is currently testing a promising new AIDS vaccine, but Montagnier travels around the world more and more these days, a much sought-after participant in international conferences. Whenever he returns to Paris, he goes back to his mycoplasmas—feeling, as he puts it, "like a cat that has let the mice run free while it was away."

"Dogmatism Is a deadly sin in science."

-LUC MONTAGNIER of Paris' Pasteur Institute

mission," Essex says. "So far, there haven't been a critical number of people infected heterosexualy. As that happens, you will get adaptation of the virus for transmission in that route. The heterosexual epidemic in the U.S. will expand."

Already American physicians are seeing more women with HIV. In many AIDS clinics in San Francisco and New York City, women make up 30% to 50% of all new patients. About half of them became infected through heterosexual contact. They range from very well educated to barely literate, but most of them say they had no idea that their sexual partners had engaged in high-risk behavior. In fact, because AIDS is still thought of as a gay man's disease in the U.S., many women discover that they are infected only after they have passed the virus on to their children.

Another alarming trend is that more and more AIDS patients are developing tuberculosis. Normally, they respond to the traditional treatments for this degenerative lung disorder. However, a growing number of AIDS patients are contracting a much deadlier form of TB that is resistant to standard drug therapy. In Amsterdam Dr. James Curran, head of the AIDS program at the CDC, called the combination a "double epidemic."

Since the bacteria that cause TB spread through the air, they threaten not only AIDS patients but healthy people as well. Those with an intact immune system can usually fight off the infection, but this does not hold true for people who harbor HIV. Until the resurgence of TB, medical personnel who were HIV-positive but still healthy could work on AIDS floors without jeopardizing their own or anyone else's well-being. Now they will face a greater risk of encountering and developing TB. More AIDS patients are thus likely to be treated under quarantine conditions to avoid spreading the TB bacteria.

Tragically, even as AIDS grows in ever more dangerous directions, government agencies throughout the world are failing to respond. Prevention programs are stalled or being abandoned. The World Health Organization's AIDS budget for this year is $90 million, down from $110 million two years ago. In the U.S., the National Institutes of Health requested $1.2 billion for AIDS in next year's budget, but President Bush trimmed that amount to $573 million and Congress is likely to cut it even further.

By the year 2000 AIDS could become the largest epidemic of the century, eclipsing the influenza scourge of 1918. That disaster killed 20 million people, or 1% of the world's population—more than twice the number of soldiers who died in World War I. "This epidemic is of historic scale," says June Osborn of the U.S. AIDS commission, "but the response has been far short of historic."
Using Peer Educators for a Classroom-Based AIDS Program

NICHOLAS D. RICHIE, PhD, DORIS STENROOS, RN, and ADELAIDE GETTY, RN

When the student health service (SHS) at Florida Atlantic University added AIDS education to its other services in 1986, the student response was disappointing. Public concern about the spread of AIDS was increasing and leaders of the American College Health Association had urged that AIDS information for students become a high priority on campus, especially in view of the long incubation period for the disease. A recent estimate that 2 out of every 1,000 college students in the United States may be HIV-positive confirmed our initial concerns.

At first, we tried traditional techniques—staffing an information booth in an area of high pedestrian traffic; showing a film in the residence halls on condom use, following up with a discussion of sexually transmitted diseases; distributing fliers and posters on campus; and advertising a weekly information session. Students showed little interest, and participation was low.

To increase student involvement, we then attempted to introduce peer educators into the process. Using trained peers on campus to assist, advise, inform, and counsel other students about such problems as substance abuse and sexually transmitted diseases has been widespread in recent years. This approach has been highly formalized in the work of Carey, who developed the Lifestyle Health Planning program for using peers in university settings.

We recruited students interested in becoming peer educators in the AIDS program, using posters and fliers, notices asking faculty members to mention our search in classes, and announcements sent to student organizations. Those selected to participate completed 10 hours of training in an interdisciplinary curriculum that covered basic information about AIDS (etiolo- y, prevention, and risks) and use of effective communication and public speaking techniques. On completion of the training program, they were certified by SHS as qualified peer educators in the AIDS program.

The Classroom-Based Program

It soon became apparent that the peer educators weren’t appreciably increasing their fellow students’ involvement and participation. Unless students were a “captive audience,” we realized, it would be difficult to reach them in the numbers we desired. This led us to develop a classroom-based program in which SHS staff and peer educators delivered the AIDS material, with the permission of the individual professor, in regularly scheduled classes.

Presentations were to last from 20 minutes to 2 hours, and faculty members who wished to participate were given the following options: (1) literature and a video tape placed in the classroom for presentation by the faculty member at a convenient time during the class; (2) a formal presentation by a peer educator, SHS nurse, and possibly a person with AIDS, with literature, video tape, condom demonstration, and a question-and-answer period; or (3) a presentation that included specific information tailored to the subject matter of the course. For example, business college faculty asked that workplace issues related to AIDS, such as hiring or firing someone with AIDS, be covered; faculty members in the education college requested that the problems of retarded and disabled persons who have AIDS be discussed; and some psychology department professors called for information about counseling for clients with AIDS. Each semester, faculty members re-
ceived notices about the availability of the program and forms for requesting presentations.

After the AIDS education program had been in operation for 2 full school years, we conducted a formal evaluation, taking into account three data sets: (1) a questionnaire completed by students who had attended the presentations; (2) a questionnaire given to faculty immediately after the presentations in their classes; and (3) a questionnaire given to peer educators who had participated in the program since its inception. It should be noted that although the formal evaluation was completed after the first 2 years, informal, ongoing evaluations and minor adjustments were made as required while the program was in progress.

Findings

Student questionnaires. Students were asked to complete an anonymous questionnaire immediately after attending the presentations. We obtained completed questionnaires during the 2-year period from 1,438 students (a response rate of more than 99%). In rating the effect of the AIDS presentation, 86% said it increased their understanding (53% “slightly increased,” 33% “greatly increased”); 13% reported “no change”; and less than 1% found some degree of “confusion.”

Ninety-three percent of the students rated the presentation as “good” or “excellent,” and about 5% rated it as “fair” or “poor.” When asked if they would recommend the presentation to a friend, 96% said they would (see Table 1).

The student questionnaire also contained an open-ended section in which students could indicate what they liked most, what they liked least, and what topics they would like to have covered in future presentations. The aspects of the program that were liked most included the question-and-answer period; the video; the use of peers and the frankness of the presenters; the material about the proper use of condoms and information on AIDS testing; and the opportunity, in some instances, to speak with a person with AIDS. Aspects of the program that students liked least included outdated information on some of the video; repetitiveness; frightening material; the brevity of some presentations; and the absence of information about AIDS testing and statistics on the AIDS situation in the surrounding community. Suggestions for future topics included more information on legal and financial aspects of AIDS, heterosexual transmission, casual contact, and research efforts. We considered this student feedback on a continuing basis during the evaluation period and made a number of adjustments, such as replacement of the video tape with a more current version.

Faculty questionnaires. At the beginning of the program and of each new semester thereafter, SHS sent detailed information to the university faculty to explain the program, describe the presentations, and provide instruction on how to schedule a classroom presenta-

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N = 1,438.
AIDS. Faculty suggestions for improving the program included the following: longer presentations; updated video; including a person with AIDS; separating male and female students in order to remove inhibitions about asking questions; and providing more information about the local AIDS situation. We used some of these suggestions to make periodic revisions.

**Peer educators.** Evaluators identified 25 individuals who had served as peer educators during the entire 2 years of the program. We mailed them questionnaires (some had since graduated, others were nonstudents) asking them to evaluate the program. Fifteen (60%) of the questionnaires were returned and analyzed.

The majority of the peer educators were women (67%), and at the time of their participation 53% were juniors. They ranged in age from 18 to 42, with a mean of 25.5 years and a mode of 24. Most surprising to us, in view of the limited participation by faculty from the college of business, was that 6 (40%) of the 15 respondents were business majors. None of the peer educators were from the college of social science, which has

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| N = 15; age range = 18 to 42 years; M = 25.5; Mo = 24. |
|†Nonstudents = persons with AIDS who volunteered to make presentations.
Evaluation

As Carey has pointed out, a program such as this requires periodic evaluation to determine whether its objectives are being met. The data we collected during this initial evaluation indicate that they have largely been achieved. The overall goal of the SHS in establishing the program and the objectives (with annotation) required to meet that goal, may be summarized as follows:

Goal. To establish and operate a classroom-based AIDS education program that imparts information about AIDS to college students in a manner that they, the university administration, and the faculty find acceptable.

Objective 1. To obtain permission from the university administration to establish such a program. This was granted with only two restrictions, namely that participation be voluntary on the faculty’s part and that the peer educators be certified through a formal training program.

Objective 2. To recruit and train a core of students to serve as peer educators. Although this objective was met and the peer educators who returned the questionnaire were overwhelmingly positive in their rating of the training program, we were disappointed that more students, especially those from the health and human services disciplines (health administration, nursing, and social work) did not participate. The SHS staff will seek assistance from faculty members and student organizations in these departments in future recruiting efforts. In addition, we will develop a more sophisticated evaluation tool that allows the peer educators to evaluate each separate subject area covered in the training program.

Objective 3. To obtain the cooperation and support of the faculty in implementing this classroom-based program. Although 65 faculty members participated in the program during the 2-year period under evaluation, this represented only 16% (65/418) of the university teaching staff. We are renewing efforts to encourage greater involvement of the faculty through meetings between SHS staff and the deans, department chairpersons, and key individual faculty.

Objective 4. To present material on AIDS to college students in a manner that they find acceptable, informative, and worthy of recommendation to friends. By and large, the students surveyed felt the presentations increased their understanding of AIDS, were “excellent” or “good,” and were worthy of recommendation to friends. As with any health issue that has an identifiable behavioral component, we were especially concerned with changing behavior and measuring that change. Just before the close of the 2-year evaluation period, we added several questions to the survey instrument in an attempt to identify students who had previously attended a classroom presentation on AIDS and to determine how it had changed their behavior—if at all. One hundred twenty (8% of the 1,438) reported that they had attended a presentation; of those, 32 (27%) indicated specific behavioral changes, including: “I now engage in safer sex” (29); “I am now more careful when working with patients on my job at the hospital” (2); and “I went for an AIDS test” (1). The SHS will continue to identify students who have attended the presentations more than once and will record their reported behavioral changes. We are considering designing a classical experiment with experimental and control groups of entering freshmen to be given a pretest on knowledge and behaviors related to AIDS. After the experimental group has received a peer education presentation, we will perform a posttest to learn how effective the program has been in changing behavior.

Summary

Frustration over their inability to reach sizable numbers of students for an AIDS education and prevention program, even after employing peer educators, prompted the staff of the SHS to devise a classroom-based program. Sixty-five faculty members gave permission for the presentations, and the students represented a captive audience for the SHS-certified peer educators. Students have given very little indication of resenting this intrusion and have, in fact, been very positive in their response. Our initial evaluation of the first 2 years of the program indicates a need for greater recruitment efforts among students to serve as peer educators and among faculty to participate. It is also evident that we need to refine our evaluative tools, especially in regard to measuring behavioral changes, through use of a pretest-posttest design.

REFERENCES

of the possibility of transmission of sexually transmissible organisms, including HIV.

It is excruciating for a rape survivor to consider the possibility of impregnation by her assailant. It is devastating for a survivor of sexual assault to have to consider the possibility of his or her exposure to potentially life-threatening sexually transmitted disease. Just as AIDS education must address rape prevention, rape and sexual assault counselors must be aware of the risk of disease transmission and the psychological impact of that possibility. Survivors of sexual assault who may have been infected with HIV during the attack need information and counseling about their sexual behavior after the assault, to prevent any possibility of their transmitting HIV to someone else.

3. Special Educational Needs of Minority Students
   a. Gay, Lesbian, and Bisexual Students

   Since much of our culture actively denigrates homosexual affect and behavior, many lesbians, gay men, and bisexuals develop an intense self-hatred and poor self-image while seeking to establish their sexual identities. Denial and fear often accompany sexual and emotional attraction. Educating gay men, bisexuals, and lesbians who do not acknowledge their same-gender attraction and behavior is more difficult than educating gay men, lesbians, and bisexuals who have accepted themselves sexually and can lead well-integrated, psychologically healthy lives. Some gay and bisexual men identify themselves as heterosexual, but engage in sex with other men under the influence of alcohol or other drugs. “Must have been drunk,” they say. The denial is often complicated by guilt and anxiety about discovery or disease. Whether this behavior occurs once or repeatedly, there is no preparation to reduce risk, and certainly no communication occurs about safer sexual practices.

   Many gay and bisexual men maintain the same values and attitudes toward relationships as the majority of heterosexuals. Anonymous sex with multiple partners occurs between some men. Public restrooms, parks, rest stops, and recreation areas...
may provide an environment for men to find casual sexual partners for brief encounters. Casual sexual behavior results from living in a society that is hostile to homosexual affection. There are few places for lesbians, gay men, and bisexuals to meet and interact in a healthy way, free from prejudice, harassment, discrimination, and violence.

While casual sex may not be psychologically and physically healthy, it is an adaptation by some people to meet their affective and sexual needs. Men who repetitively seek casual sexual partners may have fallen into an addictive behavior cycle. Reaching out to people who engage in casual sexual encounters is difficult because of the strong denial associated with the behavior. Denial is a double problem for men who identify as heterosexual, but have casual male partners. This last group is often not reached by educating the general homosexual and bisexual population. When addictive sexual behavior occurs, rehabilitation and psychotherapy must accompany education.

The development of healthy self-esteem is crucial in building accountability to oneself and others. . . . A person who feels he is worthless will not feel motivated to protect himself from HIV.

...
tional needs of international students. They are usually an underserved minority in campus AIDS programming.

4. Other Underserved Campus Populations
   a. Non-Traditional Students
      Non-traditional students demand different approaches in AIDS education. Currently, about 40 percent of college and university students are over 25 years of age. They are an ever-expanding minority who have enrolled for a variety of reasons: college for the first time, additional training for career, building new skills, or personal development. In community colleges and on urban campuses, the very diverse group of adult non-traditional students is often the majority of the population. Many of these adults have already resolved the major developmental struggles of traditional students, but have their own developmental concerns.
      Non-traditional students present a challenge to health educators. Often on campus for only a few hours a week, adult students are commonly inaccessible. Impatient with “undergraduate” programming, adult students may not stay around campus for traditional activities. Whereas residential students live minutes from classrooms and student centers, non-traditional students may have to drive many miles to get to campus. College is often by no means the only thing happening in the lives of adult students; there are jobs, children, families, careers. Their support groups and systems are unique to the group. And yet, returning or non-traditional students are highly motivated for education. If educators can identify realistic and convenient gathering times, places, and opportunities, non-traditional students can often be reached for programming. The involvement of these students themselves in planning and implementing the programs will make success more likely.

   b. Students with Handicapping Conditions
      We often view people with handicapping conditions as non-sexual — as not being sexually active and not having sexual desires, experience, or fantasies. But people with handicapping conditions have the same needs for intimacy, closeness, and touch as other people. Visually or hearing impaired students, orthopedically disabled students, and students with neurologic or other disabilities are all sexual beings who have varying needs in education about sexual relationships. In designing programs for students with disabilities, it is important to consider the physical accessibility of presentations and materials: for example, can sight-impaired students find educational brochures in Braille? Can wheelchair-bound students get to educational programs?

   c. Students with Hemophilia or Exposure to Blood Products
      Some students contracted HIV infection through contaminated blood components used to treat hemophilia or for transfusion. In most parts of the United States, the majority of clotting factor-dependent hemophiliacs who were treated prior to 1985 are HIV seropositive. A very small minority of students who received blood transfusions for other reasons (operations, injuries) prior to 1985 may also be seropositive. Awareness of the possibility of HIV infection is great among hemophiliacs, but some have not been tested for antibody to HIV. Students who received transfusions may not be aware of the risk. The possibility of HIV infection frightens anyone who has received blood products; students handle their fears differently, and some may deny the possibility of risk or dread the testing process. AIDS education programs must acknowledge the possibility of infection through blood products, and teach about the need for students who have received blood components or products prior to 1985 to protect others in sexual relationships.

   d. Other Students Perceived as Non-Sexual
      Every student body includes individuals who seem to lack interpersonal skills. Some students are shy, withdrawn, or socially inept. Other students, and some campus professionals, may view such individuals as non-sexual. Students who dress differently or seem not to value the same characteristics of appearance or style as the campus mainstream may also be judged to be non-sexual. Educators should make it possible — and comfortable — for students who do not “fit in” to find a place in AIDS education. It would be arrogant to assume that
Students must come to understand the concerns of blacks who work part-time and commute to colleges in the inner city and of blacks who attend predominantly white residential colleges in rural communities; they must understand the concerns of Latinos, of women, of international students, of students with handicapping conditions, of gay men and lesbians. Effective programs will provide accessible education for all of them, without barriers of language, culture, or sensitivity. We cannot use the same pamphlets, videotapes, and lecturers for everybody. Materials and interventions will be appropriately geared to work within the "real world" of students. Sound educational materials will not offend ethnic and cultural sensibilities. The words and images in these materials will not blame or stigmatize any people, nation, or race for initiating or maintaining the epidemic of HIV infection.

f. Effective programs will not be isolated themselves and will not teach about HIV and AIDS in isolation. They will integrate information about HIV infection and its prevention into comprehensive curricula dealing with other health issues, especially other sexual health concerns. Campus-based programs will ally themselves with other community resources to provide a diversified and multifaceted approach to AIDS education that involves churches, parents, business enterprises, health departments, health care professionals, and teachers. The result of widespread community participation will be not only that AIDS prevention messages are heard in a variety of contexts, but also that positive support will exist for safer behavior choices in the long term. These programs will evolve support for new community standards of safer behavior. AIDS education cannot productively be isolated from other health issues either: to address HIV infection and AIDS appropriately, the education program must deal with alcohol and its connection to sexual activity, acquaintance rape, steroid injection by athletes, other sexually transmitted diseases, and contraception.

g. Effective programs will encourage young people to put specific skills and information in a context of personal values.

Students will be exposed to a broad spectrum of personal, moral, and sexual values from their peers and from information and entertainment media. Students with a strong sense of their spiritual heritage, their place in the universe, their obligations to self and others, and their relationship to religious or moral principles and laws will have a strong context in which to make decisions about personal behavior. At the same time, effective programs will acknowledge and value a host of different spiritual principles and moral perspectives. Effective programs do not arrogantly offer only one point of view.

h. Effective programs will feature student involvement. Students understand and comfortably use the vocabulary and imagery of their peers. Students are aware of community standards in behavior, terminology, and concepts. Students as messengers about behavior are inherently credible, and carefully trained and supervised students are also credible messengers about health. Students commonly feel less inhibited about discussing the intimate issues of sexual behavior than do faculty and staff. In matters of health care for young people in general, the involvement of the target audience is critical to success.

i. Effective programs will be available and accessible to all students. Students with physical handicaps and learning disabili-
PRODUCTION CREDITS
AIDSFILMS
HOSTS
Ron Reagan
Beverly Johnson
Ruben Blades
PRODUCERS
Franklin Getchell
John Hoffman
CO-PRODUCER
Susan Tross, Ph.D.
WRITER
Susan MacMurchy
MUSIC
Lis Swados
EDITOR
Janet Swanson
ASSOCIATE PRODUCER
Diane Kolsky
CASTING DIRECTOR
Avy Kaufman
CAMERA
Judy Irle
Sandy Sissel
WETA-TV
EXECUTIVE PRODUCER
Rick Green
PRODUCERS
Sue Ducati
Sally Lamotte

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Additional copies of this guide and
videocassettes of the program can be
purchased from WETA. Write or call:
WETA-TV
Educational Activities
P.O. Box 2626
Washington, D.C. 20013
(703) 998-2709
(800) 845-3000

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available to you as a public service by Schmid Laboratories, Inc. It pro-
vides useful information about the AIDS crisis and helpful guidelines to
follow. The Film and Discussion Guide were produced independently
of Schmid and thus Schmid can make no representations as to the ac-
curacy of the materials or issues presented. In today's environment, the
scientific community's knowledge about AIDS changes almost daily.
Therefore, Schmid urges you to consult your physician and review the
current literature for up-to-date, precise information.

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Introduction

AIDS: Changing The Rules is a Public Broadcasting documentary about the risk and prevention of AIDS in heterosexual adults. Scientific evidence suggests that the risk of heterosexuals contracting AIDS is still relatively low. However, changing our sexual behavior now is our only means of protection against future infection with the AIDS virus. The film deals with the topic of safer sex in a verbally direct and explicit way. Particular emphasis is placed on the combined use of condoms and spermicidal jelly containing nonoxynol-9 as the most effective and feasible form of safer sex. First, Ron Reagan, the President’s son, reveals the basic facts about symptoms, transmission and treatment of AIDS. The film brings you into the poignant daily world of AIDS: two young heterosexual adults with AIDS, a mother whose baby also has AIDS and a husband who was diagnosed just two months after his marriage talk about how AIDS has affected their lives. Then, the film introduces “the New Rules” for sexual behavior. Beverly Johnson, a top model, gives specific advice about vaginal and anal intercourse, oral sex, and deep kissing. Ruben Blades, the popular salsa musician, shows the correct way to put a condom on a banana. A lunchtime discussion among three working women shows how peer pressure and support can be an important means of spreading the word about safer sex. A seduction scene shows how a woman can persuade a reluctant partner to use a condom—in a hip and sexy way. A music video, presenting ways in which the AIDS virus cannot be spread, is included to reduce fears of contagion.

The film is intended to warn and inform every sexually active person that:

- they are at risk for infection with the AIDS virus;
- there is something they can do to protect themselves against infection.

AIDS: Changing The Rules is a powerful tool for candid and emotionally-charged discussion. Such discussion can serve to further clarify what safer sex is, to reinforce individual motivation to practice safer sex, and to troubleshoot for situations in which doing so would be particularly difficult. It can also help to reduce unwarranted fear about getting the AIDS virus through casual contact. This guide has been prepared to facilitate this discussion and is intended for use in community health clinics, classrooms, drug treatment centers, and social or professional organization meetings, by experienced or inexperienced discussion leaders.

Below is a list of the tools available in this guide and explanations of how they can be used:

- A description of the scope of the problem and solutions required. Page 5
- Summaries of the documentary segments. These make the content of each segment available to the discussion leader. Page 4
- Tips for preparing for and managing the group discussion. Page 7
- A personal inventory form which is designed to be duplicated and given prior to showing the documentary. Its purpose is to focus attention on the point of the documentary and give group members a basis for measuring the effect of the program on their own thinking. Page 6
- Discussion questions. Page 6

Section 1 Exploring General AIDS Attitudes
How does the group feel about AIDS in general?
How much information do they have about AIDS?

Section 2 Safer Sex Attitudes
How does the group define safer sex?
What are their personal issues in relation to adopting safer sex practices?

Section 3 AIDS and You
How are group members affected directly by AIDS?
How are they making changes in their lives?
How do they feel about these changes?

Section 4 Teaching AIDS Prevention
As the group leader, how do you handle a group member’s discomfort and embarrassment?
As the group leader, how do you handle your own feelings of fear, anger, embarrassment or sadness?

- Fact Sheets that can be used on an overhead projector or as handouts:
  - I. Provides information about the symptoms of AIDS. Page 10
  - II. Describes the HIV Test. Page 11
  - III. Tells how AIDS is transmitted. Page 12
  - IV. Provides recommendations for safer sexual behavior. Page 13
  - V. Answers questions about purchasing and properly using condoms. Page 14
Scope of the Problem

In only seven years, AIDS, or the Acquired Immune Deficiency Syndrome, has become the primary public health problem in the U.S. It is characterized by a set of harsh realities—including rapid spread, nearly always fatal physical deterioration, involvement of brain and central nervous system, and lack of vaccine, cure, or effective treatment. By 1991, it is estimated that approximately 270,000 people will have been diagnosed with AIDS; 179,000 will have died.

It is now known that the Human Immunodeficiency Virus (HIV), which infects and destroys the immune and central nervous systems, is the cause of AIDS. AIDS is so frightening a disease that it can also create crises in the lives of people who have it and their caretakers beyond its physical and mental effects. Discrimination, due to fear of "catching AIDS" or prejudice against those in high risk groups, can lead to eviction, ixing, denial of care and insurance, and rejection by family and friends.

Among gay men, there is widespread evidence that knowledge of risk and safer sexual practices can trigger behavior change. There has also been a large increase in the number of IV drug users entering drug treatment programs in areas like the metropolitan New York/New Jersey area. These IV users cite fear of AIDS as their primary reason for seeking treatment. Educational campaigns aimed at increasing awareness of AIDS and encouraging safer sexual methods are likely to be effective in preventing the spread of HIV among sexually active heterosexuals in the general population too.

This film is intended to reach heterosexual adults—while there is still time to protect them from HIV infection. The first step in this process is to convince them that AIDS is not a disease of gay men or IV drug users—that anyone who is sexually active may be at risk for infection. The second step is to teach them how to talk about and practice safer sex—with as much comfort as possible. Since this often calls for new social skills—like sexual negotiation, assertiveness, and limit-setting, the film uses role modeling, as well as instruction, to accomplish this step. The third step is to help contain irrational fear and prejudice about people with AIDS and calm the unnecessary worries about one's own health that may go along with AIDS awareness. During the next five years, there will be someone in all of our lives, whether friend, relative, co-worker, or neighbor, who has AIDS—who will need our support, our compassion and our hope. This film is intended to help prepare us all for this experience before it happens.
Film Fact Outline

It will be helpful if you already have notes on the documentary before the discussion begins. And it may also help you to know how each segment is structured, what its major message is and the specific target audience for that message. The brief descriptions below should help you remember the details.

Segment 1 Ron Reagan poses the most important question. "If you're not gay and you're not an IV drug user why should you watch a film about AIDS, why should you care?"

A number of people who are not gay, not IV drug users then tell us "I have AIDS."

Segment 2 Ron explains that the rules that run all our sexual lives have changed. That everyone, even heterosexuals are now "at risk." He says that this film will teach people how to protect themselves from getting AIDS.

Segment 3 Ron talks about people's irrational fears of "catching" AIDS; he says "you don't get AIDS from casual contact. If you're not sure what that means watch this." A music video shows situations that represent casual contact—ways you can't get AIDS—in the work place, restaurants, homes, on the street, in gymnasiuoms, clubs, etc.

Segment 4 Ron tells us what AIDS is:
- That it is caused by a virus.
- That it destroys immune and central nervous systems.
- That it makes you sick a lot.
- That there is no vaccine and no cure.

Segment 5 While pictures of people in the final stages of AIDS are shown, Ron describes its symptoms: Fever, night sweats, hacking cough, blindness, diarrhea and fatigue. He explains two major diseases of AIDS—Pneumocystis carinii Pneumonia and Kaposi's sarcoma.

Segment 6 Ron explains that you can get AIDS by injecting the virus into your blood with a needle and introduces a former IV drug user who discovered he had AIDS two months after he was married. He has been totally drug free for five years. He and his wife tell their story.

Segment 7 Beverly Johnson gives statistics on AIDS and minorities:
- Nine out of ten women with AIDS are black or hispanic.
- Nine out of ten babies born with AIDS are black or hispanic.

Segment 8 A mother with AIDS and her infected baby tell their story and urge others to be careful.

Segment 9 Beverly Johnson outlines the new rules for sex. She explains how to protect yourself even if you're sexually active.

Segment 10 Using a banana, Ruben Blades demonstrates how to put on a condom.

Segment 11 Three women (one white, one black, one hispanic) discuss personal feelings and attitudes about condoms and sexual behavior.

Segment 12 A young couple interrupt their passionate seduction to negotiate condom use. He resists. She insists. Eventually he relents.

Segment 13 Ron Reagan recaps the film and the new rules:
- Use a condom.
- Use a condom.
- Use a condom.
- Use your head. Sex isn't as simple as it used to be.
Preparing for the Group Discussion

Preparation for the group discussion can be as important as the group discussion itself. Obviously, not all of you will have the time and resources to prepare or facilitate in the manner suggested. To the extent that you can do so, however, we suggest the following preparatory steps:

1. Read additional materials in order to be as informed as you can, both about AIDS and AIDS prevention. Some suggestions are made in the bibliography at the end of this guide.
2. Examine your own personal sexual and emotional needs and insecurities until you feel comfortable. Try to decide in advance what sexual terms you group will be most comfortable with, practice using those terms saying them aloud. Try to anticipate how you will best handle any extreme discomfort you might encounter. Will you excuse members from further discussion? Try to help them feel more comfortable. How will you accomplish this? Can you help them by sharing your own initial discomfort?
3. Contact members of the community, such as staff from local AIDS or gay self-help organizations, AIDS task forces, state or city health departments, drug treatment centers, hospitals or medical centers taking care of people with AIDS, or other groups listed in the Resource Section. Invite them to attend the session and perhaps even facilitate small groups if you have too large an audience for effective discussion. Invite them to speak to the group about their personal reactions to AIDS or HIV infection. Ask for pamphlets or posters you can use. Ask them for up-to-date information about existing community efforts and laws.
4. Set up a table to display materials that might be of interest to group members. This should include various types of condoms, spermicides and lubricants, to enable participants to preview the variety of products they might find in a local store.
5. Obtain a blackboard on which to record ideas and themes from the group.
6. Prepare visuals to help focus the group. These visuals, prepared xerox sheets or overhead viewer charts or slides could include: a list of the goals of the group discussion; a list of the names of participants from the community; or, fact sheets as already included in this guide.
7. Duplicate copies of the Personal Inventory Form, and Personal Commitment Sheet if you are planning to use them.
8. Choose one or two pamphlets in advance, from one of the groups listed in the Resource Section, and order them in bulk to distribute to all group participants.
9. Purchase a large quantity of Ramses Extra condoms, or any other condom containing spermicidal lubricant. Distribute to all group participants.

Effectively Managing the Group

Each of us has our own style of working with groups that is effective in its own way. So be yourself and make your own unique contribution. There are, however, a few principles of group leadership that might maximize the quality of the experience such as:

1. Review the key points of the film as a take-off point for discussion. Your first task is to review the AIDS information and safer sexual guidelines found on the Fact Sheets. However, avoid preaching and lecturing. Remember that when a group is stimulated to brainstorm and discuss shared personal experiences rather than being passive listeners, peer influence and support can flourish.
2. If the group is small enough, use exercises to teach the two major skills of safer sex. These exercises will "break the ice" and provide some humor to offset the awkwardness that often hinders discussions about sex. If your groups are large, consider breaking into smaller groups of no more than five people.
   - Provide condoms, spermicidal jelly and bananas to pass around, in order to practice condom use.
   - Pick pairs to role-play negotiations about condoms between various types of couples. These could include: (a) a couple who have already dated for a while; (b) a couple who do not know each other well; and (c) a couple in whom one of the partners is resistant.
3. Encourage group members to express themselves openly, without fear of being put down. One of the best ways to stop the flow of group contributions is to minimize or demean someone's ideas. If a group member is being really outrageous, the group will usually handle it.
4. Stay clear about the goals of the discussion. Keeping a group on track without hurting feelings is a real challenge! When you feel that the discussion is getting off target, or is not meeting the needs of the majority, then you might try some variation of the following statements: "That is one of my favorite subjects—I could talk about it for hours. But I'm afraid that if we do that, we won't get our goals accomplished." "That's an interesting idea. Since we have limited time for discussing it now, I suggest that those interested in pursuing it meet right after the meeting."
5. Summarize group responses and wrap-up the discussion. A vital role for the discussion leader is that of summarizing the ideas and feelings emerging from the group. This needs to be done periodically throughout the discussion as a means of focusing the group. Group responses may also be listed on a blackboard.
6. Invite individuals to speak with you privately, following the discussion. Give your office telephone number for this purpose. This provides an important opportunity for individuals with personal concerns to get the help or referral they need.
Personal Inventory

These questions are a quick way for you to get in touch with your attitudes about AIDS. There are not any right answers. You will not be graded and no one else will ever see your answers. The sole purpose of this section is to help you become better aware of what you really think and feel. Sometimes you may want to mark more than one answer.

I believe it would be better for everyone if people with AIDS were
- Quarantined
- Better understood
- Forced to register with the government

I think the blood test for AIDS should be
- Mandatory
- Mandatory for certain people
- Mandatory for gay men and IV drug users
- A matter of personal decision

You get AIDS because
- You're unlucky
- You're a person who does bad things
- You have sex with someone who has the virus

To avoid getting AIDS I should
- Give up sex altogether
- Use condoms and spermicides whenever I have sex
- Limit my number of sexual partners
- Think about sex in a whole new way
- Yes  No Knowing my partners sexual history will keep me from getting AIDS.
- Yes  No I feel responsible to my friends. I encourage them to use condoms and spermicides.
- Yes  No I am afraid to have a transfusion.
- Yes  No I would be afraid to visit a friend in the hospital if I knew he/she had AIDS.
- Yes  No I think people with AIDS should be allowed to go on working at their jobs.
- Yes  No I'm afraid my health insurance premiums are going to be very expensive because of AIDS.
- Yes  No I wouldn't want a child with AIDS living next door to me.
- True  False If your AIDS virus test comes back positive, it means you have AIDS.
- True  False If your AIDS test comes back negative, you don't have to use a condom.

Once you have answered these questions you'll be ready to see the program. We think you'll find it informative and helpful in reducing your unnecessary fears and your risk behaviors. Review these questions at the end of the discussion or better still, when you get home—to see which of your opinions have changed and which have stayed the same.
Discussion Questions

Probably no illness has ever caused as much fear, anger and confusion as AIDS. This documentary debunks the myths surrounding the disease challenging people to put aside their preconceived notions and examine the facts. This challenge may provoke a variety of responses including a reluctance to share true feelings. These suggestions (section 1-3) should help open the group to a free exchange of ideas and opinions. Because of the sensitive nature of the AIDS issue a special section (section 4) has been added to help teachers, health professionals and parents prepare for discussion of AIDS prevention, from a more objective perspective—that is free from their own special fears and prejudices.

Each of the four sections should provide at least 2 hours of rich complex discussion (even from a reticent group). Using all 4 sections could easily take an entire day.

Section 2—Exploring Safer Sex Attitudes

1. In the scene where the condom gets put on the banana, when does he say you should use a condom? What else does he say to use with the condom? Where should you put the spermicides?

2. Can straight men give AIDS to women?

3. Can women give AIDS to men?

4. What kinds of sexual acts are capable of passing AIDS from one person to the next?

5. What about oral sex? Do you have to use a condom?

6. In the office scene the three young women are discussing condoms and whether or not to use them.
   - What was the black woman’s attitude? If you were her boyfriend how would you feel about that?
   - What was the white woman’s attitude? What would you tell her if you were her friend?
   - What was the Hispanic woman’s attitude? If you were her friend what would you tell her? Did you identify with her? Did you understand why she felt that way?
   - As the male lover of any of these women what could you do to help them out?
   - Is it the woman’s responsibility to make sure a condom is used?

7. In the seduction sequence why do you think the man says “yes” to anything else but “no” to a condom?
   - Why do you think he hates condoms?
   - When she finally tells him he will not hate condoms after tonight, what does she mean?
   - What if he had refused?
   - How would you advise her?
   - If you were a friend of the man in this scene what would you say to him?

Section 1—Exploring General AIDS Attitudes

1. After seeing this program how do you feel about people with AIDS?

2. Now imagine that the person is your brother or sister. Do you still feel the same way?

3. In the film you learn that you can’t get AIDS through casual contact. What is casual contact? Can you list what that means?

4. What other kinds of casual contact can you think of?

5. Do you believe that you can’t get AIDS in these ways?

6. How can sexually active homosexuals get infected with the AIDS virus?

7. Sharing needles when you shoot drugs puts someone else’s blood into your veins. How is this dangerous? How is this different from a transfusion?

8. If you were caring for someone with AIDS:
   - Would you feel comfortable visiting him/her at a hospital?
   - Would you feel comfortable visiting him/her at home?
   - Would you feel comfortable sitting next to him/her?
   - Would you feel comfortable feeding him/her?
   - Would you feel comfortable bathing him/her?

9. Would you allow your child to go to school with an AIDS child?
Section 3—AIDS and You

1. Ask the group to do a role play—man going in to ask female pharmacist for condoms.

2. Switch—female getting condoms from a male pharmacist.

3. Imagine that you have the AIDS test and the results come back positive.
   - How do you feel?
   - What do you do? Who do you tell?
   - What are your regrets?

4. Imagine that you have AIDS. How would you want to be treated?

5. Imagine that you are a parent. How do you tell your very young adolescent children about:
   - AIDS
   - Condoms
   - Sex

6. After 15 years your ostensibly monogamous marriage breaks up. You begin to wonder whether your ex-spouse has been faithful to you, and to worry about AIDS.
   - How do you handle this?
   - Do you go for an AIDS virus test?
   - What do you do about sex?

7. Imagine that you have had enough to drink to already feel the effects. You are romantically inclined toward your date who is offering you another drink.
   - What do you do?
   - How do you handle it?
   (Discussion leader should guide participants toward a discussion of the fact that alcohol and drugs impair judgment, and that impaired judgment can make it much more difficult to use condoms.)

8. What are the new rules?
   - What is the single most important thing you need to remember to protect yourself against AIDS?
   - Do you think you will do that from now on?
   - Why?
   - Why not?

9. Should you have the AIDS virus test?
   - If you are negative on the AIDS test what does it mean?
   - If you are positive on the AIDS test what does it mean?
Section 4 — Teaching AIDS Prevention

This section is designed to prepare group leaders and other professionals leading a discussion. These are situations that group leaders might encounter. Thinking about them in advance might help you prepare.

1. Imagine that a young person or group member says “I want to have sex with lots of people before I settle down and I don’t want to be bothered with all this condom junk.” How do you handle it?

2. You are leading a group where there are Latino men present. They are mortally wounded at the suggestion of condoms. How do you help them understand?

3. Someone in the group has a friend who has AIDS. He is frightened and confused. Do a role play. One member of the group becomes a counselor, one becomes the person who has AIDS.
   - How do you help him?
   - What would you advise him?
   - What questions could you ask to help him address his true feelings?

4. Imagine the young people in your group are discussing their alcohol consumption, drug use, sexual habits etc. They seem irresponsible to you. You feel angry and frightened for them. You are about to give them a lecture.
   - First think about your own sexual practices.
   - How is your alcohol consumption?
   - What are your unspoken fears?
   - How do you deal with them now, in light of your personal assessments?

5. A member comes to you after the group is over. He is worried that he may be infected with the AIDS virus.
   - What do you tell him?
   - Do you advise him to have the HIV test?
   - Speak to his doc or?
   - Seek professional help?
   - Are you prepared to deal with these issues?

6. Someone in your group has a tragic AIDS-related issue. Their question to you is extremely emotional.
   - How do you handle that?
   - Do you try to remain in control?
   - How much should you share your true feelings with the group?

Using the Fact Sheets

The group leader should use the following questions to set up the problem for the group:

- Ever find yourself feeling totally convinced that you have AIDS on a day when:
  - You were coming down with a cold or flu?
  - You saw another frightening AIDS news report on TV?
  - You had a friend who had just been hospitalized with AIDS?

The first and best way to start talking with the subject of AIDS is to make sure you have a clear and accurate understanding of what it is and is not, how you can and cannot get it, or what you can do to protect yourself against HIV infection.
Fact Sheet

What is AIDS?
AIDS (Acquired Immune Deficiency Syndrome) is a disease of the immune system, which weakens the body’s capacity to fight infection.

What are opportunistic infections?
Infections that seldom cause disease in people with normal immune function, but “takes the opportunity” to cause disease in people with AIDS.

What is *Pneumocystis carinii* Pneumonia?
*Pneumocystis carinii* Pneumonia (PCP) is the most common AIDS-related Opportunistic Infection (OI) in the U.S. The symptoms of PCP are fever, cough, shortness of breath and chest tightness.

What is HIV infection?
Human Immunodeficiency Virus (HIV) is what causes AIDS. The virus is passed to an individual through sexual intercourse, shared intravenous needle use or shared blood or blood products. People who have been infected with HIV may show no physical symptoms.

What is AIDS-Related Complex?
AIDS-Related Complex (ARC) is a general term for an intermediate phase of HIV infection between no symptoms and full-blown AIDS. It consists of swollen lymph nodes, fever, night sweats, fatigue, diarrhea and weight loss that persist for at least 3 months.
Fact Sheet

What is the HIV Test?

- It starts with blood testing called Enzyme Linked Immunosorbent Assay (ELISA). If you show HIV antibodies on this test, it is repeated.

- If you show HIV antibodies on repeat test, then you are given a Western blot test to confirm these results. If you show HIV antibodies on this test, you are considered HIV positive.

- It may take as long as one year before these tests show that you have HIV antibodies.

- These tests are available at local blood banks (where blood is donated), AIDS research programs, and at "alternative test sites." These programs are obligated to:
  1. Develop ways of giving the test and recording results that are confidential.
  2. Offer counseling to all participants before and after testing.
Fact Sheet

How is AIDS spread?

Despite the facts that HIV infection is spreading rapidly, the established ways of getting or giving HIV have not changed since 1981.

The two main routes are:

- Through the exchange of semen/“cum” during vaginal or anal sexual intercourse.

- Through the exchange of blood during shared IV needle use.

Transfusion or treatment with blood products was previously a risk factor for infection, however, the blood supply is screened now, and these are no longer risk factors.
about their condition. Provide, or arrange for, competent and frequent medical follow-up and for detailed education of the affected student(s) regarding the transmission of HIV 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 policies and procedures for dealing with students with AIDS, an AIDS-related illness, or a positive test for antibody to HIV. 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. (See also the chapter on institutional policies and administrative liaison.)

c. Confidentiality. Guarantee that confidential medical information about students with AIDS, an AIDS-related illness, or a positive test for antibody to HIV is protected. The inadvertent or malicious "leaking" of such information can cause extremely painful consequences for the affected students and the institution. All who might potentially deal with confidential medical information should clearly understand these facts. For further discussion, see the chapter on confidentiality of information.

d. Public relations. 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 chapter on institutional policies and administrative liaison.
GOALS OF AIDS EDUCATION IN CAMPUS COMMUNITIES

The goals of AIDS education programs on campus are multiple:

1. to prevent further spread of HIV to uninfected people,
2. to delay or prevent the development of illness in people who already have HIV infection,
3. to prevent or reduce unreasonable fears about the transmission of HIV,
4. to promote compassionate and caring responses to people with HIV infection and AIDS,
5. to provide support for needed services for people with HIV infection and AIDS,
6. to combat prejudice and discrimination against people with HIV infection and AIDS, and
7. to ensure attention to the important economic, social, ethical, legislative, legal, and psychological issues created by the epidemic.

CRITICAL ISSUES IN CAMPUS AIDS EDUCATION

1. Student Development and Campus Life

The effectiveness of any AIDS education program is, in large part, contingent on an understanding of the unique qualities and perspectives of students in the campus community. College and university students make up several populations that are developmentally distinctive. Understanding the developmental issues and associated behaviors of students and implementing this knowledge in our educational strategies and materials are critically important steps.

If students change their behaviors to lower- or no-risk activities, they will have done so because such changes fit with their experience of themselves, their peers, and their world, while working within their cognitive and emotional capabilities. The more we understand students' perceptions and the way they think, the more successful we will be in translating our AIDS information into messages with impact. We need to understand our target populations as thoroughly and insightfully as the fashion industry fathoms its consumer groups. In a sense, we are "selling" something: safer behavior. Our goal is to have students "buy" it. Our success will be calculated not in sales, but in the numbers of students who control their risk of HIV infection.

Ecologically, college campuses create special difficulties in providing effective health education. At the same time, they can also facilitate it. Closely knit residential communities promote the rapid dissemination of rumors, misinformation, and myths. Students may accept information that has no basis in fact — including unsubstantiated rumors about peers who have HIV infection and misinformation about the transmission of HIV.

On the other hand, college environments enroll students who come from a very diverse range of social, educational, and economic experiences. Interaction with such a diversity of peers challenges most students' beliefs. Given enough environmental support, cognitive and attitudinal development takes into account these new and varied experiences. College students may thus be developmentally receptive to accurate, objective health education. The academic enterprise allows multiple opportunities to discuss the social, economic, philosophical, psychological, biological, and ethical implications of AIDS. In residential colleges, it is easy to gather groups of students for education, often on short notice.

2. Developmental Issues as Determinants of Risk
   a. Invulnerability

The most difficult developmental issue in health education is the sense of immortality among young adults. Feelings of mortality are in fact so rare among college and university students that we think of students who discuss those issues as being mildly neurotic or morbid. The feeling of invincibility is most commonly manifest in thrill-seeking behavior. It is difficult
to be effective in recommending safer sexual practices to someone who feels he or she is indestructible. Experimental behavior seems inherent to the developmental process. It would be unhealthy psychologically and unsuccessful educationally to prescribe all experimentation, but we can advocate healthier means of experimenting and exploring.

b. Stress, Nutrition, and Health
Entering students, whether first-time traditional undergraduates or returning commuters, often come to school with poor skills in managing stress, time, study demands, diet, and substance use. A strong developmental drive to participate in everything may overwhelm previous healthy behaviors. These busy, stressed, active lifestyles may be threatening to safety should exposure to HIV occur or actual infection exist. Lower stress and better general health are important in controlling susceptibility to HIV infection. AIDS education thus must relate to programs that promote more general psychological and physical health. In a sense, AIDS education involves time management, study skills, nutrition education, physical fitness, healthy substance use, and general sex education.

c. Peer Pressure
Peer pressure may perpetuate unhealthy behavior choices, promote feelings of immortality, and oppose risk reduction. Students may not be willing to come to presentations about AIDS when the general attitude among their peers is that HIV infection is not their problem. Men, in particular, feel exceedingly reluctant to go to AIDS education programs for fear of being labelled gay. On the other hand, peer pressure may be useful: paraprofessionals, such as peer educators, can use their position among other students to make themselves credible messengers for risk reduction. Small group or individual outreach programs may be necessary to reach certain students outside the coercive environment provided by peers. For example, campuses should provide separate outreach to gay and lesbian students, international students, part-time commuters, and athletes.

d. Gender Differences in Socialization and Relationships
During the college years, students may become painfully aware of important gender differences in the way relationships are perceived and valued. From infancy on, our society prepares men and women for relationships differently.

Women, in talking about men, may say:
* "If I don't give him what he wants, he'll leave me..."
* "He said he loved me, but all he wanted was sex..."
* "He said he'd call me, and every night I've waited by the phone, but he hasn't called..."
* "If I talk openly about safer sex, he'll think I'm a slut..."

Men, on the other hand, may say about women:
* "She thinks that when I'm not with her, I don't care about her, but I have a lot of things on my mind..."
* "Sometimes I say 'love' when I mean sex, because that's what she wants to hear..."
* "I thought we had a great close relationship, but she broke up because she says I'm too distant..."
* "I get tired of feeling obligated...just because we have sex doesn't mean we have a deep relationship..."

Carol Gilligan and other theorists emphasize that, while women grow up developing a sense of identity through relationships with others, men develop self-identity through separating and individuating from relationships. Women get a sense of "who they are" by staying in and building upon relationships;
their sense of self is grounded on affiliation and attachment to others. The threat of losing a relationship is great, because it threatens loss of self. For men, sense of self is organized around autonomy, independence, and individual achievement. Self is defined through work, productivity, and characteristics like intelligence and logical thinking. The threat of loss of self is then that of loss of work and lack of achievement or recognition.

Gender differences are relevant in educating students to negotiate for safer sex in opposite-sex relationships. These gender differences are relevant in educating students to negotiate for safer sex in opposite-sex relationships. Women feel hesitant to pressure a male partner to wear a condom or not have intercourse if they feel the male may leave the relationship. There is nothing weak, deficient, or unhealthy in this perspective: since women self-identify through relationships, it makes sense that they want to protect those relationships. The challenge for educators is to assist women in learning ways to negotiate for both safety and the maintenance of the relationship while affirming their ways of experiencing relationships. Men, on the other hand, need reassurance that partners can meet to negotiate on equal ground without a man's being weak or losing his sense of power. In working with either men or women, small group sessions with role plays will allow practice of these new skills.

Women who are uncomfortable with their bodies or their sexuality may not be able to discuss sex openly. They may find it difficult to express their sexual desires and interests. Feeling the loss of relationship or the discomfort of discussion, women may choose not to negotiate or to express their fears or reservations. Skill building is vastly important for women. The whole point of AIDS education for most women is related to power in relationships and the skills that support and facilitate it. Assertiveness training is crucial. Gathering women in small groups to discuss sex and relationships in the open will be both validating and empowering for them. During these small group sessions, women can learn and practice skills in negotiating for safer sexual contact while affirming their perspective on relationships.

e. Sexually Inactive by Word, but Sexually Active by Deed

Students may be sexually inactive by word, but sexually active by deed. They may deny sexual desire cognitively and emotionally. Many students cite religious beliefs or other value systems that forbid pre-marital sexual activity while engaging in sexual behavior actively and with feelings of guilt. Unable to accept their feelings or behaviors, they may deny both. The pattern of inactive by word but active by deed is especially a concern for gay, lesbian, and bisexual students who may not be able to acknowledge their same-sex attraction or activity.

Arranging for contraception or disease prevention to be used in an act that should not occur in the first place is difficult for many students. Cognitively, students may know that intercourse is not going to happen. Discussing safer sex practices when sex is cognitively impossible is also unlikely. By feeling, and representing to others, that intercourse was spontaneous ("one thing led to another..."), students may justify the behavior, even if it is outside their guidelines. Educators should anticipate that many students will have difficulty acknowledging sexual feelings, communicating about sex, and accepting responsibility for sexual activity.

f. Sexual Assault

Sexual activity without consent is a key element in the pattern of risk behavior on campuses. Most sexual assault among students is "acquaintance rape," or "date rape." The frequency of sexual assault far exceeds both our expectations and the rate of reporting. Rape is not limited to heterosexual women: lesbians are raped; men are raped. Reporting of male rape is even less likely than for rape of women. AIDS educators must be aware not only of the prevalence and effects of sexual assault, but also
Fact Sheet

What is Safer Sex?

Safer sex is any form of sex in which semen/"cum" or vaginal secretions are not passed from one person to another. It's not as safe as not having sex at all, but most experts believe there is little to no risk associated with safer sex.

How Safe Are Condoms?

- In laboratory studies, condoms have been shown to be an effective barrier against HIV.

- Condoms must be used correctly; if they break or fall off they will not protect you.

- Spermicidal jelly should always be squirted inside the condom before you put it on.

- These methods cannot be guaranteed to be fool-proof.

- Even when condoms and spermicidal jelly for lubrication are used, there may still be a small risk of getting or giving the AIDS virus.
Fact Sheet

How Do I Use a Condom?

Follow these steps:

• Put spermicidal jelly inside the condom before you put it on.

• Roll the condom down over the penis, smooth out any air bubbles and leave some room in the tip of the condom to catch the ejaculation/"cum"

• Put spermicidal jelly outside the condom for better lubrication.

• As soon as you're finished, withdraw. Hold on to the condom to keep it from spilling.

Where Can I Find Condoms and Spermicidal Jelly?

In many drug and variety stores, often on open shelves. If not, don't be shy—ask.

What Kind of Condoms Should I Buy?

• Latex condoms have been shown to be a good barrier to HIV.

• There are also lambskin condoms which may not be effective in preventing transmission of AIDS virus.

Will Reducing the Number of Sexual Partners Reduce My HIV Risk?

Yes, but you still need to practice safer sex. Use a condom everytime you have sex.

The Surgeon General advises that sexual abstinence or a mutually monogamous sexual relationship with a healthy partner are the best protection against AIDS.
Making the Changes

None of this information you just absorbed will do a bit of good unless you are willing to make it a part of your everyday life.

This sheet, like the personal inventory, is not to be shared, graded or judged. It is only to help you get in touch with your feelings and thoughts and help you see your behavior at the moment.

- I will use a condom whenever I have intercourse. 
  - [ ] Absolutely
  - [ ] Probably
  - [ ] Maybe

- I will use a condom whenever I have oral sex.
  - [ ] Absolutely
  - [ ] Probably
  - [ ] Maybe

- I will always use a spermicidal lubricant in conjunction with a condom.
  - [ ] Absolutely
  - [ ] Probably
  - [ ] Maybe

- I will limit my alcohol and drug use so I can keep my wits about me.
  - [ ] Absolutely
  - [ ] Probably
  - [ ] Maybe

- I will try to persuade my friends to use condoms.
  - [ ] Absolutely
  - [ ] Probably
  - [ ] Maybe

- I will try to give some of my time to an AIDS organization.
  - [ ] Absolutely
  - [ ] Probably
  - [ ] Maybe

- I will not shoot drugs.
  - [ ] Absolutely
  - [ ] Probably
  - [ ] Maybe

- I will try to help my friends overcome their fear and learn the truth about AIDS.
  - [ ] Absolutely
  - [ ] Probably
  - [ ] Maybe

Remember: It is always easier to win the game when you play by the rules.
Resources

Organizations

AIDS 800 INFORMATION HOTLINE*  
(800) 221-7044  
American Civil Liberties Union—  
AIDS Project†  
132 West 43rd Street  
New York, NY 10036  
(212) 944-9800  
American College Health Association†  
1579 Crabb Branch Way  
Rockville, MD 20855  
American Foundation For AIDS Research†  
40 West 57 Street  
New York, NY 10019  
(212) 333-3118  
American Red Cross†  
AIDS Education Office  
1730 D Street, N. W.  
Washington, DC 20006  
(202) 229-8100  
Centers for Disease Control†  
AIDS Activity Office  
1600 Clifton Road N.E.  
Atlanta, GA 30305  
(404) 329-2550  
Guy Men's Health Crisis†  
P.O. Box 274  
132 West 24th Street  
New York, NY 10011  
(212) 807-6655  
Health Education Resource Organization (HERO)†  
101 W. Read Street  
Suite B12  
Baltimore, MD 21201  
(301) 945-AIDS  
Hispanic AIDS Forum†  
c/o APRED  
853 Broadway, Suite 2007  
New York, NY 10003  
(212) 870-1902 or  
(212) 870-1864  
Lambda Legal Defense and  
Education Fund†  
132 West 43rd St.  
New York, NY  
(212) 695-8855  
Minority Task Force on AIDS†  
c/o New York City Council of Churches  
475 Riverside Drive, Room 456  
New York, NY 10115  
(212) 749-1214  
Mothers of AIDS Patients (MAP)†  
c/o Barbara Peabody  
3403 E Street  
San Diego, CA 92102  
(619) 234-3432  
National AIDS Network†  
729 Eighth Street, S.E.  
Suite 300  
Washington, DC 20003  
(202) 545-2424  
National Gay and Lesbian Task Force†  
1517 V Street, N. W.  
Washington, DC 20009  
(202) 332-6483  
National Hemophilia Foundation†  
National Headquarters  
110 Greens Street  
New York, NY 10012  
(212) 218-8180  
† National Organization  
* Tolline

Popular Books and Pamphlets

AIDS Information for People of Color. San Francisco AIDS Foundation.


Drug Users: Do Not Share Needles. H.E.R.O.

How to Use a Condom (Rubber). H.E.R.O.

SIDA: Lo Que Todos Deben Saber. New York City Department of Health.

When a Friend Has AIDS: Chelsea Psychotherapy Associates/G.N.H.C.

Professional Articles and Books


AIDS Information and Referral Numbers

National AIDS Information Numbers

National AIDS Hotline 1-800-342-AIDS
Spanish AIDS Hotline 1-800-344-SIDA
National AIDS Information Clearing House 1-800-458-5231
AIDS Clinical Trials Information Center 1-800-TRIALS-A
Project Inform (AIDS Experimental Drug Info) 1-800-662-HELP
National Gay/Lesbian Crisis Line 1-800-767-4297
National AIDS Prevention 1-800-872-8378
National Association of People with AIDS (NAPWA) 1-202-483-7979
PAN American Health Organization 1-202-861-3200

State and Local AIDS Information Numbers

AIDS Clinical Trials Unit (University Hospitals) 293-8112
Ohio AIDS Hotline 1-800-332-AIDS
Ohio Department of Health, AIDS Unit 1-614-466-5480
Franklin County Health Department Courthouse Annex, 5th Floor
410 South High Street 43215

HIV Free & Anonymous Testing Site
Columbus City Health Department
Ollie M. Goodloe Health Center
181 South Washington Blvd.

Columbus AIDS Task Force
1500 West 3rd Avenue, Suite 329
Columbus, OH 43212 (Support Groups)

Minority Education Committee on AIDS
American Red Cross
995 East Broad Street 43205

OSU AIDS Education and Outreach Program
Wise Student Health Service
1875 Millikan Road 43210

292-6162