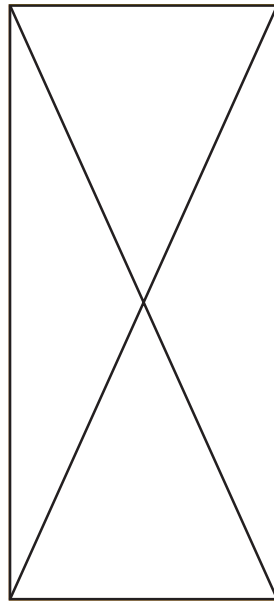


S.T.A.T.S.



Students
Teaching
AIDS
to
Students

Training Manual

amsa[®]

American Medical Student Association

S.T.A.T.S.

Students Teaching AIDS to Students

◆ an award-winning project of the American Medical Student Association ◆

Ann Mallard, National STATS Coordinator, 1997-98
Editor

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Special thanks to the AMSA national office staff for their editing and patience with me as I got this manual to them piece by piece.

KEEP UP THE GOOD WORK!

Anne Millard
National STATS Coordinator, 1996-1998
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Class of 1999

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- a cover page with the red ribbon logo

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Teacher Evaluation Form

Presenter Evaluation Form

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- Common STDs
- Diagram of the Immune System
- Search-a-Word

Introduction

For many years the American Medical Student Association has been conducting health education programs in the community. Efforts targeting adolescents have been particularly successful and well received. Teenagers enjoy interacting with medical students; and, likewise, the medical students benefit from having the opportunity to begin to function as health professionals in the community. Previous efforts have focused on sexually transmitted diseases, teen pregnancy, smoking and heart disease. All of the programs have emphasized the development of healthful behaviors as the best means to prevent various health conditions.

To date, prevention is our only guarantee of safety from AIDS. Education, therefore, is the only really effective tool that health-care professionals have to offer. According to former U.S. Surgeon General C. Everett Koop:

“Adolescents and pre-adolescents are those whose behavior we wish to especially influence because of their vulnerability when they are exploring their own sexuality (heterosexual and homosexual) and perhaps experimenting with drugs. Teenagers often consider themselves immortal, and these young people may be putting themselves at great risk.” (*The Surgeon General’s Report on Acquired Immune Deficiency Syndrome*, 1986)

Unfortunately, many states and municipalities have been slow to respond to the call for AIDS youth education. The most significant obstacle to approving and implementing programs has been sensitivity to the necessary connection between AIDS and sexual issues. Governing bodies around the country repeatedly have rejected AIDS curricula because influential portions of their constituencies have found the material deficient in meeting community standards of morality. Teenagers thus continue to be dangerously uninformed or misinformed.

AMSA launched the *Students Teaching AIDS To Students* (STATS) project in response to frustration over the failure of communities to implement programs that provide teenagers with the information they need to make responsible decisions. It is a step-by-step guide to allow AMSA chapters to train their members to enter schools or other centers for community youth and teach about HIV infection. The STATS curriculum can be presented in a minimum of two 45-minute sessions. The information is intended to be practical. It comes from an objective medical viewpoint, not an ethical one. The purpose of open presentation of sexual issues is to provide adolescents with the tools they need to remain healthy.

AMSA offers this manual to all STATS programs to help standardize the training that all medical students receive prior to entering the community. The ideas presented in this manual, like many of those in the STATS training guide, are collected from various successful STATS programs around the country. We realize that the ideas presented here may not all be appropriate for you and your school’s particular situation. To address this, we have tried to include as many different options and strategies as possible. If none of these should appeal to you, please do not hesitate to call the national STATS coordinator (contact information available from the AMSA Resource Center, (800) 767-2266, ext. 217).

SECTION I

Starting a STATS Program

Why Should I Start a STATS Program?

Since you are reading this chapter, this question may seem pointless. However, the following may serve as inspiration during the toughest hours of your program's infancy.

A few pioneering students started the first STATS program in 1986, and since then, it has reached more than 80 medical schools around the country. At each one of those schools, a few students were willing to put in a little hard work and time, and thousands of adolescents around the country have received the gospel of HIV/AIDS prevention.

Why should you start or resurrect a STATS program? Well, besides the obvious answers (you will be named to sainthood, everyone will love you, etc...), we have come up with a few tangible ones of our own.

1. **Practice medicine.** As first- and second-year medical students, most of the medicine you get to practice revolves around filling in bubbles on a grid sheet. STATS, however, allows you to actually practice **preventive medicine**. Prevention is presently the **only** cure for HIV/AIDS, and will probably remain such for many years to come.

2. **Meet the community.** Many medical students go to school in areas much different from where they spent their formative years. Consequently, the culture and attitudes of the adolescents in this region may be markedly different from their own. STATS provides a way for you to learn about the people in your community, something that will prove invaluable during your clinical years.

3. **Build community trust.** Within the last few years, there has been a growing mistrust between the medical profession and the local community. This is not the time to go into the reasons or validity of these feelings, but suffice it to say that they do exist in many areas around the country. STATS allows for the medical community (in this case a major medical center) to start rebuilding that trust by showing interest and care about what happens to the people in their region.

The Plan

As with all good projects, you need a plan before you get started.

1. **Find out who is interested.** Hold a general meeting. This can be done at your school's first AMSA meeting of the year. Remember, STATS is part of AMSA, so ask your local AMSA officers for help. The more people you have to help, the better.

A quick word about meetings. Medical students tend to walk around in a slight stupor most of the day, therefore you must really advertise to get people to come. Plaster the school with signs, make announcements in class. If you can swing it, provide food and drink. No one expects you to pay for the food yourself; ask your AMSA chapter president and/or student council if they will provide you with the funds. We are not saying that without food the meeting will fail, but rather, "You can catch more flies with honey."

2. **Delegate.** After you have a list of the people interested in helping to set-up/restructure the program, give each one of them a specific duty. Divide responsibility into three major categories:

a. **Curriculum.** These people would be in charge of reading through the STATS training manual, and deciding on an appropriate curriculum for both the STATS teachers and the students they will be instructing. They will also decide on the use of videos, handouts, etc.

b. **Public liaisons.** This is a fancy term for those who

will be in charge of recruiting schools and places to teach at. They will have to write the letters, go to the schools and work closely with the curriculum people to tailor a presentation for each school.

c. **Administrative.** These people will be in charge of the day-to-day functioning of STATS in the school. Details such as acquisition of funds, scheduling of meetings, and being representatives to both the student body and student council would fall to them.

Again, these are arbitrary divisions, and obviously what you decide will partly be dictated by how many (or how few) people you have helping you. *All of these areas are discussed in greater detail in subsequent sections.*

3. **Set goals.** Set realistic goals for the program. Give yourself enough time to get things done, but not so much time that people forget the program exists. It usually takes a semester from the first meeting to the first teaching sessions. Again this is highly variable.

4. **Hold frequent meetings.** Make sure you constantly keep the student body informed of your progress. It is a sure way to lose interest if you do not have a meeting for four months. A good rule of thumb is to have a meeting around each major vacation. This way things are fresh in their minds either when they come back or when they go home. Also, if your school has student mailboxes, use them

to give a biweekly/monthly update letter. Use of a student paper or e-mail is also a good idea.

5. **Ask for help.** Do not be embarrassed or too proud to ask for advice. As a medical student, you have loads of resources at your disposal. The national STATS coordinator is at your disposal and many of your faculty members could also be of great assistance. Faculty frequently have connections and contacts with other social interest groups who are trying to accomplish the same thing. Remember, you are not competing with other education groups for students, you are trying to work towards a common goal. Faculty members from pediatrics, internal medicine (especially infectious disease), and obstetrics and gynecology are often very helpful, and the preventive medicine folks may be of assistance.

Although no one wants to think about money, it is an aspect of reality that must be dealt with. First of all, at this point, you can expect **no** money from STATS itself, though AMSA at the national level has Local Project Grants for which you can apply (contact the Membership Department or visit the AMSA Web site). Although we are working on grant proposals, none have been approved to date. That means you are basically on your own. Since most medical students are paying a lot for their education, expecting you to fill the bill yourself would be unrealistic. Therefore, here are a number of ways that other STATS programs have found to make ends meet.

1. **Student Council.** At most schools, this body (or whatever your school calls it) is in charge of distributing money to student clubs and organizations. Therefore it is logical to assume that they would be the first people you would ask for help. Remember, when you are requesting funds, **do not just go in and ask for money.** You must have a definite amount in mind and a reason for requesting it. Make a proposed budget. Include costs such as transportation to schools, photocopying (see #4 below), supplies and food for meetings. You may not get all you want, but you will definitely get more than if you didn't bring in the budget. It doesn't hurt to ask for a little more than you need.

2. **Local AMSA Chapter.** They may have a separate budget or they may get all their money from student council. Since the latter is usually the case, please see the above section. In addition, if the AMSA chapter at your school is large and has a large budget, you may wish to have the chapter request the funds on your behalf from any source that they use, since they already have the connections, influence and experience.

3. **Deans.** If getting money from the above sources is like getting blood from the proverbial turnip, then a direct

Another place to look for help is the local AIDS coalition. Many of these organizations have people who can help you train your teachers, as well as valuable information and contacts. They may also have recent statistics about the population with HIV and AIDS in your area.

After you have done all of these things, you are ready to start training and going out to teach. *Instructions will be presented in later sections.*

These are just a few of the things that a good starting plan needs. It has purposefully been left very general due to the unique nature of each individual wishing to undertake this task. For more detailed ideas please refer to the specific sections later in this manual.

Money

request to the deans themselves may be in order. As with all money requests, tell them what **they** have to gain by giving you the money. Statements such as "It will give the school good publicity" or "It will make the school popular with the community" have worked in the past.

4. **Administration.** This is included as a separate entity, since we are discussing a specific aspect of STATS operating costs, **photocopying.** The more handouts you can give the students, the more effective your teaching sessions will be. A program that teaches 4,000 kids/year may have to make 20,000 copies. Many schools let student clubs and organizations use their administrative supplies such as copy machines, fax machines, etc. If they do, **make use of this resource to the best of your ability.** We are not advocating that you copy your biochemistry lecture notes courtesy of the medical school, but rather, use their generosity to make your presentation as effective as possible. Usually your local AMSA president will know how this works.

5. **Private Grants.** Remember that you are as eligible for a grant as any other nonprofit organization. Although filling out the application can be a royal pain, the rewards far outweigh the effort. Many local banks offer small grants (\$500 and up) to programs that provide a service to the local community. Money may also be available through private endowment funds, or even the school district itself (this has become rare of late). Again, the dean in charge of your medical school budget will probably have a list of available grants. There is no penalty for applying to more than one. (**Note**—If you decide to exercise this option, you may want to have a "financial" chairperson for your STATS program, since this can be a very large responsibility.) Also, check the National AIDS Clearinghouse WEB page—see information sources in the appendix for the address.

6. **Fund-raisers.** When in doubt, sell flowers for Valentine's day or something along those lines. Although

they can be annoying to set up, fund-raisers usually provide a safe and easy way to net a couple hundred dollars in profits. One STATS program gave away condoms with the flowers they sold for Valentine's Day—it was a huge success.

7. **Donations.** One of the major costs for your program will be the acquisition of a large number of condoms. You would be surprised how fast a successful program can go through 1,000 condoms! Writing to different condom manufacturers and asking for them to donate a thousand “for the cause” has been very successful in the past. The same strategy has also worked in the acquisition of other forms of birth control for demonstration.

8. **Government.** The Centers for Disease Control and Prevention (CDC) and the federal government will provide you with as much free information as you wish. Just call the toll-free hot line and ask (see appendix). They not only

have information on AIDS instruction, they also have pamphlets about HIV for all age groups in both English and Spanish. The Spanish pamphlets can come in handy for those of you in a large Spanish-speaking community. In general, these pamphlets are very useful if you are unable to provide handouts of your own.

9. **AMSA Local Project Grants.** These are for different amounts and are distributed three times a year. Request what you need, but you may not get all of it. You can call the AMSA national office or ask your AMSA chapter president for the application. Don't miss the deadline or you will have to wait for the next distribution date.

Although we are sure there are a few more wells to be tapped, these have been the most successful in the past. As always, if you hear of anything better, inform us immediately so we can include it in the next edition.

Curriculum

Here are a few things you must consider when you are devising your curriculum:

1. **Know the populace.** You have to know who you will be teaching before you decide what to teach them. Some things like the Pre-Test/ Post-Test will be useful in determining the factual knowledge of your population. However, only through talking to teachers and other members of the district will you be able to find out the emotional maturity of the students. For example, in some areas seventh-graders may already be exposed to “drugs and sex,” thus making some of the games designated for the “older kids” appropriate for these youngsters. Also, remember that each school, even if it is in the same general area, has a personality of its own, and you may have to constantly make small adjustments in the curriculum to meet the needs of the students. Finally, you must be aware of the cultural and linguistic background of the students as it may have a profound effect on your presentation.

2. **The school(s).** Remember that each school is different. There may be large discrepancies in knowledge and activities between students in private vs. public vs. religious schools. Also, you must find out what kind of schedule the schools will provide you. Some schools may only give you 45 minutes, others two hours. Some may wish for you to address the entire student body at once, others one class at a

time. You will have to be flexible in adjusting your curriculum. Finally, even though most of America seems to own a VCR, some schools may not have one. This is important to find out before you spend the time and money acquiring an AIDS video.

3. **A good mix.** When choosing games to use, make sure that you have “a good mix” of games. In other words, you want to make sure that the students not only know the basics about HIV/AIDS, but that you spend a significant amount of time on the behaviors involved in transmission. For example, for a 90-minute session, “Pros and Cons” and a “scenario” from this manual would suffice. **ALWAYS** use the anonymous questions so that anyone too embarrassed or shy to ask in front of the group has an opportunity to get their questions answered.

4. **Have fun.** As long as you take the above considerations to heart, just make sure that you choose a curriculum that will allow you to enjoy yourself. The more fun you have, the more effective you will be as a teacher. (**Note:** Not everyone at your medical school will have fun the same way, so give each group some freedom in deciding which games **they** would like to use.)

Where to Teach

Now that you have a curriculum, your next step is to decide where to send your medical student AIDS educators. This section will discuss the types of places where STATS groups have taught in the past. Although beggars cannot always be choosers, your program should try to focus on one or two of these types of institutions. By staying within the same “genre” of student, it will be easier for the STATS teachers to find their rhythm and be more effective teachers. Forcing them to constantly change their presentation will make it harder for them to become fully comfortable with teaching. As with all of the following types of schools/centers, there are Pros and Cons to each.

1. Public Schools

Pros—Once you can get a foothold in the public school system, you should be guaranteed a successful program. In about every area of the country, there are more students enrolled in the public school system than in all other types combined. It naturally follows that teaching in the public school will allow you to reach the most students. Also, especially in major urban areas, public school students (excluding specialty schools) are more likely to be exposed to the risk factors involved in HIV transmission, so you may be reaching the students who need it the most. When choosing a public school system, try to choose a district whose constituents will use the hospital at your medical center. This will usually add credibility to your program as well as foster trust in the community.

Cons—Although we personally feel that public schools provide the best experience for STATS teachers, we must remain objective. There are drawbacks in working in the public schools.

The main one is bureaucracy. When you deal with a school, you must usually deal with the entire district or the entire city school board. This can make it hard to start teaching in these schools, and you need to allocate a lot of time to this process.

Another problem is curriculum. Unlike many non-religious private institutions, public schools must abide by a state- or city-mandated curriculum and follow certain rules. An entire district may have a ban against condoms in the classroom, and there is nothing you will be able to do about it on an immediate basis. (You could go to the next school board meeting and try to convince them otherwise.)

Another problem can be discipline. This is especially apparent in the inner cities where many STATS programs have reported that students could be hard to control at times. However, don't let this be a deterrent; all it takes is a little practice.

2. Private Schools

Pros—The major advantages stem mainly from private schools' autonomy and their students. Most private schools function independently or within a small network of related schools. This makes it easier for them to accommodate your requests. Since they do not have to abide by state-

mandated curriculum, each school is allowed to choose about condoms, sex education, etc. It is much easier to convince a headmaster than an entire district school board. The other major advantage has to do with the students. Many STATS programs across the country have reported that, on average, the private school kids are a bit better behaved and a bit more “into” the presentation. Although this generalization may well be the product of limited data acquisition, the differences are readily apparent in areas like New York City. Because of this fact, having your first teaching sessions at a private school may help ease your new teachers into the idea of talking about sex and drugs to a class of seventh graders. But remember, do not take what we are saying as gospel. We are just trying to give you general ideas; you must be the final judge in your area.

Cons—The major disadvantage of going the private school route is linked directly to its biggest advantage. Since most private schools are small and autonomous, they usually prove an ineffective way to keep a large number of STATS teachers busy, since you must recruit each school individually (unlike recruiting an entire district, where you then have access to all the schools). Although another common complaint has been that the “private school kids are too upper class and therefore they are not at risk for HIV, so our time is wasted”... **this is not true. Everyone is at risk for HIV and everyone needs the education!**

3. Religious School

Pros—The same as any other private school.

Cons—You usually will have to deal with religious morals during your presentation. This makes it difficult, if not impossible, to teach a STATS class that will be useful and informative to the students. However, it never hurts to try—it's up to you.

4. After-School Center (Boys and Girls Clubs of America, etc.)

Pros—In many ways, these are the best of all worlds. They are autonomous like the private schools, but you are reaching public school kids. Also, since these places are not schools, they have no curriculum at all and usually give you a lot of freedom in your presentation.

Cons—As with the private schools, there are usually not enough students associated with these places to keep a large STATS program busy. Another problem is that these kids are not in school when they are at the club. Would you like to spend the whole day in school just to go get another lecture when you are done? We didn't think so. This means that you must really try to make your presentation fun and interactive; you will usually have the freedom to do so. Of course, all of your presentations should be fun and interactive.

5. Medical Center—Many major medical centers have a pediatrics out-patient clinic. Some of these have counseling associated with them. One program that we know of has set

up HIV/AIDS/STD counseling at their medical center. It has proven to be an easy way to reach about 15 adolescents a day. Again, since this is not a school environment, they are free to talk about whatever they want. Again, this is only a supplemental source of kids, as it is not large enough to keep an entire program busy. If you are interested in something like this, talk to the head of your pediatrics or pediatric/psychiatry department.

6. **Public Health Fair**—Many medical centers have public health fairs, some run by students, others by the school. These could provide an easy way for your program to reach a lot of people in one day.

7. **Covenant House/Runaway Shelters**—Don't forget about these and similar places. These teenagers are considered to be in an extremely high-risk category. Once again there is no curriculum so you are usually free to choose what to present and demonstrate.

8. **Church and Synagogue Youth Groups**—These groups are generally very receptive to having medical students come in and talk to both the parents and the children. Unfortunately, this is another place where you might be limited by religious beliefs.

Getting the Schools

Your next job is convincing the places you choose that you should be allowed to teach there. Believe us when we tell you, this it is not nearly as easy as you think. However, the numerous lessons learned from other STATS programs around the country have been combined and entered into this very manual!

1. **Decide on the type of school.** As mentioned in the previous section, there are many different locations. It is a general rule of thumb that if your teachers are happy, the program will work well. Therefore, hold a general meeting of all STATS teachers and ask **them** where they would like to teach. You never know, some of them may have connections at local schools that could bypass all of the normal bureaucracy.

2. **Get a list.** Once you have decided on the type(s) of school(s), you must next compile a list of places to contact. An easy way to do this is to:

- a. Contact local school boards to get the addresses and phone numbers of all local public schools.
- b. Look in your local blue (government) or yellow pages.
- c. Some large cities have a registry of all private schools in the area. You can obtain it either through the city school board or any random private school.
- d. Contacting the city committee on nonprofit organizations (or something along those lines) will generate a list of all groups that work with youth in the area.
- e. Contact your regional STATS coordinators and/or the coordinator of another STATS program in your area if one exists. They may also have a lot of contacts you can use.

3. **First Contact.** This is usually best achieved via a short letter accurately describing the program. Make sure that you contact your local AMSA president so that you can use official letterhead. Also, make sure that you give the **correct name of your program**. Your program should be referred to as STATS at Medical School, **not** just STATS. The same thing applies when you are talking

about your local AMSA chapter. This is done to protect all parties involved. You should make it clear that this is a program of the American Medical Student Association.

4. **Follow-up.** If you do not get a reply to your letters in a few weeks, don't get discouraged. Don't hesitate to send another letter or even call them on the phone. You will have to be a bit persistent to get what you want.

5. **Reply.** After someone decides to meet with you, then comes the hard part—really selling them on the program. The first thing you will have to do is send them a copy of the curriculum you will be using. This can be either the national curriculum, or a slimmed-down version thereof with the specific games and exercises **your** program plans to use. To avoid mailing costs, you may want to see if you can use a fax machine at your school (assuming the recipient also has a fax machine). After they have had a chance to look that over, you will probably be asked to either perform a sample teaching session for the school's leaders and/or just meet with them to talk in depth about what you plan to do. This is covered in the next section.

6. **The Meeting.** This may be the most important step toward getting your program into a school. You should dress professionally, of course. You, as coordinator, along with a partner (never go alone), should practice teaching the night before. You may not know in advance exactly what they will expect of you, so expect to be able to perform anything you have sent them in the curriculum.

Stick to the principles of your program while making diplomatic compromises. In other words, if a school will not let you distribute condoms, compromise with their letting you demonstrate condoms. Be prepared to do a **professional** condom demonstration for them (described later in this book). Most schools are very nervous about the idea of condoms in the classroom; if you want their permission, you have to really sell it.

Finally, do not be surprised if you have to perform a session at a "parent-teacher type meeting." The parents are the ones with all of the power in a school district and it is their kids who will be the focus of your presentation. It is

not unreasonable for them to ask to preview the program before it enters the classroom.

Following these steps should greatly help you in getting a few schools. Once you have worked at a few, then hopefully they will be good references for wherever else you want to teach.

Communication

This may be your most important weapon in recruiting fellow classmates. If you always have something to say about the program, people will think it is making a lot of progress. Give frequent updates and never go more than a month or two without having a meeting, with some of the best meeting times being right around the major holidays. Here are some ways in which other STATS leaders have kept in touch with their members:

1. **Announcements.** Just get up in front of the lecture hall before the next lecture begins and tell them what is going on. (Note: If your school has a good transcript service, the attendance at lecture may be too low to make this a reliable means of communication).
2. **Posters.** Print out an update sheet and post it all around the student dorms and classrooms. It is an easy way of apprising everyone in the medical center of your progress.
3. **Mailings.** If your school has student mailboxes (for receiving transcripts, grades, etc.), find out how you can put flyers in them. This is a great way to reach the entire student body since everyone loves to get mail!

One more word of advice. When dealing with a public school, try talking with the head of special/health education for that entire district. If you can get her/his permission to work in that district, it will save you a lot of time.

4. **Publications.** If your medical school has a local newsletter/student paper, submit updates to the editor every month or so. Don't forget about the hospital in-house paper/newsletter. If you keep the staff informed, you might be invited to more schools or receive donations from approving physicians, nurses, etc.

5. **E-mail.** Many schools have their medical students on a student "bulletin board" that provides easy access to everyone in the school. If that is not the case and you are an e-mail user, ask for the e-mail addresses of all of your members and send mailings. As incentive, your national officers should be on e-mail as well, so if you ever have any questions, type away.

6. **Phone.** Although calling everyone in your program for an update is probably too arduous a task, calling everyone immediately before a meeting is a surefire way to get the forgetful ones to come. Don't be afraid to divide the duty up among a few friends.

Training

Training may be the most important thing that can be done to prepare a medical student for teaching. We believe, and strongly recommend, that training should consist of at least two three-hour sessions, with a significant portion of the second session devoted to practice-teaching and trying to answer difficult questions. Remember that training never ends. All teachers should have to attend "touch-up" sessions every semester in order to fine-tune their skills. Combining this with a gripe session to discuss what is and is not working usually proves beneficial.

The American Red Cross offers several skills training workshops for instructors of HIV/AIDS education. Contact your local ARC chapter to find out more.

Here are different types of training sessions that have been used by a variety of successful STATS programs around the country. Again, we feel that you should pick at least two of these in addition to the practice teaching session. However, the more you do, the better prepared your teachers will be.

1. **Biological Training.** This session consists of training about the basic facts of HIV, usually presented by a faculty

member from the infectious disease or microbiology department at your school. Although knowing the information is essential, some schools have opted to forego this kind of training. If you decide not to do this, you **must** provide all of your STATS teachers with a packet of all of the relevant information they will need to know. Give them this packet before all of the training begins, and quiz them on it during the practice-teaching time of the second training session. If you do this, it should be adequate.

2. **Cultural Sensitivity.** It is obvious that many members of a medical school class will be living in a region of the country for the first time. You can assume that these students cannot fully understand the populace of the area (e.g., a medical student from rural Kansas attending school in urban New York City). Since the success of a STATS presentation depends largely on the ability of the teachers to gain trust and to communicate with the students, inability to understand what they are going through, etc., may severely hamper this process. You can try to curb this obstacle by asking a representative from the local community/school system to come and lecture about what the kids are like and

how they react to different things. Although useful anywhere, this type of training has found its greatest use at urban medical schools where the majority of medical students did not grow up in a major city. Finally, remember many recent immigrants and also religious groups hold different beliefs. For example, some cultures believe that you can get a disease simply by talking about it. (This is a very difficult group to teach about HIV.)

3. Sexual Orientation Sensitivity. Although the purpose of STATS is to disseminate information about HIV and AIDS, gay and lesbian issues are tightly interwoven. As teachers, your prime goal is to reach as many kids as possible, while alienating as few as possible. As human beings, you are inclined to insert your own biases when you lecture. This can be detrimental when talking about gay-lesbian issues. If a teacher constantly phrases sexual acts in terms of a heterosexual relationship, then s/he will most likely alienate any gay-lesbian students in the class. To combat this, some programs have asked people who work with gay-lesbian youth to hold an “awareness session,” to try to eliminate as much heterosexism as possible during future teaching sessions. You can contact your chapter/regional/national representative of AMSA’s Lesbian, Gay and Bisexual People in Medicine advocacy group (LGBPM) at via AMSA’s Web site at <http://www.amsa.org> or the Gay and Lesbian Medical Association (GLMA) at <http://www.glma.org> for help if there is no one at your school willing or capable.

4. Ethics Training. There are many psychosocial/ethical issues involved with HIV that the average medical student may be unaware of. Having a psychiatry and/or ethics professor at your medical school (or from the community) address these issues could be of great benefit to the program. **As with all of the training sessions mentioned, if you are unable to, or do not wish to implement it, you must make sure that you still supplement this information via another source, such as guest experts or handouts.**

5. Practice Teaching. As previously mentioned, practice teaching **MUST** be done by all programs. The way that you run this session is highly variable, but the overall goal is the same. Medical students should perform a mock session to an audience of their peers in pairs (male-female when possible). It is imperative that the other medical students ask them tough questions about HIV and sex. Hopefully, by this point, you will have some idea as to the age and type of students you will be teaching. You can then have the teachers practice the games and educational tools they will most likely use.

6. Teacher Observation. Although a few people may be natural teachers, ready to go out on their own immediately, many medical students may not be as gifted. Each new teaching group should observe a “veteran” group for at least one teaching session to make sure they have the hang of it.

You may be saying to yourself, “No one at my school has ever taught STATS, so who will run the practice teaching session that we **have** to have?” There is no easy answer. Hopefully, there is a nearby medical school with a strong STATS program and some of their experienced teachers might be willing to come over for an evening (a pizza bribe usually helps the cause). Or contact the National STATS Coordinator or the AMSA national office and they will see what they can do. If all else fails, fear not. Have the people who tailored your curriculum and yourself try a practice teaching session **before** you train everyone else (a small private school would be perfect for this). This way you will have some experience to lead the training session yourself.

Finally, in order for your program to grow and flourish, you must get constant feedback. Devise a quick questionnaire to distribute to all of your teachers. It should allow them to express their opinions on each of the training sessions. Since training is a long process for a busy medical student, nothing could be worse than if they all hate it. Training should be fun and interesting. If your biological training was too simplistic and/or no one learned anything new, you may wish to scrap it for next year and replace it with something else. However, **the only way you will find this out is by asking!**

As always, if you have any questions, do not hesitate to contact your national STATS coordinator.

Scheduling Teaching Sessions

Scheduling is never as easy as it appears. During your meeting with a school’s administration, you **must** talk about scheduling and timing. You must not only tell them how long you would like to be with each group of kids, but also if and when you plan to return. (We recommend that you spend at least 90 minutes with each group of kids per semester). Since private schools are usually smaller, they are more likely to more fully accommodate your requests. Public schools are usually a different story. Most junior high schools work on a home-room type system. This means (in case it has been too long ago for you to remem-

ber) that each homeroom goes around as a cohesive group from one class to the next. This makes keeping the students in one classroom for two periods nearly impossible. Therefore, suggest to the principal (or whomever you are talking to) that you follow the kids from one class to the next. In other words, you will show up to the Math room for Ms. Jones homeroom in period four. For period five, when Ms. Jones’ homeroom goes to Social Studies, you **follow** them to the Social Studies classroom and continue your presentation there. This should make life much easier on the school since they do not have to worry about finding

empty rooms for two consecutive periods. Another idea is to try to arrange your sessions during the time they have allotted for their science lab or home economics/shop class, which is generally two periods.

High schools on the other hand, are usually more difficult to schedule. Since everyone has their own schedule, your best bet is to take what the school gives you. In other words, if a period is 60 minutes long, teach that group for only 60 minutes. However, **return to the same class as soon as possible so that they get the full 90-120 minutes.** Also, if possible, have the same teaching pair return to the same class, since they should already have some kind of rapport with the class.

Another option, which takes a lot more planning and courage, is to hold an assembly. If you have a lot of trained teachers in your program, you may wish to consider having an "AIDS DAY" at one of the local schools. You start out the day with an assembly in the morning. There you can show a video, give a small lecture and even play "The Envelope Game" (in the Games section). After the assembly, send two teachers with each homeroom for at least one period. Although it takes a lot of teachers, it may be an easier way to reach high school students for 90 minutes in a day since schools usually have an "assembly day" schedule which they use for just such an occasion.

The next problem you will have to face is getting your classmates to sign up to teach. Since everyone involved (teachers and students) has classes during the day, medical students may have to miss a class or two to teach, depending upon your particular medical school's schedule. You should have a meeting once a month to deal with sign-ups. A huge poster-sized calendar, outlining tests, lectures,

holidays, etc., should make it easier for your classmates to make a specific commitment at that point. The way you actually handle the sign-ups is totally up to you. Some programs elect to schedule "teaching days" with the schools in advance, and then try to fill all of the slots they scheduled. Other programs just ask for people to sign up whenever they want and then they submit the schedule to the school. Whichever you choose, make sure you clear it with all of the members of your organization as well as your contacts at the schools where you will be teaching. Some may have a preference for one way or the other.

Finally, we get to partners:

No one should **ever** teach alone. The optimum scenario is to have two teachers for every 30 students or so.

In addition, the teaching pair should contain one member of each sex. Since it is unreasonable to assume that you will have exactly the same number of male and female teachers, just try to do the best you can.

Another good idea is for the teachers to be of different ethnic backgrounds, if possible. Since a good teacher usually develops a rhythm and style which allows him/her to better communicate with the students, it is natural to assume that the more a pair works together, the better they will become. Therefore, you may wish to encourage people to teach with the same partner whenever possible. An important exception to this deals with the "breaking in" of new teachers. Although newly trained teachers can practice and observe all they want, there is no substitute for actual teaching. Therefore, you may wish, just for one session, to pair up a new teacher with an experienced one. This should allow new teachers to get their feet wet in a pseudo-controlled manner.

What to Bring to a Session

The last area that needs to be addressed is what you should bring to these sessions to give to the students, and also to prepare your teachers. A typical teaching packet should contain of the following:

1. Copies of the pre- and post-test for distribution.
2. As many handouts and items for distribution as possible. The more students can bring home with them, the more they will remember.
3. More than one male condom so you can demonstrate the right and wrong way to put it on (using a banana or balloon to demonstrate). Also, bring a female condom—many kids will have never seen one (and probably most of your teachers haven't either!).
4. A handout with the location and phone numbers of both national and local hot-lines, and testing/counseling centers. If you don't make this into a handout, remember to write it on the blackboard so the students can copy it down. It is also helpful to arrange for a mailbox at the hospital where students can send questions. Another possibility is to include a part-time secretary (shared with student govern-

ment, or perhaps one of the medical school departments) in your budget to take calls, and maybe even do your typing and photocopying.

5. Fact Sheets. Some groups like to make an outline of all of the facts about HIV/AIDS that they will discuss and distribute it to the students at the end of the class.
6. Materials for the classroom teacher. They have to be able to answer any questions these kids may have about HIV/AIDS the other 200 days of the school year! Provide them with as much information as possible so that they can fulfill this duty.
7. Transportation receipt forms. Your ability to get funding in the future will depend on your having accurate records of how much your program spends. Since transportation to and from the schools can be a major expense, make sure that you keep an accurate tally.
8. Evaluation Forms. Don't forget to have the evaluation forms (found on the disk) filled out so that you can have feedback on your program's performance.

A Few Final Points

Just a few last hints and reminders before we wrap this up. First of all, always keep detailed records of how many students you teach and how well the program was received. This will not only help you gauge your program, but helps STATS at the national level as well.

Secondly, remember you are there to present only the facts. You should **never** give a bias one way or the other. All sexual acts should be referred to in an orientation-neutral manner in order to eliminate the possibility of either a hetero- or homosexual bias.

Finally, remember that **abstinence** is still the only **100%** effective way to prevent HIV transmission. Amidst all of

the talk about sex and condoms, people sometimes forget to mention this most obvious and perhaps most important point.

The purpose of this section was to give you some helpful hints and pointers regardless of whether you are starting a program or rebuilding an ailing one. As always, if you have any questions or comments about this manual, or feel that we left something out, please do not hesitate to contact the national STATS coordinator.

GOOD LUCK!

SECTION II

Information and Facts

Important Information About Blood Tests for the Presence of Human Immunodeficiency Virus (HIV) Antibody

What is HIV and is it the only cause of AIDS?

HIV is a virus. It is the cause of Acquired Immune Deficiency Syndrome (AIDS). Biologically speaking, it is a retrovirus, classified as HTLV-III. Other members of this family include HTLV-I, which is the cause of a rare T-cell Lymphoma in Japan.

For the purpose of this manual, HIV stands for HIV-1. There are other strains of HIV not commonly found in the United States; they will be discussed separately.

As a retrovirus, the genome is composed of a double stranded RNA. Upon entering the cell, via the CD4 receptor found on the T-4 cell and macrophages, the virus's RNA is translated into three major proteins. One of these is the "pol" gene which codes for the reverse transcriptase. As soon as the reverse transcriptase has been made, it transcribes the viral RNA into DNA. This DNA is then incorporated into the host's genome. At this point, the virus will remain part of a cell's DNA until the cell dies.

At the time of compiling this manual, there has been considerable debate as to the presence of other causes of AIDS besides the HIV-1 virus. It is known that in Africa, Haiti and now the U.S., there is a distinct strain, HIV-2, which causes a milder form of AIDS in infected individuals. Scientists, through genetic hybridization, have found that certain risk groups (IV drug users, heterosexuals, etc.) have genetically different forms of the virus. There have also been many reported cases of people with AIDS who do not test positive for any of the known HIV viruses by any of the known tests, including PCR (see below). What this means to you as educators is that you must constantly keep aware of any new facts and especially any new rumors that surface about HIV and AIDS.

Obviously this is a very simple overview of the virus; it is not necessary that the kids you instruct know the depths of the microbiology involved. However, as medical students, you will be expected to know this at some time, and therefore, we recommend a standard microbiology text for a more complete discussion.

Where is HIV found in the body?

As previously mentioned, the virus gains entry into cells via the CD4 molecule. CD4 is found primarily on the surfaces on T-Helper cells (T-4 cells) as well as members of the monocyte lineage. As a result, the virus is found in the blood and anywhere else cells of this type may reside. This includes the central nervous system in the microglia (which are of monocyte descent) and **all** glandular secretions. Excluding blood, the highest titers of the virus are found in secretions from the reproductive glands/organs. The levels found in sweat, tears, and saliva have been on the order of 10^6 lower than in the reproductive glands and are therefore **not** considered a probable route of transmission.

How is the presence of HIV detected?

Currently there are three major ways to detect the presence of HIV. They are:

1. **The Enzyme-Linked Immunosorbant Assay (ELISA) Test.** This is the first-line antibody test currently used in the detection of HIV. As with all antibody tests, it is dependent upon the fact that the host produces a very specific antibody to the invader and in quantities large enough to detect. With HIV infections, the antibody levels are usually not high enough until 3-6 months after infection to be measured. This is what constitutes the "window period," since people in this time frame *are* infected and are capable of transmission but do not test positive by antibody type tests. The ELISA itself has a high sensitivity but a very low specificity. This means that it will pick up a lot of positive results, but many of them (up to 20% by some studies) will be considered false positives. Therefore, if a person has a negative ELISA, then they may truly be HIV negative, or they may not have antibody titers that are high enough to measure. A positive test may denote that the person is HIV positive, or that the person simply has an antibody to something else that cross-reacts with HIV antibodies. This test can be performed on blood and urine samples.

2. **The Western Blot Test.** This is a second-line test and is only used when patients have tested positive by the ELISA test, or if they feel the patient is of particularly high risk. The Western Blot is also an antibody type test, and therefore it also has a window period of 3-6 months postinfection. This test, unlike the ELISA has a very high specificity but a low sensitivity. The means that although it will miss a sizable percentage of those with high antibody levels, those who are positive will have HIV. Thus by combining the ELISA and the Western Blot tests, only four percent of people being tested will have a false negative result. If a person tests positive by both the Western Blot and the ELISA, they are actually infected with HIV. However, with the possible development of new strains of HIV, it is possible that patients develop antibodies which are not picked up by these tests and they will therefore test negative. The HIV-2 strain used to fall into this category; however, recently tests have become available to identify this strain.

3: **Polymerase Chain Reaction (PCR).** This is a new method of testing as it actually tests for the presence of the viral genome in human blood cells. This test is both highly sensitive and highly specific for HIV. Since this test in no way relies on the presence of antibodies for a positive result, and infected person can usually be detected only

two weeks after infection (something very useful for anyone who is positive that they put themselves at risk, such as a needle stick from an HIV+ patient). **This test should also be the only one trusted and used in the diagnosis of HIV in newborns.** Since a newborn's body contains high levels of maternal IgG, a newborn of an HIV-positive mother will test positive until the maternal antibodies leave the infant's system in six to seven months. Obviously, testing the infant via either the ELISA or Western Blot will prove useless, since the baby will be positive. However, the infant will only test positive via PCR if it is actually infected. Although PCR is not widely available at this time, it will be in most major hospitals and testing centers in the near future.

What does a positive test result mean?

A positive test (by either PCR or both ELISA and Western Blot) means that you are a carrier of the HIV virus. It also means that you can transmit this virus to others by intimate sexual contact, by sharing needles or through blood and organ donation. A pregnant woman can pass this infection to her developing child.

A positive test does not mean that you have AIDS since AIDS is a description of a set of signs and symptoms found in people with HIV. As of 1992, scientists estimated that about half the people who become infected with HIV will develop AIDS within 10 years.

What does a negative test result mean?

A negative test via ELISA or Western Blot means that no antibody to HIV is detected in your blood. This does not necessarily mean that you have not been exposed to or infected with HIV. Here are two other possible meanings:

- Although you may have been infected with HIV, it is possible that your body has not yet made an antibody to the virus that is detectable by current screening methods.
- Although an antibody to HIV may actually be present in your blood, for some reason the test may fail to detect it. As previously mentioned this is only a problem with the Western Blot and is the reason that the ELISA is used as a first line test (this is known as a false negative result).

If you test negative via PCR, then you do not have the HIV virus in your blood, assuming it has been at least two to three weeks since exposure.

Who should be screened for HIV?

HIV is currently found in all aspects of our society and, therefore, the list of who should be tested has grown as well. As a basic rule of thumb, anyone who has had unprotected sex (either heterosexual or homosexual) should be tested for HIV.

The risk and necessity for testing increases dramatically if the person or a partner has had any other STD, or if they fall into any of the following groups: 1) past or present users of intravenous drugs, or 2) anyone who was the recipient of blood or blood products from 1978 to May 1, 1985, including hemophiliacs. Some public health officials

recommend that these individuals be tested because they feel that knowing one's test results might help one make permanent behavioral changes to protect everyone.

The test is useful in certain clinical situations and may help the patient and the physician make certain decisions. Antibody-positive women should think seriously before becoming pregnant since pregnancy may cause the disease to progress and because the virus may be transmitted to the developing child. Current studies show that 30 percent of babies born to HIV-positive women actually contract the HIV virus and subsequently develop AIDS. Antibody-positive mothers should not breastfeed their children since the AIDS virus can be transmitted during breastfeeding. The immunization schedule for HIV-infected children may also have to be modified.

It is important to note that the test results do not change the recommendations concerning practicing safer sex. In general, any individual in the groups mentioned above should practice safer sex techniques, regardless of whether he/she has a positive or negative test result.

How should my test be done?

When addressing your students you must tell them two things. First—where they can receive a free HIV test; and second—what types of tests are available.

Usually you can tell anyone to call the local board of health and they will be provided the name of an anonymous testing site which will also provide pre- and post-test counseling. This is the best option and should be strongly suggested. People can also be tested when they donate blood, since all blood is screened for HIV. One must be aware, however, that the Red Cross does *not* provide pre- and post-test counseling, nor are they required to inform someone of their HIV status. This is a *confidential* type of test as opposed to an *anonymous* test and therefore it is not as highly recommended for anyone worried about the privacy of their results.

Finally, any family doctor or hospital can perform any HIV tests, but these are not anonymous, nor are they always free. As a result, **you as educator should prepare a handout listing all of the major testing centers, as well as the type of test performed (confidential or anonymous), to all of the students you instruct.**

Home testing kits are the newest way to determine HIV status. There is only one kit approved by the FDA—Home Access Express HIV-1 Test System, by Home Access Health Corporation. This kit is available in pharmacies and by mail. The first home-testing kit, *Confide*, by Johnson and Johnson, was pulled by the manufacturer for liability reasons, not because there was any problem with the test. The *Home Access* kit is labeled with a "pin" number that identifies the sample as yours and is used to obtain the results by telephone. It contains a special paper to place the sample on, a lancet for puncturing the skin to obtain the blood sample, a mailing envelope, and instructions as to how to use the kit. The basic instructions are as follows: 1) prick a finger with the lancet; 2) place some drops of blood

on the special paper and allow it to dry; and 3) put the specimen in the mailing tube and send it to the testing lab. Seven to 10 days later, the person calls a toll-free number, punches in his/her pin number and gets the results. If he/she wishes, there are trained representatives who will answer any questions the person has. The test is 99 percent sensitive and 99 percent specific. As with everything else, there are pros and cons. The pros include anonymity, no transportation required because it is done in the home, relatively quick results by phone for free, and available counseling. The cons include no mandatory pre/post-test counseling, the cost (about \$50), user error, and getting lost/destroyed in the mail. Since this method **DOES NOT** include mandatory counseling and is cost prohibitive, it's not recommended for these students.

There are other, non-FDA-approved home test kits available. These kits claim that results are available in five to 15 minutes in the home. A sample of blood or saliva is placed on paper and the paper is placed in a special solution. If the test is positive, a red dot appears on the paper—similar to many home pregnancy kits. However, these test are unreliable and not sensitive or specific, with many false-positives and false-negatives. These should NOT be recommended.

Secondly, it is also important that you stress the difference between *anonymous* and *confidential* testing. The two terms are easily and often confused. An **anonymous** test is one in which no one will know your name. You are known only by a randomly assigned number. The test result cannot be placed on your medical record, and no one will know your results except you. However a **confidential** test means that your test results will be placed on your medical record, and therefore a doctor, a nurse and probably a few other associated medical personnel and office workers will be able to link your name to your HIV status. The results, theoretically, will not be released to any outside agency without your written permission. However, people who have had confidential tests done have had their results leaked out to insurance companies and other agencies. **Therefore, the only way to ensure the privacy of your results is through anonymous testing.**

Finally, remember to stress that a positive test result is **not** good news, and that anyone who does test positive, can and should take advantage of free counseling provided by the local board of health.

Treatments

1. Vaccination

There are two types of vaccines that researchers are working on—one that prevents infection with the virus, like the influenza and measles vaccines, and one that helps eradicate the virus after someone is infected, like the rabies vaccine. At the time of this writing, a vaccine that prevents infection by injecting a weakened virus into a person uninfected with HIV-1 has reached human clinical trials, although there are many people who object to using anything except a killed virus vaccine or viral parts. The second vaccine, for those already infected, is still in the research stage.

2. Medications

A. Inhibitors of viral replication

These can be used after a person is infected to slow down the virus before it destroys the immune system. The following nucleoside analogs have been approved by the Food and Drug Administration: AZT (Zidovudine), DDI, DDC, d4T, and 3TC. Once HIV enters the cell, viral RNA undergoes reverse transcription to produce double-stranded DNA. This is inhibited by the nucleoside analogs.

B. Inhibition of viral maturation

These can also be used after a person is infected to slow down the virus before it destroys the immune system. The following protease inhibitors have been approved by the FDA: saquinavir, ritonavir, indinavir and nelfinavir. These drugs prevents HIV-1 protease from cleaving the large, nonfunctional (immature) polypeptide released from the

infected cell into smaller, functional (mature) proteins. This renders the HIV virions non-infectious.

Current drug therapy, called combination therapy, is the use of at least 3 drugs—a combination of anti-retrovirals/nucleoside analogs and protease inhibitors. AZT prophylaxis is used in HIV+ pregnant women to decrease the chances of trans-placental transmission to the fetus and is also used in newborns of HIV+ mothers.

3. Bolstering the immune system

These therapies can be used after a person is infected to prevent the immune system from deteriorating to the point that it cannot fight off diseases. There have been some attempts made to use bone marrow transplants, but with no success so far. Alternative therapies and nutrition, exercise and stress reduction may have an impact in this area.

4. Treatment or prevention of opportunistic diseases

These can be used after a person has started showing symptoms and diseases associated with HIV. Although there have been some successful treatments for Pneumocystis Carinii Pneumonia (PCP) and “thrush,” there has been more success in prophylaxis treatment for the above illnesses once a person's T4 count is below 400. Bactrim is the most commonly used drug as prophylaxis for PCP. Tuberculosis (TB) status is also monitored, since the current increase of TB cases, and especially of multi-drug resistant TB, is largely due to the occurrence of HIV.

Remember, once you are HIV positive, you can only receive medical treatment. There is no cure.

Transmission

Transmission of HIV occurs through exchange of certain body fluids:

- Blood, semen and vaginal secretions have a high enough concentration of HIV to transmit the virus.
- There is also an association between breast feeding and HIV transmission to newborns. However, it is unknown at this time whether it is due to infected breast milk, blood transmission via cracked nipples or both.
- Urine, saliva, tears, sweat, vomit and feces **DO NOT** have a high enough concentration of HIV to transmit the virus (assuming that there is no blood in them).

Transmission of HIV can occur in the following ways:

- sexual contact (for both partners)
 - anal sex
 - vaginal sex
 - oral sex

- sharing needles
 - to inject drugs (heroin, cocaine, steroids)
 - for other purposes (tattoos, ear piercing, acupuncture, inadvertent needle sticks, or exposure to infected blood)
- perinatally (mother to unborn infant) during birth or breast-feeding
- exposure to infected blood and blood products

HIV can be transmitted from:

women to men
men to women
men to men
women to women
mother to fetus
mother to child

Remember: “It’s not who you are, it’s what you do.”

Casual Contact

HIV is not spread through casual contact such as shaking hands, sharing utensils, hugging, dry kissing, eating in a restaurant, etc.... Casual contact is not a means of transmission because:

1. HIV is very fragile outside the body since it can only survive for about 30 seconds unless it is in a pool of liquid blood. Once the blood dries up, the virus dies shortly thereafter.
2. Unbroken skin is good protection against the virus.
3. The only body fluids with a high enough concentration of the virus to transmit it are blood, semen, vaginal secretions and breast milk/breastfeeding.
4. Remember that HIV cannot be spread via aerosol and therefore coughing and sneezing are **not** modes of transmission.
5. About dentists and other health-care professionals—there have been six cases of HIV transmission from one infected dentist. Otherwise, there are **NO** documented cases of transmission from a health-care worker.
6. There is not a single case of transmission of HIV from casual contact, even in cases of people sharing a living environment with someone who is infected or has AIDS. HIV cannot be transmitted by mosquitoes or other insects because:
 - HIV doesn’t live very long outside the body (even if it’s an insect’s body). HIV needs **human GENETIC** material to survive.
 - If HIV could be transmitted by mosquitoes we would see more cases of HIV in certain geographic areas and in children (who tend to get more insect bites). This is not the case.
 - The most likely reasons for mosquitoes and other insects not being a route of transmission include both the amount of time between bites (long enough that the virus can’t survive) and the fact that the insect’s internal environment is not close enough to a human to allow the virus to survive (e.g., temperature differences, enzyme action, etc.).

Risk Reduction: Sexual Behavior and IV Drug Use

Abstinence (no sexual intimacy)

100% effective, free, a viable option. But not the choice for everyone.

Mutual monogamy

Only having sex with someone who is only having sex with you. Only works if neither partner is infected.

Problems:

- How do you know if your partner is infected?
He/she/they may not know it themselves.
Even if he/she/they does know, will they tell you?
- How do you know your partner is monogamous?
- What if your partner shares needles?

Safer sex

No such thing as safe sex, but can make sex safer.

- Can practice low risk activities that avoid exchange of blood, semen and vaginal fluid.
- Can use condoms for vaginal, anal and oral sex.

It is important to remember that male condoms are only 98 percent effective (when used correctly) for preventing pregnancy; therefore, they cannot be 100 percent effective at preventing HIV infection! Female condoms are equally reliable when used correctly, which may be a bit more difficult, since they are placed in the vagina and cannot be visualized to check for proper placement. NEVER USE A MALE AND A FEMALE CONDOM TOGETHER!

Instructions for correct male condom use:

1. Check the expiration date on the condom and inspect the package for damage.
2. Use **only** latex or polypropylene (for those allergic to latex) condoms since **natural skin condoms will allow HIV to be transmitted**. Also, novelty condoms (glow-in-the-dark, etc.) are just that, novelties. They should not be relied on for prevention of HIV transmission or pregnancy.
3. Put on before there is any genital contact.
4. Put on when penis is fully erect.
5. Use a reservoir tip condom or leave 1/2" at end to leave room for ejaculation.
6. Make sure there are no air pockets in the condom which can facilitate breakage.
7. Have intimate sexual contact.
8. Withdraw before losing erection to prevent leakage of semen, holding onto condom during withdrawal to prevent slipping or leakage.
9. Use of a spermicidal lubricant can add a further layer of protection against both pregnancy and HIV and is also good in preventing breakage due to friction. However, spermicides can irritate the skin of either partner, leading to skin breakdown and/or sores with an increased risk for HIV transmission. Currently, it is not

recommended to use extra spermicide if a condom comes with spermicide on it.

10. Although most condoms can be bought pre-lubricated, if you choose to use your own, make sure you use only water-based lubricant; oil-based lubricants will damage latex. Oil-based lubricants do not damage polypropylene condoms, but the majority of the students will have easier access to latex condoms, so using water-based lubricants only should be stressed.

Instructions for correct female condom use:

1. Check the expiration date on the condom and inspect the package for damage. Female condoms are made from polypropylene, so no worries about latex allergies.
2. Place inside the vagina before there is any genital contact and, preferably, before any foreplay is begun. It is important that the internal ring is placed over the cervix (similar to a diaphragm) and the external opening is placed over the labia.
3. Have intimate sexual contact. The penis must stay sheathed within the female condom—it cannot be allowed to go between the outer side of the condom and the vaginal wall. **AIM IS CRITICAL!**
4. After withdrawal of the penis or the end of oral sex, remove the condom carefully and discard. The vaginal area should be washed before any further sexual contact with it.
5. The female condom also comes lubricated with spermicide, so no extra spermicide should be necessary.

For oral sex on a woman or oral-anal contact, use a dental dam (square of latex or plastic wrap). Place over genital or anal area to prevent exchange of body fluids. However, just like with condoms, make sure you:

1. Do not use both sides since it will expose the mouth of the partner to the vaginal/anal secretions.
2. Do not use oil-based lubricants since this will destroy the latex.
3. Do not wash and reuse it since you will not be able to fully sterilize it.

IV Drug Use

HIV can be transmitted by sharing needles and works, including cooker, reconstituting solution, etc. To reduce risk of HIV transmission from needles: **DON'T USE IV DRUGS!**

If you do use IV drugs, don't share needles or works. If you do share, clean needles and works in the following manner:

1. Flush bleach or alcohol through syringe and needle twice. Make sure all paraphernalia is cleaned (e.g., cooker and plunger).
2. Flush water through twice to rinse out. Be sure to wash needles out thoroughly—injecting bleach can be dangerous.

3. Throw away cotton or other implements that cannot be cleaned.
4. NOTE: Needles bought on the street are often used needles that have been repackaged. Clean all needles and works bought on the street.
5. Other needles to watch for: tattoos, ear/body piercing and acupuncture. Make sure that these needles are cleaned with bleach and water or alcohol or use new needles and paints each time.
6. **Many cities have a needle exchange program. Make sure that you find out if your community has one, and if so, provide information on its access to all of your students.**

Facts About Oral Sex, Birth Control and STDs

Here is some general information about the various types of birth control available and their effectiveness in preventing the transmission of HIV.

Abstinence is always 100% effective in preventing both pregnancy and HIV transmission.

Diaphragms can be very effective in preventing pregnancy, especially if they are used with a spermicidal jelly. However, they require a doctor's prescription, must be fitted for each woman and must be inserted correctly, which can be difficult. Consequently, they are not the method of choice for many young females. Remember, even if you use a spermicidal jelly, **the diaphragm does not protect you or your partner from any STDs, including HIV.**

Latex Condoms are very effective in both preventing pregnancy and the transmission of HIV. They are also useful in preventing the transmission of HIV during oral sex, using male condoms on men and female condoms for women. Those who rely on condoms must realize that they should check the expiration date of a condom before using it. Do not use any condom with perforations, punctures or tears. The use of a spermicidal cream, jelly or foam, can add an additional layer of protection if the condom should happen to break, as well as help prevent breakage due to friction. However, the skin can be irritated by spermicides, leading to skin breakdown or sores, so large amounts of spermicide should not be used. For anal sex, since the anal canal does not have any natural lubricant, you should recommend using either extra strong condoms or, better yet, a water-based lubricant. Other things to keep in mind are that lambskin condoms are **NOT** effective in preventing the transmission of HIV or any other virus. Also, for those men who complain that they lose sensation when they use a condom, you can suggest putting a little spermicidal jelly inside the condom to enhance sensation. **Remember, you should NEVER use an oil-based lubricant with a condom, since it will dissolve it!** Perhaps most obvious to medical students, but not to others: **Only use a male or female condom once!** **FINALLY, INSTRUCTION ON THE CORRECT USE OF CONDOMS CAN RAISE THE EFFICACY TO NEAR 100%!**

Dental dam is a fancy word for a square of latex. They can either be bought as such, or made by simply cutting up the side of a condom lengthwise. Their main purpose is to prevent the transmission of HIV and other STDs when performing oral sex on a woman. Also useful is a square of plastic wrap.

Spermicidal creams/jellies/foams are a very effective second line of defense but are not effective when used by themselves. Although the chemical Nonoxynol-9 has received much press as being viricidal, it is now believed that all spermicides are effective in lysing the HIV virus. However, they have the potential to irritate the skin of the penis and the lining of the vaginal canal, so large amounts should be avoided. (Try to keep aware of further changes on this subject). One thing you should be aware of is that foams should never be used in the anal canal since they can cause severe mucosal irritation.

The pill is very effective in preventing pregnancy, but offers zero protection against HIV!

Oral sex can transmit all STDs except *Trichomonas vaginalis*. This is readily apparent by the presence of Herpes Simplex II lesions on the mouth of those performing oral sex. The data on HIV has not been compiled as yet, but knowledge of where the virus is found and how it can be transmitted should provide you with enough arsenal for the average adolescent. *You are at risk for getting HIV from performing oral sex on someone.* The highest risk is if it is to a woman who has her period (blood, right?). Since there is an enzyme in saliva that may kill HIV, performing oral sex is a lower risk than unprotected anal or vaginal intercourse. Also, performing oral sex on a woman is a lower risk than on a man, since the volume of semen is greater than the volume of vaginal secretions. Take only educated risks—you may decide to have unprotected oral sex with a person who has never had unprotected intercourse with anyone, but decide to use a barrier (condom, dental dam) with someone else who has had many partners. **Receiving oral sex** is a lower risk for transmitting HIV. If the person performing the oral sex has bleeding gums and the recipient has a break in the skin, there is a risk. Overall, the take-home message is that there is a definitive risk for both partners when performing oral sex. The easiest way to protect oneself is through the use of a barrier, either a condom or a dental dam.

Safety of the Blood Supply

The Red Cross does several things to protect the blood supply.

1. Since the spring of 1985, the Red Cross has been testing all donated blood for antibodies to HIV. The ELISA and Western Blot tests are used. Any blood that tests positive is destroyed.
2. Self-Exclusion: Anyone who has participated in high-risk activities is asked not to donate. See “What You Must Know Before Giving Blood.”
3. Donors are screened for early symptoms of HIV infection (swollen glands, fever, diarrhea, night sweats, weight loss).
4. Donors can anonymously request that their blood not be used, even after they leave the donor center.
5. Autologous blood donation is recommended, that is, in some cases people can donate their own blood to receive in surgery.

Taking all of the precautions into account, the chance of becoming infected from a blood transfusion is 1 in 100,000.

Clotting factors for people with hemophilia are heat- and chemical-treated to kill any HIV. Therefore, these products are now safe. In addition, many of these products are now recombinant products and therefore not derived from donated blood.

You cannot get HIV from donating blood. All equipment (needle, blood bag, etc.) is only used once then disposed of properly.

Spectrum of HIV Infection

This section details the progression of HIV from infection to “Full-blown AIDS.”

Infection

Point at which virus is taken into the body. From this point on, the person is infectious (can transmit the virus to others).

Seroconversion

Point at which HIV antibody test is positive.

There is a time period between infection and seroconversion (known as the “window period”). This is the time it takes for the body to create enough antibodies to HIV for the test to detect them (see “Testing”). Most people will develop antibodies in six to 12 weeks, although some may take up to six months or even longer. Remember that those tested via the PCR test will be positive within two to three weeks of infection.

During this stage, most people show a mild mononucleosis-like illness whose signs/symptoms include fever, diarrhea, weight loss, fatigue and swollen lymph glands. However, more severe initial infections, such as aseptic meningitis, are common.

Asymptomatic:

During this time the person is infected and infectious, although they show no symptoms of HIV infection.

This state lasts about five to 10 years, although it can be shorter or longer.

It is important to point out that you cannot tell if someone is infected just by looking at them. In fact, most people do not know if they are infected.

AIDS

The diagnosis of AIDS is both a clinical and laboratory one and is constantly changing. A few of the more common ones seen in the United States are described in greater detail below.

Constitutional disease. This basically refers to the wasting syndrome associated with AIDS. The patient usually has a severe weight loss due primarily to severe diarrhea. The cause of this is unknown, but recent evidence has pointed towards either Cytomegalovirus or Cryptosporidia. No effective treatment for this has been found. Please note that although “wasting syndrome” is not part of the Centers for Disease Control definition of AIDS, it is included in the World Health Organization definition.

Neurologic disease. The current literature suggests that every HIV+ person will eventually progress to develop CNS disturbance if they do not succumb to an opportunistic infection. This usually presents as a chronic progressive dementia. This is believed to be caused by HIV itself. A more acute and fulminant form of dementia called Progressive Multifocal Leukoencephalopathy is exceedingly rare but found in a much higher percentage of AIDS patients than in the regular population. Its etiology is thought to be a Parvovirus at this time.

Opportunistic infections. These are, by definition, infections that are found only in individuals who are immunocompromised, and not in the general population. Some of the more common ones include:

1. **Pneumocystis Carinii Pneumonia.** This is the most common opportunistic infection seen in AIDS

patients (excluding the wasting syndrome). It currently has a 50 percent mortality rate, and most patients are treated prophylactically with Bactrim to prevent infection once the infected person's T4 count is less than 200.

2. **Candida albicans.** This fungus very often causes an oral mucosal infection known as "thrush." However, systemic candidiasis is not uncommon. In addition, many HIV-positive women present with recurrent vaginal yeast infections.

3. **Cryptococcus neoformans.** This fungus causes a severe meningoencephalitis with high mortality.

4. **Toxoplasmosis.** A parasitic infection caused by *Toxoplasma gondii*. It usually presents a focal encephalitis with numerous brain abscesses, although multiorgan involvement is not uncommon.

5. **Mycobacteria.** These cause a variety of infections in AIDS patients. The most common, *M. tuberculosis*, is the cause of tuberculosis, and there has been a much higher rate of reactivation of the bacterium in HIV+ patients. As a result, HIV+ patients with active TB are not considered to have AIDS, according to the new CDC definition. *M. avium-intracellulare* (MAI) is an

atypical Mycobacteria which causes systemic infections in immunocompromised patients and is very common in AIDS patients.

6. **Cancers.** Patients with AIDS are more likely to get certain cancers than the general population. It is not known why they appear, but it is believed that they are not directly caused by HIV itself. The three most common cancers seen with AIDS are:

1. **Kaposi's Sarcoma.** This is a cancer of the endothelial lining of small blood and lymph vessels. It is found on the skin as well as on the mucous membranes. In severe cases it can infiltrate any and every organ in the body.

2. **CNS Lymphoma.** Patients with AIDS are at a much higher risk for a primary CNS Lymphocytic Lymphoma.

3. **Cervical Cancer.** Women who are HIV+ are more likely to develop cervical cancer. This has recently been included in the new definition of AIDS.

Once someone develops full-blown AIDS, the mean survival time is less than two years with rapid death in two to three weeks not being uncommon.

Terminology: Tips, Trips and Traps

These comments are meant to help those creating and delivering education and training to be as clear as possible. Terminology reveals the biases and perspectives of those who create it and as educators we want to borrow other terms carefully. Our objective is to give providers a clear description of the unseen behaviors of those they see in their clinical practices so they can better respond to the epidemic. Words that are charged with history and emotions can obscure the case at hand.

Make clear and consistent distinctions between AIDS and HIV. HIV is a virus and being HIV+ is the state of having an infection. AIDS is not a disease but a syndrome; it is also used to characterize the final stage of HIV infection. Use the term disease when meaning a specific pathological process.

In referring to persons affected by this epidemic, use terms that accurately portray their identity as people first and foremost. Use empowering terms and not ones that make individuals passive or helpless, such as victim. Those with AIDS and HIV infections now use the terms "person with HIV infection" and "person living with AIDS (PWA)." The latter often replaces the "person with AIDS" term and focuses attention on the increasing importance of the day-to-day problems that become greater as diagnosis is earlier and the episodic infections are successfully treated.

Similarly, "children with AIDS" or "person with AIDS" acquired from a blood transfusion are preferable to

"innocent victim." Use "person with hemophilia" and not "hemophilic."

Care should be taken in characterizing sexual behaviors. Homosexuality, heterosexuality and bisexuality are commonly used as rigid classifications of behaviors, beliefs and social norms. This is not the case, since in these groups there is considerable variation in sexual practices and other behaviors. "Sexual practices" is the preferable term because it refers to the behaviors themselves and does not limit a behavior to a particular sexual orientation. "Life-styles" associated with HIV infections are not as clear as in earlier stages of the epidemic when only "gay" men and drug users were thought to be involved.

IVDU (Intra-Venous Drug Use) is a term that describes only one of the means of transmitting HIV with a hypodermic. It does not cover other parenteral modes of injections, such as skin popping and intramuscular. Instead, use "TV Drug User" or "Drug User." Avoid the judgmental "abuser" and be clear about the roles of drugs in transmission: HIV can be transmitted via contaminated paraphernalia used for "recreational" drugs, steroids, in making tattoos and in ear/body piercing.

Use the terms "sex-for-money" or "sex-for-drugs" in preference over prostitution to convey some of the contexts and contingencies surrounding the actual behaviors. Prostitution limits attention to adult women/men who have sex for money as their primary occupation.

SECTION III

The Curriculum and Teaching

By this point, enough information has been presented that the actual task of teaching must be addressed. As mentioned in the introduction, teaching can be very difficult and frustrating at times. Unfortunately, this is also the one area where there are no definite answers. Everyone who reads this manual will naturally have a different approach to teaching, dictated not only by their personality, but by the personality of their students as well. Consequently, we have included in this section general information and a wide variety of different teaching methods. In addition to a breakdown of characteristics found among students within

specific grade levels, a variety of different games and exercises has also been included. You do not have to use all of these games; as a matter of fact, you may develop better ones of your own (if you do, please send them to us so we can include them in the next edition). Therefore, please see this section as suggestions or ideas that have worked for other STATS programs around the country. If you do not feel that any of these games are appropriate for the area in which you are teaching and are having a hard time developing games of your own, please do not hesitate to contact the national STATS coordinator.

Educational Methodologies for Teaching About HIV Infection

As students yourselves, you probably realize how boring a lecture can be. Therefore, you can imagine how boring it can be for a ninth-grader if you stand up in front of the class and just ramble off facts for 90 minutes. Remember, teaching about HIV infection and AIDS requires a great deal of discussion about sexuality, risk behaviors, values, attitudes and safer sex techniques. Consequently, discussing sexuality in a classroom setting with students and teachers who are not familiar with you as an instructor may raise anxieties and lower eyelids.

In the field of human sexuality, sensitive topics, such as safer sex, often confront attitudes and values as well as religious beliefs. All STATS instructors must be sensitive to these issues with all classroom presentations. A STATS instructor must also keep in mind that this is not the forum for expressing opinions. It is critical that this information be presented in a neutral, objective manner.

Knowing how to teach in a sensitive manner can help decrease anxiety and make your audience less threatened. Different approaches to teaching, such as role-playing, videos, games, etc., may work for you and others may not.

It is essential that you explore your own comfort levels with the topics and the teaching methodologies prior to entering a classroom. Although lecture format can be used for a brief overview of the facts or updates on HIV, students can become bored and often shut off the instruction. Most students you will be encountering are used to lecture format and will be receptive to alternative ways of learning.

Since this is peer teaching, we recommend casual or business casual dress—clean jeans and tee-shirts or sweaters and slacks. Wearing a white coat, tie, etc., tends to alienate the audience and defeats our purpose—to relate to them. We talk *with* the students rather than *at* them.

Also, arrive before the class is supposed to start. This gives you time to write the timeline, national AIDS hotline number, etc., on the board before the students get there. You can also talk with the teacher about the class and greet the students and learn some of their names before the class actually begins. If you are able to, set up the class in a half-circle so people are looking at each other and not the back of someone's head.

General Teaching Outline

One of the hardest things to do when running a STATS session is to actually decide what you are going to do with your time. As a result, we are enclosing a sample outline of how a STATS session should run. We recommend that you go to each class twice, each time for approximately 90 minutes. We know that some schools will not accommodate that request and you may not have the luxury of having that much time. As a result, all items marked with an asterisk we feel are essential and should be completed whether you have 45 minutes or two hours, as long as they don't conflict with local restrictions.

1. * Introduction—

Introduce yourself and your partner (who should be of the opposite sex), *set ground rules* and perhaps give some statistics about HIV in that area of the country (3-7 minutes).

Good Ground Rules:

- Respect others. No interrupting, ridiculing or intentionally embarrassing another student or educator.
- Confidentiality. Say something like, "Everything in our discussion should remain confidential. What is said between the students during the class is not to be discussed later with students outside the class."
- EVERY question and comment is helpful.
- All disagreements must be polite. Personalities do NOT belong in them.
- Everyone has the right to NOT answer a question.
- We will not request personal info from one another. This puts an end to one of my favorite questions, "What kind of condom do YOU use?"

2. **Video**—

Some STATS programs have been showing an AIDS video, such as the Magic Johnson video, in order to initiate discussion about HIV. Although it has proven helpful (as have slide shows), we realize that not all schools have the audio-visual capabilities to accommodate your needs. We will list some sample videos later.

3. * **Knowledge Testing Games**—

Games such as “Pros and Cons” and “Risk Sheet” are essential to assess their knowledge, especially for younger children. Although the main goal of STATS is to eventually modify risky behavior, it is essential that all children you instruct have basic knowledge about HIV and AIDS. The time to complete this will depend greatly on the knowledge of your class.

4. **Behavior Modification Games**—

Scenarios and other games that force the students to connect facts and actual behavior are the actual goal of STATS. Too often, kids will say one thing and then do another. Exercises such as these should be the main focus of your presentation, especially if it is the second or third visit to the same class.

5. * **Condom Demonstration**—

Again, this is essential. Studies have shown that condoms are only 60 percent effective among teenagers. This is not due to defective condoms but to defective use. If you tell the kids about condoms but do not explain, in detail, how to

use them, then they are not much better off than before. We realize that some schools may not allow you to bring condoms into the classroom and most will probably not allow you to distribute them, but do the best you can (use bananas and balloons, etc., to demonstrate). This type of situation is perfect for the “Condom Comfort” game, since it will still give the kids the correct information.

*

6. ** **Anonymous Questions**—

This is essential and no STATS teacher should ever forget to do this (the actual procedure is explained in the “Games” section). Remember, you are dealing with many kids who are self-conscious and possibly embarrassed to ask questions about sex in front of their peers. Make sure that you leave at least 10-15 minutes (based on a class of 20 kids) to answer questions. If you will be returning to the class within a short period of time (less than one week), then it is acceptable to answer them upon your return.

Overall, there are a few important take-home lessons. First, you must make sure that the kids get all of the essential information (some programs give handouts with hotline numbers, essential facts, etc.), but you should do this in a way that is comfortable for you. Remember, if you are comfortable, the students will be more likely to open up to you. Secondly, you should tailor a specific style of teaching for you and your partner. Practice ahead of time and see who does what better. Finally, remember whom you are teaching; kids in different areas and environments will have different knowledge levels.

Modifications For Grades Four Through Six

These younger students are different from the teenagers normally taught in STATS classes. While they may be exposed to the same amount of sexual information and drug use as the older students, many will not be actively participating or have the more explicit knowledge found in teenagers. Again, it depends on the population of students you are teaching. Here are some ways to modify your STATS program to reach the younger students.

1. Keep in mind that the attention span of these students is usually shorter than that of older students. They do not always understand abstract concepts as well as older students—such as the concept presented in the Envelope Game. Also, use concrete examples that the kids can relate to—Pac-man gobbling up dots for WBCs phagocytizing bacteria and viruses. These students may also have some difficulty distinguishing between HIV and AIDS. Explain the difference and see how they do—if they can’t distinguish between them, don’t force the issue.

2. Students at this age are much more impressionable than teenagers, which is both good and bad. The advantage is that they are more likely to believe anything you say; the disadvantage is that it can be more difficult to explain concepts in a way they can understand.

3. We are reaching these students when the majority will be on the threshold between seeing sex and drugs in the media (and possibly around them) and actually experimenting with these behaviors. (This will vary with the students you are teaching.) This means that a large part of the focus of the STATS lessons—normally on safer sex and “clean” drug use—is not a major area of emphasis in this population. These topics *should* be discussed at a depth these students can handle.

4. A great idea is to train your teen STATS students who are interested in helping teach the younger students and have one join your pair of medical student teachers. The teens really enjoy being able to help and the younger students appreciate having “peers” to whom they can relate.

5. A big focus for this age group is decision-making skills. The focus doesn’t have to be on sex, drugs, etc. See the scenarios in the games section for some ideas on how to incorporate this skill-training into your classes.

6. Assertiveness/refusal skills training is another skill to incorporate into your classes. Teaching students at this age that they are responsible for their health is a great way to teach life-long behaviors.

7. Students at this age will ask some incredible questions. “If you get AIDS from having sex, why don’t people just stop having sex?” Be prepared for some very pointed questions. Just keep your wits about you and use common sense—you’ll be fine. As always, don’t weenie around the point—be honest. Kids can see through lies easily. And if you don’t know the answer, just say so. Sometimes there are no answers, just choices.

8. Some suggestions have been made to teach boys and girls separately at this age. This has both positive and negative points. The positives include less fear in asking questions (from both sexes) and less disruptive behavior. The negatives: 1) each group wonders if they are being told the same things as the other group (when the girls were split off in fifth grade for the movie on menstruation—the boys at my school got to play dodgeball!); 2) not as much discussion and exchange of ideas between the sexes (something that’s a problem at every age); and 3) splitting up the teaching team. We recommend that the sexes stay together, unless the school/center requires you to teach them separately. Even then, bring them back together and go over each group’s thoughts and ideas so that they can hear what each thinks.

9. Many students may be anxious about catching HIV and AIDS. They should be realistically reassured. They should be taught that risk for HIV is linked to certain behaviors over which they have control.

10. Important concepts to cover:
- HIV is a virus—just like the flu and a stomach virus. Point out similarities and differences, e.g., you can’t catch it from sneezing, etc.
 - You can’t tell whether someone has HIV from just looking at them.
 - Common AIDS-related illnesses.
 - People in every state and most other countries, from both sexes, every age, every occupation, all types of communities, and all nationalities have been infected with HIV. *NO ONE IS IMMUNE!*
 - Transmission should be discussed in general terms—sexual contact, sharing needles and mother to infant. Also, be prepared to identify the four fluids containing HIV. Details should be individualized to the sophistication of the class being taught.

Teaching Pointers for Older Students

For those of you who are a little hesitant to go out and teach a class because you are not sure how to teach junior and senior high school students all of the facts we have taught you, read on. Here are some simple facts and sample ways to present them that have worked in the past.

1. As you start your first session, it is important to warn people to be sensitive to the feelings of others. For instance say: “Today we’ll be discussing a really sensitive topic that is difficult to talk about. We want you to feel comfortable talking to us and each other, but try to remember that there might be a homosexual male or female here, a bisexual or heterosexual person or a virgin. Try to phrase your comments in a way so as not to offend anyone, whatever your own beliefs are.”

2. It is often important to discuss the immune system and how it works in general terms. A good way to do this is: “This might seem a little silly, but would everyone please take a deep breath in (breathe), and now let it out (hhhh).

A: (*first teacher*) As you pulled air in, your RBCs (red blood cells) picked up oxygen, and as you exhaled, your RBCs let CO₂ escape.

B: (*second teacher*) But what about all the bacteria and fungal particles and dust that are in the air every-day?

A: Well, there are cells in our nose, throat and lungs that attack these particles by engulfing them and

eventually killing them—this is part of the immune system.

B: There are other types of cells that do the same thing but they are located in your blood; these are the WBCs (white blood cells). The problem is, you have a lot of blood and very few cells that recognize each different foreign particle.

A: Don’t worry—our bodies have overcome this problem. In our blood we have helper cells (T4 or CD4). When these cells are stimulated, they **help** stimulate other types of WBCs and enable the body to fight foreign particles at a much faster rate.

B: Right, so we don’t usually get sick when we inhale a foreign particle or get a cut or a splinter.

A: Unfortunately, people who have become HIV positive begin to lose their helper cells and have trouble mounting attacks against foreign invaders. The HIV virus not only attacks WBC, but also attacks all cells throughout the body.

Okay, enough of this word-by-word syllabus. The rest of the facts presented on this sheet will be simply stated with a few brief suggestions below them. Please remember that the above two examples do not have to be used word for word, nor do any of the examples have to be used. They are simply useful facts that you might want to use in your presentations.

3. Something that we have found particularly useful is the HIV/AIDS timeline. (Note, it is more effective to write the words associated with the letters, rather than the letters, on the timeline.)

A-----> B-----> C-----> D-----> E

- A. Risky behavior—exposure to HIV virus
0 weeks
- B. Slight cold, flu-like symptoms
2 weeks
- C. Will test HIV positive (Antibody test)
3 weeks to 6 months
- D. Become symptomatic or T count<400 (AIDS)
5-10 years
- E. Death
1.5-2 years following D.

Ideas:

1. List or ask students to list risk behaviors
2. Talk about the four fluids (see #7 below)
3. Talk a little about the immune system
4. Talk a little about some of the infections that people with AIDS get and why they are so dangerous.

5. Ask the students to add up how much time it takes for someone to come down with AIDS after they are exposed to the HIV virus and combine with the statistic that a significant portion of newly diagnosed AIDS cases occur in people between the ages of 20 and 29.

6. Remind the students that from the time of the risky behavior, the person can infect others and not even know that they are doing so.

7. The four truly infectious body fluids are:

	<u>Average { } in fluid*</u>
a. Blood	10,000 particles/dl
b. Semen	8,000
c. Vaginal Secretions	5,000
d. Mother's breast milk/ feeding	4,000

** Please NOTE, these numbers are rough estimates to show the relative risk as compared to the other fluids.*

8. Saliva, sweat and tears have 1 particle/dl transiently. The presence of the virus in these three fluids is of considerable concern to teenagers. It is extremely important to stress that one virus particle may be present in a given fluid at 12 o'clock, gone at 12:15, and not present at 11:55 either, but in any case, there is **not** enough virus for transmission according to the most recent research.

Psychosocial Impact of HIV

Dealing with the psychosocial impact of HIV infection is often equally as painful as the actual physical symptoms associated with both early and later stages of HIV infection. Understanding the psychological and social ramifications of this disease, for both you as an instructor and for your student audience, is necessary to help students confront their attitudes and beliefs about the disease and PLWA (People Living With AIDS). Empathy towards these HIV-infected persons may help break down negative perceptions and myths surrounding the disease. Many times society's response is to reject and "blame the victim" for the behaviors that led to an individual acquiring this disease. Discussion about the psychosocial stressors and the harsh realities of HIV as a disease can help you as an instructor reach beyond the facts and into the hearts of the students.

TOPICS TO BE COVERED:

1. Psychological Ramifications

- Issues surrounding testing, contact-tracing and informing partners
- Testing sites: confidentiality vs. anonymity
- Depression and other psychological disorders
- Loss of loved ones due to rejection
- "Coming out" for a gay person

- "Blame the Victim" syndrome
- Religious/spiritual needs of the person with AIDS (PLWA's or HIV-infected)

2. Financial Burdens

- Issues surrounding illness and employment
- Discrimination in the workplace/being ostracized
- Loss of stable income due to increased illness
- Increased costs for medical care/treatments
- Loss of insurance and/or the raising of premiums to astronomical levels
- Significant others taking on financial burdens
- Need to alter life-style, e.g., moving, traveling, comforts

3. Quality of Life

- Acceptance of decreased life-span
- Frequent hospitalizations
- Debilitation and decreased mobility
- Pain, depression and loss of control over one's life
- Stress reactions, both physiological and psychological
- Family's acceptance/moving back home
- Dying young

4. Ethical Issues/Legal Concerns

- Medical community's response to HIV-infected persons
- Societal prejudices/moral implications of the disease

- Health and life insurance policies cancelled
- Confidentiality in the workplace
- Social Security/Medicare access

Useful Facts and Statistics

- It took 10 years for the U.S. to have 100,000 AIDS cases.
- It took only two years for the U.S. to get its second 100,000 AIDS cases.
- As of June 30, 1997, 612,078 cases of AIDS have been diagnosed. In men >13 years old—511,934; in women >13 years old—92,242; in children 13 and under—7,902. Of these cases, 379,258 are now dead—374,656 were >13 years old and 4,602 were 13 years old or less.
- In 1985, the breakdown of AIDS cases was as follows:
 - 66% were men having sex with men (MSM)
 - 93% were men
 - 17% were IV drug users
 - 7% were women
 - 2% were heterosexual
- In 1995, the breakdown of AIDS cases had changed to the following:
 - 42% were MSM
 - 81% were men
 - 26% were IV drug users
 - 19% were women
 - 11% were heterosexual
- Of the 11% of heterosexual transmissions in 1995:
 - for newly infected women (65% of cases):
 - 37% were partners of an IV drug user
 - 59% don't know how their partner was infected
 - for newly infected men (35% of cases):
 - 33% were partners of an IV drug user
 - 65% don't know how their partner was infected
- Breakdown by region of the U.S.:

	<u>1985</u>	<u>1995</u>
Northeast	42%	31%
South	24%	36%
West	28%	20%
North Central	6%	10%
- 30,671 cases of AIDS (42%) were reported in men having sex with men, esp. in the 13-19-year-old age group.

	<u>1985</u>	<u>1995</u>
African-Americans	25%	40%
Hispanic	15%	19%
Caucasian	60%	40%
Other	—	1%
- In 1994, one in three deaths of African-American males aged 25-44 was due to an HIV-related illnesses; this rate was one in five of African-American females of the same age.
- Between 650,000 and 900,000 persons in the U.S. are HIV+, with 40,000 new cases per year (1995 statistics). Of the 40,000 new cases, 10,000 are in people between 13 and 20 years of age—that's two people newly infected with HIV every hour of every day.
- Fastest growing group of newly HIV positive people is 15-year-old females.
- In newly infected individuals 13-24 years old in 1995:

males:	55% were men having sex with men
	10% were from IV drug use
	6% were from heterosexual contact
females:	51% were from heterosexual contact
	17% were from IV drug use
- Risk of transmitting HIV from mother to unborn child is about 40%; however, this decreases to 10% with AZT prophylaxis.
- Prostitute population is 60-75% HIV positive.
- HIV virus is thought to have existed for a longtime but only recently mutated enough to infect humans.

What to Bring to a Session

The answer to this is obviously very dependent upon who your audience is and what games you decide to play with them. Some basic rules of thumb are:

1. Bring copies of the Pre/Post Test to be completed by the students. Also have the teacher and student evaluation forms with you (these can be found on the enclosed disk).
2. Bring as many handouts and items for distribution as possible. The more they can bring home with them, the more they will remember.
3. Bring more than one condom so you can demonstrate the right and wrong way to put it on. Bring bananas or balloons as props for demonstrating the condoms.
4. You may wish to bring the AIDS Hotline Sheet seen on the adjoining page so the students can practice calling it.
5. If you have access to cheap or free photocopies at your school, it would be great if you could prepare a handout

with the location and phone numbers of both national and local AIDS Hotlines and testing/counseling centers.

6. Some groups like to make an outline of all of the facts about HIV/AIDS that they will discuss, and distribute it to the students at the end of the class.
7. Do not forget the classroom teachers! They have to be able to answer questions these kids may have about HIV/AIDS the other 200 days of the school year! Provide them with as much information as possible so that they can fulfill this duty.
8. DO NOT FORGET TO HAVE THE EVALUATIONS FORMS FOUND ON THE DISK FILLED OUT SO THAT YOU CAN HAVE ACCURATE FEEDBACK ON YOUR PROGRAM'S PERFORMANCE.
9. Do not forget to send the results of the Pre/Post test to the National STATS Coordinator.

Pre-test/Post-test

The pre-test and post-test are important in evaluating the effectiveness of our teaching program and in assessing the target population's fund of knowledge. Pre- and post-test forms can be found on the disk. Because so much class time is necessary to distribute, administer and collect even the simplest of quizzes, we strongly recommend that the test be administered **on the days before and after the curriculum is taught**. No names are required on the tests because they are designed to evaluate *you*, not the students. When your pre-test and post-test scores are

tabulated, please send the results (or the originals) to the AMSA National Office. We are accumulating a database to use in revising the project and in obtaining funding for future project expansion. Your results can be sent to:

STATS Project
c/o AMSA Resource Center
American Medical Student Association
1902 Association Drive
Reston, VA 20191

Criteria for Evaluating an AIDS Curriculum: A Summary of the Report by the National Coalition of Advocates for Students

DISCLAIMER—This section is included as a source of reference and was not compiled by either STATS or AMSA. It is included solely to serve as another viewpoint on the development of a good AIDS curriculum. The information is presented verbatim from its original source and therefore much, if not all, of the information has been repeated elsewhere in this manual. (Copyright, National Coalition of Advocates for Students, used by permission.)

Curriculum Content

1. Does the curriculum help students acquire the necessary self-esteem and assertiveness to choose to abstain from sexual intercourse?
2. Does the curriculum inform all students about effective ways to prevent infection when they become sexually active, including information about condoms and their correct use?
3. Does the curriculum focus on teaching students how to make healthy sexual decisions and not just on the medical aspects of AIDS?
4. Does the curriculum strongly convey the message that **ANYONE** can get AIDS, regardless of race, sex, age or sexual orientation?

Developmental Characteristics of Students Grades 6 through 9

Students are likely to be:

- engaged in a search for identity (including sexual identity); asking “Who am I?” and “Am I normal?;” very centered on self;
- influenced by peer attitudes;
- concerned about experimenting with relationships between boys and girls;
- confused about the homosexual feelings many of them will have experienced;
- worried about the changes in their bodies;
- able to understand that behavior has consequences, but may not believe the consequences could happen to them;
- fearful of asking questions about sex that might make them appear uninformed.

Grades 10 through 12

Students are likely to be:

- still struggling for a sense of personal identity, especially those who are confused about their sexual identities;
- thinking that they “know it all”;
- seeking greater independence from parents;
- open to information provided by trusted adults;
- near end of this period, beginning to think about establishing more permanent relationships;
- experiencing an illusion of immortality;
- sexually active

Appropriate Approaches to AIDS Education Grades 6 through 12

The primary goal is to teach students to protect themselves and others from infection with the AIDS virus.

- Students should learn all of the information listed under “What Adolescents Should Know About AIDS” (next page).
- AIDS issues should be made as real as possible without overly frightening students. Movies about, or classroom visits from, people with AIDS have helped students in some schools overcome their denial of the disease and give AIDS a human face.
- The focus should be on healthy behaviors rather than on the medical aspects of the disease.
- Students should examine and affirm their own values.
- Students should know they have a right to abstain from sexual intercourse or to postpone becoming sexually active. They should be helped to develop the skills to assert this right.
- It must not be assumed that all students will choose abstinence or heterosexuality.
- Information about AIDS should be presented in the context of other sexually transmitted diseases (STDS);
- Students should rehearse making responsible decisions about sex, including responses to risky situations.
- It is important to be honest and to provide information in a straightforward manner. Be explicit. Use simple, clear words. Explain in detail and use examples.
- Sexual vocabulary **should** be connected with slang, if necessary, to be certain students understand the lesson.
- It is important to be non-threatening and to work to alleviate anxiety.
- Students should be given the opportunity to ask questions anonymously.
- Discussion of dating relationships can provide opportunities to teach decision-making skills. Students should be helped to think through how to make responsible decisions about sex before questions arise in a dating context.
- Teaching about AIDS is often enhanced by:
 - movies and other visual aids;
 - role plays and other participatory exercises
 - same-sex groupings (to encourage more candid discussion), followed by sharing in a mixed-sex group (to increase comfort level in discussing sexual subjects with members of the opposite sex.)
 - involvement of students in planning and teaching—let young people speak the message to each other whenever possible.
- AIDS education should also include discussion of critical social issues raised by the epidemic, such as protecting the public health without endangering individual liberties.
- Teachers should have resources to help students find answers to detailed medical questions.

- Students should be taught skills that will enable them to continue to evaluate the AIDS crisis.

What Adolescents Should Know About AIDS

The information adolescents need is simple and straightforward. Home and school instruction should emphasize prevention through teaching safe behaviors. While adolescents need only minimal knowledge of the medical aspects of the disease, some may seek a more in-depth understanding of the virus and its manifestations. Teachers and parents should be prepared to answer their questions.

This is what should be appropriately communicated to all adolescents:

Definition of AIDS

A disease syndrome triggered by infection with the human immunodeficiency virus (HIV) which weakens the immune system causing the infected person to catch certain diseases that healthy people can fight off, but that can be fatal to a person with AIDS. Unlike most infections, HIV infection does not go away. The virus remains in the person's body for the rest of her or his life.

Transmission of HIV

HIV is extremely difficult to catch. It is not transmitted by casual contact such as hugging, sneezing or sharing bathrooms. There is no danger of getting AIDS by donating blood. A few years ago, some people became infected with HIV through receiving blood transfusions. Now, however, all blood donations are screened and tested so that the blood supply is quite safe.

HIV is transmitted in three main ways:

1. through infected semen and vaginal secretions (by vaginal or anal sexual intercourse or, possibly, by oral sex);
2. through infected blood (by sharing intravenous IV drug needles or using unsterile hypodermic needles for steroids, tattoos or any other purpose);
3. from an infected mother to her child either before or during childbirth and, possibly, through breast milk.

Anyone who engages in risky behaviors can become infected, regardless of gender, sexual orientation, age or race.

Three Manifestations of Infection

1. Many people who are infected with the virus have no symptoms of disease. Since they look and feel healthy, these people may not know they are infected. They can, however, transmit HIV to others through unprotected sexual intercourse, sharing unsterile needles or childbirth. Many, if not all, of these carriers will eventually become symptomatic. Most of them, however, will not become sick for three to seven years or more after exposure.
2. Persons who are infected with HIV may have no symptoms of AIDS, but can be considered to have AIDS because their CD4 count is below 400. (Note: This

number is constantly changing and maybe up to 500 in a year or two, so it is your responsibility to keep abreast of all changes.)

3. Manifestations of AIDS can include opportunistic infections and cancers, as well as neurological and psychological problems.

Testing

It is now possible to test blood, in most cases, to determine if a person is a carrier of HIV. At this time, the Centers for Disease Control and the U.S. Surgeon General do not recommend testing of the general population. It is also illegal to test anyone without first gaining their consent. However, men and women who are considering parenting and who practice risky behaviors are advised to be tested. (Anyone thinking of being tested should contact an alternative test site which tests anonymously and offers pre- and post-test counseling.) State and local public health departments can give addresses of local testing facilities. (See Testing Sites Fact Sheet for a more detailed explanation.) *

Adolescents can prevent AIDS by:

- abstaining from or postponing becoming sexually active;
- only having sexual relations within the context of a mutually faithful relationship with an uninfected partner. (However, you must emphasize that people do cheat on their "mates" and therefore no relationship can ever be assumed to be 100% mutually exclusive.)
- always using latex condoms (even in combination with other birth control) from beginning to end of all types of intercourse, preferably with a spermicidal containing nonoxynol 9;
- not using intravenous drugs or having sexual relationships with someone who does. Those who do should never share needles or syringes and should be encouraged to enter a drug treatment program. Those who continue to share needles should be told how to sterilize their equipment. Tattoo needles and needles used for injecting bodybuilding hormones or for piercing ears or other body parts should also never be shared.

Local Telephone Number

Students should be given a local telephone number to call for additional information. *Sources of AIDS information in other languages should also be provided.* Some local AIDS hotlines have Spanish-speaking staff available during certain hours. Find out what these hours are and provide this information to Spanish-speaking students. Health clinics and other community organizations serving Latino, Chinese and other language minority communities may also be able to provide AIDS counseling in those languages.

National AIDS Hotline

1-800-342-7514

AIDS information in English and Spanish
24 hours a day.

SECTION IV

Games

Teaming Up Against AIDS

Target grade levels: 7-12, but best for 7-10

Objectives:

1. Allow students to demonstrate what they have learned about AIDS facts and myths.
2. Encourage students to openly ask questions of each other when they don't know the answer to a question about AIDS.

Process:

1. This game is similar to a spelling bee. The class is separated into two teams. Each team forms a single-file line. One facilitator asks questions while the other keeps score on the blackboard or with a specially made scoreboard.
2. The facilitator asks the first question, and the person at the front of line #1 has ten seconds to answer. If a correct answer is given, two points are awarded. If there is no correct answer, the front player may ask a team member for help. If a correct answer is given by the fellow team member, one point is awarded. The front player then sits down, and the facilitator moves on to the other team for the next question.
3. The game ends when all class members have had a turn (when everyone is sitting down).
4. You may enjoy designing your own game to use with the questions below, e.g., "AIDS Jeopardy."

Questions:

1. What does AIDS stand for? HIV?
 - acquired immunodeficiency syndrome
 - human immune deficiency virus
2. What causes AIDS?
 - a virus
3. What are the two most common ways to spread the virus?
 - through unprotected sex or sharing needles
4. What two body fluids are most involved in spreading HIV?
 - blood and semen
5. How do drug users get HIV?
 - by sharing needles contaminated with the virus
6. Besides taking drugs, how else can you get HIV from needles?
 - from shared tattoo needles, piercing, steroids (IM)
7. What body system does HIV attack?
 - the immune system and other cells in the human body
8. People of what ages can get HIV?
 - any age
9. What type of diseases do people with AIDS get?
 - "opportunistic" infections
 - various types of cancer
10. If someone has HIV, how sick do they have to be before they can spread it to someone else?
 - they don't have to be sick at all
11. If you are thinking about sharing a needle with a friend, how can you tell if the person is safe (that is, that they don't have the virus)?
 - you can't be sure, so it is always unsafe
12. If you are thinking about having sex with your boyfriend or girlfriend, how can you tell whether or not you should have safer sex?
 - people who decide to have sex should always have safer sex
13. How does the virus spread in people who share needles?
 - blood from one person stays in the needle and goes into the next person
14. How do condoms reduce the risk of spreading the virus?
 - they are a barrier to keep one person's body fluids away from another's
15. Why are condoms less than 100 percent effective?
 - because they can break, they are used improperly, or both
16. For people who are dating, what is the only 100 percent effective way to prevent the spread of the virus?
 - do not have sex; do not share needles
17. How is HIV different from many other viruses, like the one that causes the common cold?
 - HIV is not transmitted via casual contact
 - our immune system is unable to overcome HIV
18. List two reasons other than HIV prevention for using condoms if someone does have sex.
 - avoid pregnancy, avoid other sexually transmitted diseases
19. List two myths about how people get HIV.

- mosquito, any casual contact situations, being a homosexual (gay), belonging to a “risk group,” donating blood, etc.
20. What is the cure for AIDS?
 - there is none; prevention is an acceptable answer
 21. The AIDS Hotline number is?
 - 1-800-342-AIDS
 - Phone number of local AIDS hotline
 22. Do all people infected with HIV develop AIDS?
 - doctors believe that all people who are HIV+ will eventually develop AIDS
 23. Is there a vaccine to protect people from getting HIV?
 - no, not yet
 24. How contagious is HIV (high, medium or low)?
 - very low via casual contact
 - high by sexual contact or other risk behaviors
 - very high via blood transmission and sharing needles
 25. Many of the AIDS cases so far have been in gay men. In the future, do scientists think AIDS will be more or less common in the heterosexual (straight) population?
 - more common
 26. Which race does HIV affect?
 - all races
 27. If someone has a positive blood antibody test, does that mean that he/she has AIDS or will get AIDS?
 - it only indicates exposure to the virus, the person is HIV+ and will most likely come down with AIDS in the future
 28. Have there ever been any reported cases of someone getting HIV from kissing?
 - no
 29. Have there ever been any reported cases of someone getting HIV from an insect bite?
 - no
 30. Can teenagers get HIV?
 - yes
 31. Is the supply of blood in blood banks now safe?
 - yes (but it is always safer to donate your own blood or have a family member donate for you.)
 32. How is the blood supply kept safe so that people receiving blood will not get HIV?
 - all donated blood is tested for antibody to HIV. Infected blood is thrown away.
 33. Many people, including many children, with one particular disease were infected by contaminated blood transfusions before the blood test was available. What disease do these people have?
 - hemophilia
 34. Most babies with HIV get it how?
 - from their mothers, either transplacentally, during delivery or breast feeding.
 35. In central Africa, the AIDS problem is much more severe than in this country. What is the main method the virus has been spread there?
 - heterosexual sexual intercourse
 36. What is the only way to know for sure if someone has been exposed to HIV?
 - A blood test, and even the test is not guaranteed if the person was recently exposed.
 37. What types of sex are believed to spread HIV (vaginal, oral or anal)?
 - all three, if no protection is used
 38. What are the two most common diseases that people with AIDS get?
 - pneumocystis pneumonia, CMV, Cryptosporidiosis
 39. What kinds of problems besides health problems do people with AIDS have to deal with?
 - other people’s fears, financial, work, housing, staying in school, etc.
 40. What can you do to help fight AIDS, besides making sure that your own behaviors are safe?
 - correct other’s myths, volunteer to help AIDS charities, help a person with AIDS, donate money to AIDS charities, etc.
 41. What are some ways to protect yourself if you do decide to have sex?
 - latex condoms with spermicide
 - Discuss sex and its consequences with your partner
 42. True or False? “Using an oil-based lubricant like vegetable oil, petroleum jelly or Vaseline will decrease the chance of a latex condom breaking and, thus, decrease the risk of being exposed to HIV.”
 - False, oil-based lubricants will damage a latex condom. Use water-based lubricants such as spermicidal jelly or water.
 43. What type of condom does not prevent the passage of harmful germs?
 - Natural or lambskin condoms

Pros and Cons

Target grade levels: all

Objectives:

1. To encourage teenagers to think of all the barriers to utilizing risk-reduction behaviors
2. To prioritize the barriers
3. To create ways of eliminating these barriers
4. To encourage the students to think of all the reasons they should use the risk-reduction behaviors

This exercise is simple, and all or part of it may be used to explore the pros and cons of various risk-reduction behaviors. The following behaviors can be explored: sexual abstinence, sexual fidelity, condom use, not taking drugs, avoidance of sharing needles or syringe.

Process:

1. The facilitator draws two columns on the chalkboard.
2. The students are asked to think of all the reasons they might not want to use a certain risk-reduction behavior. Their responses are listed in the first column.
3. The students are asked to think of all the reasons why they would or should use that risk-reduction behavior, and these are listed in the second column. Notice that many of the reasons in the first column can be crossed out as issues are raised in completing the second column.
4. If time permits, you may go back to the first column and ask the students to prioritize the top three barriers. They can be ranked by a show of hands.
5. Through class discussion, the students should then create solutions for eliminating each of the barriers.

Examples next page----->

Examples:

Risk-reduction

#1

Sexual Abstinence

No, I won't because...

Sex is fun
Peer pressure
My friends don't have HIV
Boyfriend/girlfriend might dump me
Only gays get HIV/AIDS
We're in love

Yes, I will because...

Protect from AIDS
Prevent pregnancy
Prevent other STDs
Infected person may look healthy
Anyone can get AIDS
Boyfriend/girlfriend will understand
Not ready yet

#2

Condom use

Embarrassing
Not spontaneous
Not available
She's on birth control (the pill)
He/she doesn't like them
Boyfriend/girlfriend won't allow it
Only 80-90% effective

Talk about this before
Have them handy
Readily available
Birth control (the pill) won't stop the virus
All who are informed are using condoms
Some protection better than none
If you love someone, wear a condom
(all the reasons for #1)

#3

Not using IV drugs

I will use IV drugs because:
Peer pressure
Drugs relieve stress
No HIV in my friends
I can't quit
Makes me feel good
Rebel against everyone
Experiment just once

I won't use IV drugs because:
Protect from HIV
Prevent overdose
I make my own decisions
Avoid addiction
Prevent hepatitis
Infected person may look healthy
Athletes have died of steroids and drugs
Drug treatment programs exist in most communities

#4

Monogamy

My friends will think I'm not macho
Haven't found right person yet
I'm too young to settle down

Less risk of AIDS
Less risk of STD
Would know more about partner's sexual and drug habits

#5

Needle Exchange

Would encourage use
Waste of tax dollars
Hard to distribute needles
Against the law in some states
Afraid of being caught

Less risk of Hepatitis and HIV transmission

RISKS

Target Grades: 7-10

Objectives:

1. To evaluate students knowledge about the basics of HIV and transmission
2. To dispel any myths about HIV
3. To facilitate discussion and interaction with the students.

Process:

1. Have one of the facilitators write the following risk column on the blackboard. If you wish, providing a handout for the students to write on would be even more effective.
2. For each item, ask the students under which category they feel it falls under. If two students disagree, encourage the debate.
3. Remember, you do not have to do every item on the sheet. You may wish to pick only the most controversial ones in order to spark “good” debate

Over---->

RISK SHEET

Activity	Definitely safe	Probably safe	Probably risky	Definitely risky
1. touching, hugging				
2. mosquito bites				
3. French kissing (wet)				
4. cough or sneeze				
5. oral-genital sex				
6. sharing drug needles				
7. social kissing (dry)				
8. anal intercourse				
9. swimming pools				
10. tattooing				
11. vaginal intercourse				
12. talking about sex				
13. sharing toothbrushes				
14. masturbation				
15. touching doorknobs				
16. abstinence (no sex)				
17. donating blood				
18. infected mother having baby				
19. living with family members who have AIDS				
20. attending school with a person who is HIV+				

RISK **Teacher's Key**

This worksheet is probably best done together as a class exercise. The distinctions between probably safe and probably risky are sometimes vague, so do not worry about grading papers.

1. **Definitely safe.** No evidence of transmission by casual contact
2. **Definitely safe.** No evidence of transmission by insect bites.
3. **Probably safe.** No evidence of transmission by saliva, but small amounts of virus have been found in saliva and it could be transmitted through sores in the mouth.
4. **Definitely safe.** No evidence of transmission through the air.
5. **Probably risky.** Any exchange of semen or vaginal fluids between partners is probably risky because the virus is in large concentrations in these fluids. Some of these fluids are always exchanged in oral-genital sex unless a condom is used.
6. **Definitely risky.** This accounts for 25 percent of transmission in the United States.
7. **Definitely safe.** No evidence of transmission by casual contact.
8. **Definitely risky.** Most efficient method of sexual transmission of the virus because of tears in rectal lining.
9. **Definitely safe.** No evidence of HIV transmission. HIV is very fragile and does not survive long out of the body.
10. **Possibly risky.** If the needle and paints are re-used and not sterilized, then the virus may be transmitted.
11. **Definitely risky.** Unless in a mutually monogamous relationship in which both partners do not have the virus, there is a high risk of passing the virus with this activity, both female-to-male and male-to-female.
12. **Definitely safe.** No evidence of transmission by casual contact.
13. **Probably risky.** Toothbrush or razor may be contaminated with blood and could transmit the virus.
14. **Probably safe.** As long as semen, blood or vaginal fluids do not get from one person into the body of another person, there is no risk.
15. **Definitely safe.** No evidence of transmission by casual contact with objects such as dishes, toilet seats, towels, glasses.
16. **Definitely safe.** Best way to avoid HIV.
17. **Definitely safe.** Equipment is used only once so you only come into contact with your own blood.
18. **Definitely risky.** 33 percent of all babies born to HIV-infected mothers are infected with the virus.
19. **Definitely safe.** There is no evidence of transmission by casual contact.
20. **Definitely safe.** There is no evidence of transmission by casual contact.

Scenarios for Younger Students

Target grades: 4-9

Objectives:

1. To encourage students to talk openly about difficult issues.
2. To teach students to argue for the proper action when faced with a difficult problem.
3. To help link information and behaviour so that students are more likely to make safer choices.

Process:

1. One facilitator plays the role of a person faced with a difficult decision.
2. The class is presented with the scenario and then asked to convince the facilitator to make the “right” decision.
3. The role-player must direct the discussion by his/her responses to comments and questions.
4. The other facilitator can help direct the discussion by asking questions of the class and of the role-playing facilitator.

SCENARIO #1

Jim is John’s best friend. He is joining the football team and wants John to play, too. John is already playing in the band and running track.

Issues:

- Should John play football?
- Should John still play in the band and run track if he decides to play football?
- How will John find time for his homework with three extra-curricular activities?

SCENARIO #2

Anne’s friend Shannon has invited her to a party tomorrow night. Shannon’s parents are out of town. Some of Shannon’s friends brought beer to her last party.

Issues:

- Should Anne go to the party when Shannon’s parents aren’t home?
- What should Anne do if Shannon gets mad at her for deciding no to go to the party?
- Is it safe for Anne to go to a party where there is underage drinking?
- Will Anne get in trouble if she goes to this party and her parents find out Shannon’s parents weren’t home? that there was beer at the party?
- Is having a good time at a party worth getting in trouble at home?

SCENARIO #3

Mike’s friends have started smoking cigarettes after school that they get from the nearby 7-11 (Stop & Go, etc.) Mike knows smoking is bad for him, but he wants to be cool and hang out with his friends.

Issues:

- Why do people choose to do things that are not healthy for them?
- Can Mike still be friends with his friends who smoke?
- What should he do when they ask him to smoke with them?
- How should Mike respond if his friends say he’s not cool unless he smokes?

SCENARIO #4

Susan is asked by Tony and Steve to go roller-blading with them. Susan likes to roller-blade. She also likes Tony and Steve, but she knows that they like to try dangerous stunts when blading. Tony has already broken his arm this year.

Issues:

- Should Susan go roller blading with Tony and Steve?
- What can Susan do to make sure she doesn’t get hurt if she decides to go?
- What else could Susan suggest that she and Tony and Steve could do so that she might feel more comfortable?

OVER---->

SCENARIO #5

A girl in the local grade school has AIDS. She is a person with hemophilia and was given blood infected with HIV. She has been ill for a while, but is feeling better now and wants to return to school. Some people want to make sure she is not allowed to return to school.

Issues:

- Should she be allowed to return to school?
- Why would some people not want her to return to school?
- What is a person with hemophilia and how would he/she get AIDS?
- Do the other children in her class have to worry about catching AIDS from her?

SCENARIO #6

(Both sexes should be in both parts)

Fred and Maria go to the school dance where they have a good time. When Fred kisses Maria goodnight, she pulls him closer and puts some heavy moves on him. Fred likes Maria but he doesn't think he knows her well enough to get this involved this quickly. When he says this to Maria, she says he really doesn't like her.

Issues:

- Is Fred wrong to be uncomfortable about getting closer if Maria is willing?
- What should Fred do if Maria pressures him some more?
- What risks are there in becoming more physical?
- How can Fred discourage Maria without alienating her?

Scenarios for Older Students

Target grades: 10-12

Objectives:

1. To encourage students to talk openly about AIDS-related issues.
2. To reinforce correct information on a variety of issues surrounding HIV infection.
3. To teach students to argue for the proper action when faced with a difficult AIDS-related problem.
4. To help link information and behavior so that students are more likely to make the safer choice.
4. The other facilitator can help direct the discussion by asking questions of the class and of the role-playing facilitator.
5. The role-player should play devil's advocate, making incorrect statements based on myths and misinformation, thus requiring the class to correct him/her. Gradually being convinced of one point, he/she may move on to the next issue.

Process:

1. One facilitator plays the role of a person faced with a difficult AIDS-related decision.
2. The class is presented with the scenario and then asked to convince the facilitator to make the "right" decision.
3. The role-player must direct the discussion by his/her responses to comments and questions.

SCENARIO #1

The male facilitator portrays a boy trying to decide if he should go out with a girl who has a reputation for sleeping around.

Issues:

- Is there any chance she is infected with the virus?
- Can you tell whether or not she is infected?
- Should he have sex with her?
- Is he safe just going out with her?
- Is he in control of what happens on the date?

SCENARIO #2

A male facilitator pretends to have a friend who he just found out is infected with HIV. He won't go near his friend for fear of getting the disease. He is thinking about telling everyone in school about it.

Issues:

- Does his friend have AIDS?
- Is it safe for him to go near his friend?
- Is it understandable that he is afraid?
- Should he tell everyone at school about his friend's condition?

6. **Please remember that you should not put any hint of sexual orientation in these scenarios.** For the ease of publication, these scenarios have been presented as either hetero- or homosexual. However, when you address your students, clarify that these issues are the same for people of *all* sexual orientations. If you assume one sexuality over another, you will alienate one whole group of students in the class.

SCENARIO #3

The female facilitator plays a young woman who wants to have a baby. She has used IV drugs in the past. She is going to try to get pregnant.

Issues:

- Is she at risk for becoming HIV-positive?
- Would her baby be at risk?
- Is there anything she can do to find out whether or not she has been exposed to the virus?

She takes the blood test and the result is positive (she is infected with the virus).

Issues:

- Can she still have a baby?
- Should she tell her husband (if he is around) about the positive test?

OVER---->

SCENARIO #4

The male facilitator plays a young man who is trying to decide if he should shoot heroin for the first time. His best friends want him to try some. They only have one needle.

Issues:

- Will he be at risk for becoming HIV positive?
- What will his friends think of him if he doesn't shoot up?
- How can he convince his friends that he just doesn't want to shoot up?
- What are the possible consequences of shooting up?

SCENARIO #5

One of the facilitators plays a parent who does not want any children with AIDS in his/her child's school. The newspaper has just reported that there is a child with AIDS in the neighborhood. The other facilitator plays the principal and—with the class's help—tries to convince the parent that the child should be allowed to come to school.

Issues:

- Does the child pose any risk? (biting, blood spills)
- Is this child likely to bite?
- What should you do if there is a blood spill?
- What will happen to this child if he/she is not allowed to attend school?
- How should the other kids treat this child? Do they need to know about his/her condition?

SCENARIO #6

The male facilitator plays a young man recently diagnosed with Herpes. He fears that if he brings up the issue of condoms again, his boyfriend will leave him.

Issues:

- What risk does he pose to his boyfriend?
- Should he just have sex with him?
- What are his alternatives?
- Should he continue this relationship?
- Should his boyfriend be tested for Herpes?
- Should he be tested for HIV?
- Should his boyfriend be tested for HIV?

How might he reason with his boyfriend? What is his risk for contracting HIV if a condom is used sometimes? All the time? What is the boyfriend's risk? Is it more difficult or easier to transmit HIV sexually if the boyfriend has Herpes sores? What other things would the use of a condom prevent?

SCENARIO #7

The facilitator pretends that he/she was invited to the party, and the person hosting the party has a crush on him/her. How should the facilitator act?

Issues:

- Should the facilitator bring condoms?
- If he/she does bring condoms, does that mean the facilitator expects to have sex?
- If there is alcohol at the party, will that increase the risk of acquiring HIV?

SCENARIO #8

The facilitator plays a boy who is alone with his boyfriend in the house. He wants to have sex with the boyfriend. How should he broach the subject?

Issues:

- Should the facilitator have brought condoms with him?
- Should he try and discuss safe sex?
- Should he ask his boyfriend to have an HIV test?
- What if his boyfriend does not feel he is ready?

Monologue

Target grade levels: 11-12

This exercise is a 3- to 7-minute monologue by one of the facilitators. The medical student explains that he/she will be telling a story about fictional characters and will be pretending to be one of those characters. Questions will be asked at the end about how the students felt and what they would have done in similar circumstances.

Objectives:

1. Dramatize the emotions experienced by a person with HIV and those who know him/her.
2. Clarify issues of transmission and prevention.

3. Emphasize the point that carriers of the virus may look healthy.
4. Dramatize the emotions experienced by a person who is seropositive or at risk for seropositivity.

Ideally, the example offered below should be used to write a different monologue that is comfortable for the person who will be acting it out. We suggest that you do not memorize the entire monologue, but commit to memory an outline of important points to be made. Then speak from the heart.

“My name is Mark. I wanted to talk to all of you about something. My girlfriend is in the hospital right now and she’s really sick. She’s always been so healthy that I don’t understand what happened. She’s lost a lot of weight. And she’s got this weird pneumonia that gives her trouble breathing. I’m afraid she’s going to die.

“We’ve been going out for four years. We used to have so much fun. I guess it all started about three years ago. We went to this party together, and some of our friends wanted us to try some drugs they had. I didn’t want to try it because I had never shot anything into my veins before. But they kept asking us and asking us. And finally she decided to go ahead and shoot up.

“Ever since then she seemed fine. She looked healthy; she kept up her swimming on the team. Then all of a sudden, about a month ago, she got sick. She hasn’t gotten any better. The doctors say it’s AIDS.

“I guess I’m sort of afraid for myself. It makes me feel sort of selfish. You see, even though she’s very sick now, I think it’s possible that I was exposed to the virus too. We found out that one of the people at that party a year ago has died since then. It sounds like it was AIDS. We had no idea at the time that he was even sick. I guess when she shot up those drugs, she used a needle that had some of his blood in it. So the virus has been in her body for a year.

“At first Karen and I thought we should save sex for marriage, or at least we weren’t ready for it yet. But after a

long time, we decided we were in love and went ahead with it. It was only a couple of times. That’s why I’m scared for myself. You see, we never thought there would be anything wrong with it. Now the doctors think I should be tested, too, to see if she passed the virus to me. If I’ve got it, it’s possible that I could give the virus to someone else. I will have to think about that every time I meet a girl I want to go out with.

“When I look at her and think that could be me, I get so scared. I hate to think that my life could end so soon. You see, AIDS is fatal; and Karen’s probably going to die before I graduate. If we had only been more careful. We had no idea this guy at the party had AIDS. She never should have shot up with that needle. And then how was I to know that she was infected. She looked—great. We never should have had sex, or we should have at least thought to use a condom. We even talked about that, but we decided it was too much trouble. Too much trouble....

“Well, now Karen is in that hospital room, and I’m afraid for her too. But the awful thing is I don’t even want to go in and see her. When I went in the first time, she looked so pathetic. This disease has taken away all of her energy and life. She wanted me to hug her, but I was afraid that if I didn’t have it now I would get it by touching her. I know that’s stupid. You can’t get AIDS by just being near someone or touching them, or even kissing them. But I’m still scared. At least her parents will go in and talk to her.

“She’s so alone right now.”

OVER for Discussion Questions---->

Discussion Questions:

1. How did Karen get infected with HIV?
2. How could she have prevented it?
3. Karen was healthy until just recently. Could she really have had the virus in her body the whole time since the party? Could she have given it to Mark or anyone else during that time? How could she? Were her classmates at school and her friends on the swim team safe?
4. Mark thinks he could have the virus in him now. How can he find out if he's been infected? If he is infected, what does that mean? Does he have AIDS? Could he give it to someone else? How do you think Mark feels knowing he might have the virus in his body?
5. Mark said that he and Karen thought that using a condom would be too much trouble. How do you think he feels now? If they had used a condom, would that have been a 100 percent guarantee that he would not have the virus?
6. Why won't Mark go see Karen? Can you understand his fear? From what you now know about HIV and AIDS, do you think it's safe to him to go see her? What do you think he should do? (What would you do if someone you loved were alone in the hospital with AIDS?)

The AIDS Switchboard

Grade Levels: 7-12

Objectives:

1. Present students with real-life situations to which they must apply their knowledge about HIV infection.
2. Encourage participants to discuss AIDS issues with their peers.
3. Distribute one caller question to each group and give the students five minutes to formulate an answer. Make sure they know that they must be able to explain their answers.
4. When time is up, ask one spokesperson from each group to read the caller's question and present the group's response. After each presentation, ask if the other groups agree and whether they would have answered differently.

Process:

1. Divide the class into groups of three or four.
2. Explain that each group is now manning a switchboard that people call when they have questions about HIV and AIDS.

Sample caller questions:

1. "I have three children who like to go swimming at the pool in the park. With all this talk about AIDS on TV, I'm afraid my kids will get it from someone at the pool. Should I keep them home?"
2. "My friend just started shooting drugs with some of the guys he knows from work. I told him he shouldn't do that because of the HIV virus. He says it's okay because his friends are all healthy. Is he really safe?"
3. "Back when I was in high school I used drugs with some other kids. Now I'm married and I want to have a child. I'm worried about AIDS. If I have the virus, could my baby get it? How can I find out if I have the virus?"
4. "My boyfriend Steve and I have been going out for a few months now, and last week he told me he wants to have sex. I really like him, but I'm just not sure. I told him that I worry about HIV. He says it's safe as long as we only have oral sex or if we use a condom. Is that right?"
5. "I heard someone on TV say something about AIDS last night. She said that when you go to bed with somebody these days, you don't just go to bed with that person—you go to bed with everyone they ever slept with. What did she mean?"
6. "I have never had sex, and the only drug I ever used was some marijuana I smoked a couple of times. I'm really worried about AIDS because I have been sick several times this year. Should I go get tested for AIDS?"
7. "I just found out that one of my best friends is gay. Does that mean he will get AIDS? I'm worried. I learned in school how I can keep myself from getting AIDS, but what about him? What can he do?"
8. "Last week my sister found out she has AIDS. She's really sick, and she's so scared. When I asked my parents if I could go visit her, they freaked out. They said they wouldn't let me. They said that I might get it, too, and that they couldn't stand it if we both got sick. What should I do?"
9. "I am the boss at an office with more than 30 employees. When I learned from TV that people could have the AIDS virus without even looking sick, I started to worry about all the people in the office. I told everybody that I wanted them to get tested and to bring the results back to me. As their boss, I think I have the right to know. They got upset about that, and now they're all about to go out on strike. Who is right?"
10. "One of my old teachers has hemophilia. Yesterday it was in the newspaper that he tested positive for the HIV antibody. The article said he got it from some contaminated blood he got before there was a test for infected blood. Some of the parents are keeping their kids at home now, and others are trying to get him fired. He's a great teacher, but I guess he should quit if he's dangerous to his classes. What do you think?"
11. "My boyfriend refuses to use a condom. He controls our relationship and I usually go along with what he wants, but I'm afraid of getting AIDS (and/or pregnant—if caller is female). I want to use a condom (or if female, I want him to use a condom). I don't want to lose him. What should I do?"
12. "I'm waiting for the results for my HIV test. I am so scared. My last relationship was with an IV drug user. If I am HIV+, I'm going to kill myself."
13. "I'm so worried about this AIDS epidemic. I don't think I'll ever become sexually active."

The Envelope Game

Target grade levels: 7-12

Objectives

1. Make adolescents aware that they are at risk for HIV.
2. Allow them to consider that prevention is a matter of making personal decisions.
3. Encourage discussion of various social issues regarding people who are infected with the virus.

Process:

1. Before entering the classroom, prepare enough envelopes so that every class member receives one. Under the flap of each envelope, write the letter A, B or C. Distribute the letters such that approximately one in 10 will bear the letter A. (For example, if you have a class of 30 students, assign letters as follows: 3 As, 14 Bs and 13 Cs.)
 2. Explain to the students simply that this is “the envelope game.”
 3. Distribute one envelope to each student, and tell them to look at the letter, remember it and reveal it to no one.
 4. Allow 10 seconds for each student to exchange envelopes one time. The students should look at the new letter and write their old letter next to it. Now they need to remember both letters.
 5. Allow another exchange. This time they look at the new letters and write down both of their old letters next to the new ones.
 6. Now announce: “Each of you has seen three envelopes. If you have seen an A on any of them, you have the HIV virus in your body and you may die of AIDS. If you have only Bs and Cs, you are still uninfected.
“Now, each of you choose one more person to exchange envelopes with, (pause) if you want to.”
 7. Next, begin discussion. Remember, the object is to elicit the class members’ feelings. Following is a list of suggested questions or points to include:
 - a. What does each “exchange” represent?
 - b. Can you tell ahead of time which people have As on their envelopes?
 - c. If you got an A, how would you feel about exchanging with your boyfriend or girlfriend?
 - d. Whom do you think you should have to tell about your letters? (teacher, family, boyfriend/girlfriend, employer, doctor, government, coach, friends, etc.) Why or why not?
 - e. If you still haven’t seen an A, how do you feel about continuing the game?
 - f. Does it bother you to know there are many people in the classroom with As, even though you know you will not be exchanging any more envelopes?
- g. Even though you know it is dangerous, some of you will choose to exchange envelopes again in the future. How can you try to lower the chance of getting AIDS? (Students might compare licking shut the envelope to using condoms or cleaning needles—not 100 percent, but it may work.)
- A variation of this game can be played with index cards:**
1. On the back of one index card, place an X, on a second card place a P.
 2. Distribute an index card to each student.
 3. Give the class 3-5 minutes to get as many people to sign their card as possible after explaining that they do not have to sign a card just because they are asked. (The time allowed can vary depending on the size of the class).
 4. Ask the person with the X on their card to stand up. Explain to the class that this indicates HIV+.
 5. Ask everyone with the name of the person already standing up to stand up. Explain that they too are infected. (This step can be repeated again.)
 6. Ask the person with the P on their card to raise his/her hand. If he/she is standing, he/she may sit, because protection was used during the risk behavior that he/she participated in: he/she has not been infected with the HIV virus.
- A third variation, using vinegar and baking soda:**
1. Make a solution of baking soda and water and place in two cups with X’s on the bottom (infected with HIV). The other 18 cups should have plain water in them.
 2. Ask students to find one other person and mix the solution in their cups together, with each taking half of the mixture.
 3. Now, have them mix with a different person, with each person taking half.
 4. Ask them to look on the bottom of their cups and have the two with the Xs come up.

OVER---->

5. Add a small amount of vinegar to their cups—they should fizz.

6. Then have everyone else bring their cups up and add vinegar—those that fizz have contracted HIV.

Devil's Advocate

Target Grades: all

Objectives:

1. To encourage teenagers to discuss the importance of AIDS education.
2. To demonstrate to students the myths that exist concerning AIDS.
3. To encourage students to analyze, and not avoid, thinking about controversial and "touchy" issues concerning sex, drugs and AIDS.

Process:

1. One facilitator stands in front of class and plays the role of a person who is against AIDS education. The facilitator, throughout this exercise, uses certain myths as his/her argument against AIDS education.
2. Class members must attempt to convince this character of the importance of AIDS education.
3. Class members must also try to identify any incorrect statements the role player makes and explain why the statement is not correct.

Sample Characters:

- A parent protesting against AIDS education in school because "talking about drugs and sex and condoms may give students bad ideas."
- A teenager who resents being lectured that "sex is wrong," and claims that "scientists have not proven anything about AIDS."
- A student who feels AIDS education is not really needed in schools because "it mostly affects homosexuals and drug addicts."

The Impact of Others

Target Grades: all

Objectives:

1. To demonstrate that AIDS is not isolated to one group of people but that it affects the whole human race.
2. To encourage students to reflect on how people with AIDS have made a positive/negative impact on teenagers' outlook towards AIDS.
3. To assess the different reactions people with HIV have had towards their infection, i.e., denial, shame, guilt, acceptance, desire to educate others, etc.

Process:

1. Have facilitators ask the class to list on the blackboard famous or well-publicized people with HIV.
2. Stimulate discussion among the students by asking such questions as:
 - How did this person deal with his/her HIV?
 - What would motivate some of the people to conceal their HIV infection from others?
 - Which of these people do you think have made a positive impact on students' ability to deal with the AIDS epidemic? How?
 - What do all these people have in common besides having HIV?
 - What differences exist among these people?

The Facts in Fictions

Target Grades 10-12

Objective:

1. To encourage students to assess the risks of contracting HIV as a result of various actions.
2. Stimulate the class to think about how various media, such as TV, art, theater, literature, have ignored or dealt with the existence of AIDS.

Process:

1. Have facilitator choose a certain well-known fictional character, mentioning what is attractive and exciting about this character's life. Facilitator should eventually lead to the idea that while the character may have not taken precautions to protect him/herself against HIV, the possibility that this character may get HIV was not raised in the movie, TV, program, music lyrics, etc.
2. Next, facilitator should ask the class to give a few examples in which fiction blatantly ignored issues dealing with AIDS, and which fiction effectively dealt with AIDS issues.

Opening Example:

Why have James Bond movies been so popular? Maybe, because it helps many people leave their routine lives and spend a few hours in Bond's exciting, adventure filled life. He has money, he travels, he saves nations and women are all over him. But have you ever thought about Bond's risks for being HIV-positive? Does he use a condom? Does he ever worry about the sexual history of his past contacts? Do his partners ever worry? Has Bond ever been tested for HIV or is his blood invincible and unable to contract HIV? Yes, Bond is a fictional character, but he is a human being with human blood that is susceptible to HIV.

Sample Questions To Ask Class:

1. What other songs, books, programs, movies, etc., ignore the issues regarding AIDS in spite of their characters' risky behaviors?
2. What songs, books, programs, movies, etc. have dealt with these issues effectively? How have they done so?

Further Suggestions:

Have facilitators discuss their own personal experiences with AIDS patients that they have followed in the past. Discuss possible concerns the facilitator may have had; the fears of the patient; how the patient changed in his/her outlook towards AIDS; how the patient changed physically; how the medical student changed in his outlook towards HIV and AIDS; etc.

Anonymous Questions

Target Grades: all

Objectives:

1. To provide an environment in which students can ask questions that they would be too embarrassed to ask otherwise.

run out of time, write down the answers to the remaining questions and send them to the student's teacher. (Make sure to read the cards in a random order to prevent identification of any particular student.)

Process:

1. At the beginning of your session, ask every student to take out a sheet of paper.
2. Explain to the students that you want every one of them to write down at least one question that they may have about AIDS, HIV, sex, birth control, etc....
3. With 10-15 minutes remaining, collect all of the questions and proceed to answer them one at a time. If you

4. If you will be returning to the same class within a few days, you may elect to answer the questions upon your return.

5. Make sure you collect a piece of paper for every student; if you only collect one piece of paper, everyone will know who's question it was.

Condom Confort

Target Grades: 10-12

Objectives:

1. To explain in detail the proper use of condoms.
2. To facilitate discussion about condoms and safe sex.
3. To provide a forum for the actual demonstration of condoms.

Process:

1. Write on the blackboard the jumbled list of items provided below (or make a handout).
2. Give the students a few minutes to think about the list and have them put them in the correct order.
3. Facilitate discussion by asking the class which event should occur first. There is usually some argument about the first four events and that is acceptable. It is a good medium for promoting discussion about safer sex. However, there should be no argument about the correct order, once you have gotten to the point of opening the condom.
4. While you are explaining the correct order of how to put on the condom, demonstrate it visually with an actual condom (using a banana or a balloon or similar item on which to place the condom). It helps if you bring two condoms; this way you can first show them the wrong way and then show them the correct way.
5. Both facilitators should participate in the demonstration of condoms, since this fosters the idea that it is both partners' responsibility.
6. This is also a good point to demonstrate any other forms of birth control you have brought.
7. After you have finished the demonstration, provide the students (if possible) with a handout concerning the correct order. Even if you do not play this game, the handout may prove to be very useful to the students.

Correct Order:

- Discuss having sex
- Agree to have sex
- Discuss safer sex
- Choose and buy condoms
- Hug, kiss, cuddle, massage
- Get aroused
- Inspect and open condom package (making sure to check expiration date)
- Squeeze air out of tip
- Place condom, right side out, on head of penis
- Roll down to the base of the penis
- Begin intercourse/oral sex
- Achieve orgasm
- Withdraw condom holding onto base of the condom
- Lose erection
- Remove condom and dispose
- Wash up
- Relax

For the jumbled order, all you have to do is put the items on this list in any random order you choose. All that is important, is that the students eventually learn the correct order. As previously mentioned, regardless of whether you play this game or not, you may wish to consider handing out a "correct order" list just as a source of reference.

Closing Remarks

No, this is not a game, but exactly what the title says. There are a couple of things that we would like to remind you of before you depart this section.

First, remember to always talk in **gender-neutral** terms. For example, you would describe oral sex on a man as “when **someone** puts **their** mouth around a man’s penis...” Remember, you do not want to make any assumptions about the sexuality of your audience.

Secondly, do not forget to talk about anal sex. More than 20 percent of women have had anal intercourse, so it is not an activity confined solely to homosexual males.

Finally, if you do not know the answer to a question, DON’T MAKE ONE UP!!! The only thing worse than no information is misinformation. You must go home, look up the answer to the question, and send it back to the students’ teacher as soon as possible.

In conclusion, we would like to reiterate that these games are merely samples, and that nothing should be ever taken as 100 percent engraved in stone. Depending on the area in which you teach, some games may not even be appropriate for the 12th graders, while the 7th graders may be able to handle any game you throw at them. You must be the final judge.

SECTION V

Sensitive Questions

How to Handle Sensitive Questions

When a student asks an awkward, embarrassing or personal question, HOW you answer can be as important as WHAT you answer. The following guidelines may help you.

<u>What</u>	<u>Why</u>	<u>Technique/Response</u>
1) Legitimize the question.	Let the student know you have heard and understood the question.	“That’s a good question; lots of students your age ask about that.”
2) React positively.	No matter how unusual or revealing the student’s question, she/he needs to know you won’t reject it. The student may be embarrassed to ask the question.	Look the student in the eye and smile. “I’m glad you asked that. I know it must be hard for you to talk about this. I’m really glad you asked.”
3) Be careful of your own negative feelings.	Don’t show your feelings to the student. Remember, a negative response cuts off communication.	Keep body language relaxed. React positively, as above, and avoid put-downs, e.g., “You’re too young. Where did you get that idea?”
4) Don’t laugh or make jokes about the student’s questions.	Many questions may seem humorous because they are based on misconceptions or lack of information. A serious question deserves a serious response.	“A lot of people think that, but actually…”
5) If you are embarrassed, admit it.	Students can learn from your response that even adults can suffer embarrassment.	“This is a little hard for me to talk about, but I’ll try to answer as best I can.” / “When I was young, no one would talk to me about…”
6) If you don’t know, say so.	Admit early on that you may not know all the answers. Agree to follow up on questions you can’t answer.	“That’s a good question. I’d like to know the answer myself. Suppose I find out and let you know tomorrow?”

Sample Questions

Since one of the hardest things about teaching is being able to handle and answer questions posed to you by the students, we have given you a whole bunch of sample questions and appropriate answers. It would not be a bad idea if you require new STATS teachers to be able to answer these questions during their training.

Commonly Asked Questions

Q. My teammate is HIV+ and I'm not. If we both have open cuts, and our cuts touch each other's cuts, can I become HIV+?

A. There is a definite risk involved in such an action, but there are no known cases as of yet resulting from such an activity.

Q. Is the HIV virus in the menstrual flow?

A. Yes.

Q. If two people with HIV have sex, will their infections get worse?

A. There are two theories. One states that you can become reinfected with the virus because several different strains of it exist. The virus in following with such a theory would then replicate at twice the rate and therefore you will get sicker faster. The second theory states that even if you pick up a different strain of the virus, you will not get sicker faster. However, it is known that co-infection with another STD will definitely complicate the patient's clinical course.

Q. Can you become HIV+ by being bitten by a wild animal?

A. No, no wild animals in the U.S. harbor HIV or an HIV-related virus that we have found. Although monkeys in Africa do have the Simian Immunodeficiency Virus (SIV) and this is very similar to the HIV-2 virus, it has not been proven that animal bites have been, or ever were, a mode of transmitting this virus.

Q. How close are we to finding a cure or a vaccine?

A. There are some sources that say that a vaccine will be developed within the next five to 10 years. The problem with this is that the same thing has been said for the last 10 years. It is therefore difficult to say when and if a vaccine will be developed. The common cold is a virus which we have been aware of for hundreds of years, and there is as of yet no vaccine for it either. Unfortunately, the outlook for a total cure for those who become infected with HIV appears to be much bleaker as we have yet to "cure" anyone of any type of viral illness yet.

Q. What is AZT and for how long does it stop the virus?

A. AZT is a drug that works by blocking reverse transcriptase and therefore inhibits the replication of the HIV virus. The problem is that AZT is ineffective unless the virus is outside the cell. The duration of its effect varies from patient to patient. However, once AZT has shown to be of no further use to a patient, the patient may still respond favorably to other reverse transcriptase inhibitors such as DDI or DDC.

Q. Can you contract HIV if the blood of someone with the virus hits your skin?

A. Yes, but only if your skin is broken or you have an open wound and the virus is allowed to enter your bloodstream.

Q. Can you have sex with a person who has AIDS and not contract the virus?

A. Yes, but there are no guarantees since HIV is still an infective agent. However, taking a risk such as this is very similar to playing "Russian roulette" with your life—if it isn't the first bullet, the odds are greater that it's the next one.

Q. What is the risk of becoming HIV-positive due to an operation?

A. There is little to no risk because all needles that are used are sterile, disposable and never reused. All instruments used are sterilized and all blood used for transfusions is tested thoroughly. Also, if you are having an elective or planned procedure, you can always donate your own blood ahead of time for use in transfusions, just to be extra safe. (Note: This also cuts down on the risk of a transfusion reaction as well.)

Q. How did the HIV virus originate?

A. The following are just a few of the many theories that have been postulated:

1. The virus originated in the green monkeys and was spread via the polio vaccine work of the 1950s.
2. The most accepted theory: It's a virus which has existed since the beginning of time but has only recently mutated enough to be able to infect people.
3. It just does not matter any more since we are stuck with it whether we like it or not.

Q. What is the longest period of time someone has lived with the HIV virus?

A. There are a few people who have been positive for at least 10 years at the time this manual was written.

Q. Do hospitals check for HIV as a standard procedure with other blood tests done on a patient?

A. No, it is illegal at this point in time to test for HIV without the patient's permission anywhere in the United States.

Q. Can you get the HIV virus from a mosquito?

A. No, because the digestive enzymes in the saliva of the mosquito kill the virus.

Tough Question

Q. I don't need to use protection for oral sex, do I?

A. It may be possible that you can become infected from oral sex if your partner has the virus. HIV can be transmitted through the blood, semen or vaginal fluids of infected men and women. Although condoms do not offer 100 percent protection, they greatly lower your risk of HIV infection if your partner has HIV.

Q. Where did AIDS come from? Who started it?

A. There are many different theories of the origin of HIV. None of these have been proven. At this point, the information about where it came from will not help in our efforts to combat the disease. This is why research efforts are focusing on vaccines, treatments and prevention education. "If you have a tiger in the house, do you worry about whether it came in the front door or the back door, or do you just try to get rid of the tiger?"

Q. I don't want somebody with AIDS, or who is HIV-positive, in this school.

A. Reinforce that HIV is not transmitted through casual contact.

- HIV cannot live long outside the body. Unbroken skin is good protection. The only body fluids with a high enough concentration of HIV to transmit the virus are blood, semen and vaginal fluid.
- A study was conducted with people sharing a household with people who had AIDS. There were no cases of transmission through daily household contact, even though they shared a living space, utensils and bathrooms.
- Unless you are having sex or sharing needles in school, it is a safe place from HIV transmission.

Q. Can I get AIDS if somebody bites me?

A. There have not been any cases of HIV being transmitted through bites. Reinforce that HIV is only transmitted through blood, semen and vaginal fluid. Saliva does not have a high enough concentration of HIV to transmit the virus. Set up a scenario: If I have HIV and I bite you, even hard enough to break the skin, you are getting my saliva, and we know that saliva does not transmit the virus.

Q. Where can I get tested? Will my parents find out if I do?

A. Keep referral list handy, give phone number of local test sites. Take the opportunity to reinforce the difference between confidential and anonymous testing. Again, remember that anonymous testing means that no one can ever find out your results or that you were even tested, including your parents. Also, be sure to recommend pre- and post-test counseling.

Q. Why don't we just test everyone and quarantine people who are infected so they don't spread the virus to others.

A. There is no reason to test everyone in order to stop the spread of the virus because YOU CAN PROTECT YOURSELF. In addition, there are several problems with mandatory testing:

- If a person is tested during the window period, they would test negative even if they were infected.
- Testing everyone is very expensive. This money may be put to better use in education, research and care for people with HIV and AIDS.
- Although people are quarantined for some illnesses, these are only water-borne or airborne illnesses. There is no reason to quarantine people with HIV since it is not blood or water-borne.

Q. Can I get AIDS from open-mouthed (French) kissing?

A. It is highly unlikely that HIV could be transmitted through open-mouthed kissing. There is, however, a theoretical possibility because, although HIV is not transmitted through saliva, there is sometimes blood present in the mouth. If this blood got into a cut or sore in someone else's mouth there is a possibility that transmission could occur. No documented cases of HIV infection have been reported through open-mouthed kissing.

Q. What is the link between Tuberculosis (TB) and AIDS?

A. Although the two diseases are spread by totally different means (TB is spread by aerosolized droplets only, and HIV is spread via blood and genital secretions) there is considerable overlap between groups infected with each of these respective organisms. Since TB and HIV have the highest incidence in the inner cities, this is not surprising. In addition, HIV+ patients with TB are more likely to develop active TB and at a much higher morbidity and mortality than the HIV- populace. Due to the high degree of reactivation, any HIV+ patient with active TB is now considered having AIDS regardless of his/her T-cell count.

MORE---->

Hot Seat Questions

“Can AIDS be transmitted by mosquitoes?”

Arguments:

- Mosquitoes share blood between people, and AIDS is spread through blood.
- What about malaria? That’s spread by mosquitoes.
- I heard about a place in Florida where everybody got AIDS from mosquitoes.
- My husband and I were bit by the same mosquito just last night. What if he had AIDS?
- I read about some French researchers in Africa who found AIDS virus in the blood of 40 different insects.
- A laboratory here in the U.S. fed mosquitoes AIDS-contaminated blood and two days later they found the virus still present in the stomach of the insects.
- There was a whole article in an *Atlantic* magazine a year or so ago all about insect specialists who believed AIDS could be spread by insects.

Facts:

- Many studies have looked at the possibility of insect transmission of HIV, and none have shown any convincing evidence that this occurs.
- The clearest way to see this is to look at epidemiologic studies. Malaria, a widespread disease in Africa that is spread by mosquitoes, affects people of all ages, including children and elders who may not be sexually active. The HIV virus, on the other hand, a disease spread most often by shared needle use and intimate sexual contact, affects people in both Africa and the United States who fall into specific categories of risk. They do not represent the more general population of individuals bitten by mosquitoes. In the U.S., children between the ages of about two and twelve, who frequently play outside at dusk in areas infested with mosquitoes and receive dozens of mosquito bites, are not infected with HIV unless they have other known risk factors.
- In thorough epidemiologic studies of Bell Glade, Florida, a community with an unusually high incidence of people who are HIV+, no evidence of mosquito transmission was found. Six percent of people 18-39 years of age were HIV+. None of 138 children 2-10 years of age were HIV+ and one of 131 persons 60 or older was HIV+, even though they received as many mosquito bites as infected adults. The risk factors in Bell Glade were the use of IV drugs and sexual contact with infected persons. The sexual contact cases were primarily heterosexual.
- If insects were implicated in HIV transmission, we would expect to see cases of AIDS appear within households of known infected persons. Within a household, individuals would be exposed to the same fleas, ticks, mosquitoes, etc. There are no cases of transmission within households except where known risk factors (needle sharing, sexual contact) exist.

- For biologic transmission of a disease by insects (such as malaria), the pathogen (in this case HIV) must be able to multiply inside the insect. Studies looking for suggestions that HIV can multiply inside insects found no such evidence.
- For mechanical transmission of a disease by insects, the pathogen must be present in large enough quantity on the mouth parts of the insect to cause infection. In the studies where HIV infected blood was fed to insects and the virus was found in their stomachs two days later, the concentration of virus in the blood used for the study was at least 100 times greater than in infected humans. Even at this level, mosquitoes and bedbugs were unable to transmit HIV from infected to uninfected blood during interrupted feedings, probably due to the extremely small quantity of blood found in the insect’s “mouth.”
- Robert Gallo, an international expert on AIDS, says that studies showing the presence of AIDS within insects offers “no (other) evidence except that a mosquito can take in blood.”

“How can they prove that AIDS/HIV infection is not casually transmitted?”

Arguments:

- There is so much we don’t know about AIDS.
- New information is being reported all the time.
- How can we be sure of anything when the incubation period for AIDS is so long? How do they know that there aren’t a lot of people who were infected through casual transmission who just haven’t gotten sick yet?
- How can we trust anything the federal government says? (Or the Centers for Disease Control—they’re a federal agency.) The “feds” have a history of misleading people, like when they carried out syphilis studies on Black men by not treating them, or gave LSD to military personnel, or conducted germ warfare experiments in San Francisco.
- I know a doctor who says he (she) doesn’t believe that AIDS is not casually transmitted.
- What about all the people with AIDS who have no known risk factors? They were probably infected through casual transmission.

Facts:

- We actually know a great deal about AIDS. The things we don’t know have to do with how to cure the disease, how to develop an effective vaccine, how to get people to change their risk behaviors and so forth. The information about HIV transmission is thoroughly documented and well established.
- New information is being reported all the time, but the information about transmission, and particularly about preventing transmission, has not changed substantially since 1984.

- That information is that HIV can be transmitted through sexual intercourse, the sharing of needles in IV drug or other use, or other contact which involves an exchange of blood or blood products. New information continues to verify what is already known.
- The incubation period for AIDS is long, averaging over seven years and being as long as 11 years in some cases. However, after a person is first infected with HIV, he or she will usually develop HIV antibodies within three months. Therefore, there is a way to check for HIV infection quite soon after the infection has occurred.
- It is difficult to believe some of the information about AIDS if you do not trust the federal government. It is important to remember that these conclusions about HIV transmission are not only reported by federal agencies or federally-funded researchers, but by other scientists throughout the country and internationally who have no connections at all to the federal government.
- Doctors, like the rest of us, need to be educated about the HIV virus and AIDS. Those who are specialists in this area are quite confident that AIDS is not casually transmitted, and they are likely to have quite a bit of “casual contact” with their patients—touching them, hugging them, sometimes crying with them.
- People with AIDS who have no known risk factor will generally fall into one of several categories:
 - 1) they have been lost to follow up, so that risk information cannot be gathered.
 - 2) They have refused to be interviewed by their doctors or anyone else about risk activities.
 - 3) They have been too ill to be interviewed at the time of diagnosis.
 - 4) They have been diagnosed after death, and further information has been unavailable.
 - 5) They have been unwilling to admit to risk factors such as homosexuality or IV drug use because of the stigma associated with these behaviors.
 - 6) They may have become infected through heterosexual contact, but unless they are able to identify a sexual partner with a known risk, they are placed in this category.
 - 7) Rarely, a person may meet the diagnostic criteria for AIDS (having CPC or an opportunistic infection, for example), without actually being HIV infected: this might be counted as an AIDS case when it is not, in fact, a case of HIV infection.
- A number of studies have evaluated over 700 household or boarding school contacts of both adults and children with HIV infection. These contacts have included many kinds of interactions, including helping individuals bathe, dress and eat. Eating utensils, kitchens, bathrooms and other household items have been shared. These contacts are usually repeated and occur over a lengthy period of time. There are no cases if HIV transmission in any of these studies.
- In 1993, two cases of “household transmission” were reported. However, further investigation into the cases

determined that the transmission occurred via sharing razors in one case, and secondary to frequent nose bleeds and eczema in the other.

- There have been more than 500,000 cases of AIDS reported in the U.S. (1995), and not a single case that suggests casual transmission as a route of infection.

“There is only one good choice for teens, and that is abstinence. I don’t think we should teach them about condom use at all. It just encourages them to be sexually active.”

Arguments:

- It is wrong and immoral to teach about condoms in schools.
- Condoms don’t work anyway. It is wrong for us to suggest they do by promoting their use for AIDS prevention.
- When we talk about “safer sex,” we just put ideas into the kids heads that they might not already have.
- Maybe teens who are sexually active need to suffer the consequences of those choices—pregnancy, STDs, AIDS. Maybe that will teach them to be more responsible.
- I find it personally offensive that this sort of material is discussed in classrooms. I don’t want my child to hear it.

Facts:

- Condoms are not 100 percent effective in preventing the transmission of HIV (as is abstinence), but there is clear evidence that their use is effective to a significant degree.
- Studies have shown that teaching about the proper use of condoms could raise their effectiveness as much as 30 percent among certain groups of adolescents.
- Laboratory tests have shown latex condoms to be effective barriers to a number of sexually transmitted organisms, including HIV, Herpes, Hepatitis B, Chlamydia trachomatis, Neisseria gonorrhoea and Human Papilloma Virus (HPV).
- In studies of sexual partners and spouses of persons who are HIV+, consistent use of condoms is associated with seronegativity—that is, in those couples where condoms were used consistently, the uninfected partner was more likely to stay uninfected.
- Failure of condoms is most often caused by “user error,” including: 1) failure to use a condom during each act of sexual intercourse; 2) failure to put the condom on before genital contact occurs; 3) failure to put the condom on correctly; 4) failure to remove the condom before the erection is lost and the semen spills out.
- Whether or not an individual, teenager or adult, decides to use a condom is certainly a personal decision. But if someone does choose to have sexual intercourse with a partner who is or may be HIV infected (or whose antibody status is unknown), condoms (used along with the spermicide nonoxynol 9) offer the best possible protection from HIV transmission.

- Research studies have consistently shown that sex education in schools has not led to greater levels of sexual activity, nor does it lead to earlier sexual activity.

Opinions:

- We would like to encourage young people to delay sexual activity until they feel they are ready. However, we know that a significant number of teenagers have already made the choice to be sexually active. Nationally, half of high school males and one third of high school females have had intercourse. (These numbers are usually much higher in urban areas.) Much of this sexual contact is unsafe, carrying a potential risk for HIV infection: one in 10 teenage girls becomes pregnant each year, and one in seven teenagers contracts an STD each year. Despite the efforts of education professionals, civic leaders and religious organizations, we have been unable to have a significant impact on this level of sexual activity so far. We hope in the future to discover how to do this, but at the present time, to help save teenagers' lives, we must promote abstinence and educate about safer sex and condom use.
- Parents who do not want their children to participate in sex education or AIDS education programs should have the right to withdraw them from these classes. We hope such parents will offer careful education at home.

“I don’t think the risk of heterosexuals contracting AIDS is really significant. The risks have been exaggerated.”

Arguments:

- I don’t know any heterosexuals who have AIDS.
- We were warned about a huge explosion of heterosexual cases, and it never happened.
- We know that the reason homosexual men have contracted AIDS in such great numbers is because of the practice of anal sex. Vaginal intercourse is not really a risk for AIDS.
- I read in the newspaper that the risk of a heterosexual contracting AIDS was about one in a million.
- Researchers have really hyped this up, so they can get more funding. No one would fund them if they felt this was just a disease of homosexuals and IV drug users.

Facts:

- In the U.S., heterosexual contact has not been as a great an HIV risk as homosexual contact or IV drug use. In Africa, virtually all cases of AIDS are among heterosexuals, and in Thailand, a 1990 study reported that nearly 10 percent of the population had acquired the virus through heterosexual contact.
- Nationally, heterosexual contact cases have accounted for about 11 percent of total AIDS cases. This may not sound like a significant number, but in 1995 alone, this meant that more than 4,400 individuals have contracted AIDS through heterosexual contact only. Another 11,000 individuals have contracted AIDS through IV drug use

and did not have a history of male homosexual contact (so presumably most of these are also heterosexual individuals). This adds up to a total of nearly 15,000 individuals who may be or may have been heterosexually active and who have been diagnosed with AIDS.

- In 1983, when the CDC started collecting data on HIV and AIDS, they set up a hierarchy of groupings for people diagnosed with HIV. It stated that if a newly diagnosed HIV-positive male cannot definitively demonstrate the source of his infection, he is assumed to have acquired it through either IV drug use or homosexual behavior if the person had participated in either of those activities at least once since 1983. Therefore, there may be many men who are considered to have acquired HIV through IV drugs who actually were infected via heterosexual contact. For women, the same hierarchy exists, except homosexual behavior is put at the bottom.
- In some areas, seroprevalence among heterosexuals has been disturbingly high. In a study reported at the IV International Conference on AIDS in Stockholm, 5 percent of sexually active heterosexuals tested were HIV+. These were individuals in Miami who acknowledged being sexually active or who have had an STD, but who were not prostitutes and had no other known HIV-associated risk.
- A report offered by the Centers for Disease Control at the Fourth International Conference on AIDS analyzed trends in the first 50,000 cases of AIDS reported in the U.S. and concluded that small but significant changes in trends have been occurring, most particularly that the proportions of all AIDS patients who are women, who are heterosexual men and women, and who live in areas other than California, Florida, New Jersey and New York are increasing.
- Heterosexual transmission is documented bidirectionally, meaning that men can pass HIV to women and women can pass HIV to men. HIV can be transmitted through anal and vaginal intercourse, and several reports now exist of presumed transmission through oral intercourse.

“Why should we believe the things you tell us? Do you consider yourself an AIDS expert?”

Arguments:

- How sophisticated is your understanding? Can you really evaluate the accuracy of the materials you’re using?
- Why are some of the things you’re telling us in conflict with known scientific experts? Do you know as much about this as some of them?
- We’ve asked you questions today that you haven’t known the answer to. How do we know that there aren’t other facts that you aren’t sure of?
- New facts get reported about AIDS all the time. You said you can’t keep up with it all. What makes you so sure that you haven’t missed something really important?
- You don’t always seem that confident about what you’re saying. I wonder if you really believe some of these things yourself.

Facts:

- Some material about AIDS is quite sophisticated but much is not. A person of reasonable education and intelligence can understand quite a bit of the material reported about AIDS, even some of the original source material in medical journals. Many of these journals have long-standing reputations for accuracy in reporting and most have been active since well before the AIDS epidemic. I feel I can trust the reputation of these sources, and if you have further doubts I hope you will go directly to some of them yourself.
- In looking at the research on AIDS, we do see some areas of controversy, but general scientific opinion usually favors one view over another. A few scientists for example, continue to argue the possibility of insect transmission. The great majority of informed scientists do not believe insect transmission is possible, and a persuasive body of research supports their view. I don't know as much as a lot of the scientific experts, but I do feel persuaded when many professionals who are very well informed collectively agree with a point of view and can show me evidence to support their belief.
- One of the signs of a good educator, whatever the topic, is to know the limits of your knowledge and to avoid misrepresenting your knowledge in any way. There is much I do not know about AIDS. On the other hand, there is a lot I do know, and I am confident in that knowledge.

SECTION VI

Information Sources

Information Sources

NATIONAL AIDS HOTLINE (Centers for Disease Control and Prevention)

English: 1-800-342-AIDS

Spanish: 1-800-344-7432

Deaf service (TDD): 1-800-243-7889

WEB SITES—

Centers for Disease Control and Prevention:

National AIDS Clearinghouse: <http://www.cdcnpin.org>

Updates, statistics, information, educational materials and funding opportunities. Also has many links to other Web pages that may be of use to you.

HIV/AIDS Resources: <http://www.cdcnpin.org/hiv/start.htm>

Related Links: <http://www.cdcnpin.org/hiv/rellinks.htm>

Prevention info: <http://cdcnac.aspensys.com>

National Center for HIV, STD and TB Prevention: http://cdc.gov/nchstp/hiv_aids/dhap.htm

NIH (National Institutes of Health) AIDS-Related Information: <http://odie.niaid.nih.gov/11/aids>

HIV InSite (UCSF): <http://hivinsite.ucsf.edu>

HIVTesting.Com: <http://www.hivtesting.com>

The Safer Sex Pages: <http://www.safersex.com>

Gay Men's Health Crisis: <http://www.gmhc.org>

Food and Drug Administration HIV/AIDS information: <http://www.fda.gov/aashi/aids/hiv.html>

HIV InfoWeb: <http://www.infoweb.org>

AIDS Virtual Library: <http://planetq.com/aidsvl/index.html>

OTHER SOURCES OF INFORMATION—

- The **AIDS CD-ROM**—available at most medical school and hospital libraries.
- The **SAL** system—available in most libraries with Medline access, is a list of books.
- **Medline**—available at almost any computer outside the computing center in the library—a list of journals.
- **AIDS Medex**—a subdivision of Index Medicus.
- **SEICUS** (Sex Information and Education Council of the United States) has guidelines that may be useful: SEICUS, Publication Dept., 130 West 42nd St., Suite 2500, NY, NY 10036; (212) 819-9770.

VIDEOS—

There have been enough requests about videos that we're including a few that might interest your program. They are not produced or endorsed by AMSA and whether or not you use them is up to you. There are no doubt many other videos available; check out some of the Web sites on the previous page if you are interested in pursuing this aspect.

- “Teens and AIDS” video—Available from the Centers for Disease Control and Prevention, National AIDS Clearinghouse.
- “A Conversation with Magic”—Available from the Magic Johnson Foundation, <http://www.magicjohnson.org>
- “Time Out: The Truth About HIV, AIDS and You”—Also from the Magic Johnson Foundation, but may be available for rental or purchase at local video stores.

Stephen Tyler
125 E. 44th St.
New York, NY 16754
December 18, 1992

Dr. John Barleycorn
President
City School District 25
1234 12th Ave.
New York, NY 19876

Dear Dr. Barleycorn:

The American Medical Student Association (AMSA), the largest organization of medical students, is keenly interested in issues concerning child and adolescent health. Currently, AMSA is concentrating much of its energy towards the topic of HIV and AIDS.

With this in mind, the AMSA chapter at the New York University School of Medicine (AMSA at NYU) is currently sponsoring a program called "Students Teaching AIDS To Students" (STATS). The goal of STATS is to have medical students present information to local children ranging from grades 7-12 about HIV/AIDS and its spread. The presentation will consist of two parts. First, a short lecture will be used to provide general information on HIV/AIDS. The second part will consist of interactive games and exercises to further reinforce the lecture, and to give the students an ample environment to voice their questions and concerns. We believe that local junior and senior high schools will provide an excellent environment for a program such as this.

STATS has many advantages, chief of which is the education of an at-risk population about AIDS. Medical students are in an ideal position to teach about AIDS because they learn about new developments as they unfold. In addition, other health education projects sponsored by AMSA have been extremely successful and well received.

We will be contacting you shortly in hopes of setting up an appointment to discuss this further with you. Thank you in advance for your time and consideration in this important matter.

If you have any questions, please do not hesitate to reach me at 212-555-1234.

Sincerely,

Stephen Tyler
STATS Coordinator
AMSA at NYU

PRETEST/POSTTEST

- | | | | |
|-----|---|---|---|
| 1. | HIV is life threatening. | T | F |
| 2. | A person can become HIV positive from a mosquito bite. | T | F |
| 3. | A person can get the HIV virus from donating blood. | T | F |
| 4. | If you touch someone who is HIV positive, you can become HIV positive. | T | F |
| 5. | Most men who have sex with men have the HIV virus. | T | F |
| 6. | Anybody can get HIV. | T | F |
| 7. | The HIV virus can be spread by using someone's hairbrush. | T | F |
| 8. | Having sex with someone who is HIV positive is one way of becoming HIV positive yourself. | T | F |
| 9. | HIV can be cured if treated early. | T | F |
| 10. | If a pregnant woman is HIV positive, there is a chance her baby will be HIV positive too. | T | F |
| 11. | Using a condom during sex can lower the risk of getting the HIV virus. | T | F |
| 12. | You can get the HIV virus by getting a tattoo. | T | F |
| 13. | People with HIV may get other diseases because of being HIV+ . | T | F |
| 14. | A negative HIV blood test means you are not HIV positive. | T | F |
| 15. | People can be infected with the HIV virus without knowing it. | T | F |
| 16. | If your girlfriend/boyfriend has tested negative for HIV in the past, you are not at risk if you participate in a risky behavior with them. | T | F |

PRETEST/POSTTEST ANSWERS

1. T
2. F
3. F
4. F
5. F
6. T
7. F
8. T
9. F
10. T
11. T
12. T
13. T
14. F
15. T
16. F

Remember to do this!! It will not only help you to prepare, but may be the only gauge you have towards the evaluation of your program. Also, please remember to send the results to the AMSA National office or the National STATS Coordinator. Finally, you do not have to send us each test but rather use the tabulation sheet on the Presenter' evaluation form for each session.

STUDENT EVALUATION

This form is to be completed by all students being taught by STATS teachers. This is their opportunity to give you feedback about your presentation.

1. What did you like best about this program?
2. What did you dislike the most about this presentation?
3. Tell us one new fact that you learned?
4. Is there anything else that you wish we had covered in our presentation?
5. Were the medical students who talked to you approachable? well prepared?
6. Did the program last long enough, too long, or not long enough?
7. Please use the space below to make any additional comments.

TEACHER EVALUATION FORM

Once the STATS program has been taught, this form is to be completed by a representative (teacher, coach, counselor, etc.) of the group addressed.

1. Please comment on the appropriateness of the material presented to your particular group of adolescents. Was it too simplistic, over their heads, too explicit, not explicit enough?

2. Do you think the adolescents benefited from the sessions?

3. How much time did the class take? Was this enough?

4. Did the medical students and teenagers interact well?

5. Would you employ the STATS program again in the future? Please explain.

6. Please use the space below to describe how you would have changed the STATS presentation, or to make any additional comments.

PRESENTER'S EVALUATION FORM

Date and location of presentation: _____ Facilitators: _____

Test scores

Grade test used in (circle one): 7/8 9/10 11/12

Pre:

Post:

16 _____	16 _____
15 _____	15 _____
14 _____	14 _____
13 _____	13 _____
12 _____	12 _____
11 _____	11 _____
10 _____	10 _____
9 _____	9 _____
8 _____	8 _____
7 _____	7 _____
6 _____	6 _____
5 _____	5 _____
4 _____	4 _____
3 _____	3 _____
2 _____	2 _____
1 _____	1 _____

Average _____

Average _____

The number of times questions were missed:

1 _____	
2 _____	
3 _____	Number of People In Audience _____
4 _____	Number of people who took the test? _____
5 _____	Further suggestions?
6 _____	
7 _____	
8 _____	
9 _____	
10 _____	
11 _____	
12 _____	
13 _____	
14 _____	
15 _____	
16 _____	

HIV: SOME BASICS

Answer the following questions.

1. What do the letters A I D S stand for?

A _____ D _____

I _____ S _____

2. AIDS is caused by a _____ called _____ virus (HIV).

3. The body system that protects you from disease is your _____.

4. If you acquire HIV, your immune system can become weakened or damaged and unable to

_____.

5. Name three ways that HIV can be spread:

6. Name three ways that HIV cannot be spread:

7. What are the two most effective ways you can protect yourself from HIV infection?

8. Write a question you have about HIV infection:

UNFINISHED SENTENCES

1. A girl who carries condoms is _____.
2. A boy who carries condoms is _____.
3. A 17 year-old girl who is a virgin is a _____.
4. A 17 year-old boy who is virgin is _____.
5. Gay people are
_____.
6. Straight people are _____.
7. Preparing in advance to have sex is _____.
8. Having sex wherever and whenever you want is _____
_____.
9. People who pressure others into sex or drugs are _____
_____.
10. People who are pressured into sex or drug use by others are

_____.
11. Using a condom for sex is _____.
12. Not using a condom for sex is _____.
13. Talking about sex with adults is _____.
14. Talking about sex with friends is _____.
15. Safer sex is _____.
16. A person with AIDS is _____.
17. A person who shoots drugs is _____.
18. Being around someone with AIDS would be _____
_____.

WHAT DO YOU THINK?

Read the first part of each unfinished sentence. Complete each sentence in the way you think it should be answered. Remember, there are no right or wrong answers.

- 1) Learning about AIDS has made me think about ...

- 2) People should know about AIDS because...

- 3) People who get AIDS are...

- 4) If there was someone in my school who had AIDS, I would...

- 5) If I had a friend who had AIDS, I would...

- 6) Saying "NO" to sex and drugs is...

- 7) Hearing people say things that hurt or make fun of people with AIDS makes me feel...

- 8) I am angry about AIDS because...

- 9) The thing about AIDS that worries me the most is...

- 10) People can help people with AIDS by...

- 11) Something about AIDS that I'm still not sure about is...

- 12) The most important thing I would tell my friends about AIDS is...

- 13) I can help stop AIDS by...

grown-ups or kids—to say no to tempting risky situations. But saying no is a skill, and, if you practice that skill, it's easier.

“If I decide to say no, what should I do?”

Say no as soon as possible.

Do not apologize for saying no. It's your right.

You do not need to give a reason—“No” is enough.

You do not have to respond to arguments and pressure—keep saying no.

If you need to, leave the situation.

“Yeah, but what do I say?”

Practice some responses.

How would you respond if someone said to you:

ARGUMENT

YOUR RESPONSE

Everyone is doing it.

You would do it if you loved me.

Are you afraid?

Oh, grow up. You act like such a kid.

I know we're not supposed to. That's
part of the fun.

If you don't say yes, I'm leaving.

Do you have a problem or something?

Come on. It'll be fun. Just try it.

Why do you say no? Nothing bad will
happen.

Twenty Ways to Say NO to Sexual Involvement

- 1) I don't want to have sexual intercourse now. I've decided to wait.
- 2) If I were going to have sexual intercourse with anyone, it would be with you. But I'm not going to do it now.
- 3) When you don't listen to what I've said, it really makes me angry.
- 4) I really care about you, but when you keep pressuring me it makes me feel that you don't care about my feelings.
- 5) Sure I wonder what sexual intercourse is like, but I'm not ready for it now.
- 6) I don't think everyone is doing it, but even if they are, I'm not.
- 7) It's not because of you; it's because of me. I want to wait.
- 8) I have enough pressure on me. I'm not ready for sexual intercourse, too.
- 9) Don't try to confuse what I'm saying. We're not talking about caring. We're talking about sexual intercourse and I'm saying no.
- 10) If you loved me, you wouldn't pressure me.
- 11) You keep asking me to do something I don't want to do. It makes me feel like you don't care about how I feel.
- 12) The idea of sexual intercourse is exciting, but there's more to it than that and I'm not ready yet.
- 13) I said no and I meant it—that's all there is to it.
- 14) The only sure way not to get pregnant is not to have sexual intercourse.
- 15) If I wanted to do it, I wouldn't be saying no.

16) Having sexual intercourse doesn't prove you're a man/woman. It's not for me right now.

17) If all I mean to you is a body to have sexual intercourse with, then we'd better look at why we see each other. You have no right to use me.

18) What other people do is their business. I make my own decisions and I've decided to wait.

19) Having sexual intercourse won't prove we love each other. I have too much self-respect to do it before I'm ready. I've decided to wait.

20) Fill in your own _____

from Teen Age Health Modules, Education Development Center, Inc.

A Plan for Resisting Sexual Pressures

- Write down what your beliefs are about what is sexually right for you and why.
- Talk with parents or legal guardians you can trust about sexual decision-making. Often they had similar questions or ideas when they were adolescents.
- Talk with another adult you trust, such as an aunt or uncle, grandparent, member of the clergy, guidance counselor, health care worker, youth leader, neighbor, or coach.
- Talk with friends about sexual decision-making. Support friends in a decision to withstand pressures and ask support from them. For example, discuss that:
 - >Sexual intercourse involves the risks of pregnancy and sexually transmitted diseases (STDs). STDs may impair health, cause infertility, and—as in the case of HIV infection—prove to be fatal.
 - >Sexual intercourse may cause emotional stress.
- Prepare in advance how you might answer anyone who tries to pressure you to have sex. Write down a list of things you can say.
- Practice using these responses by role-playing a pressure situation with other students.

Student Guide to HIV Antibody Testing

Who may wish to consider getting tested?

A person who suspects she or he may have contracted HIV through one or more of the following behaviors:

- sharing needles/syringes/works/skin-popping equipment with an HIV-infected person (whether for illegal or prescribed drugs, for injecting steroids, or for tattooing or piercing parts of the body).
- having sexual intercourse with an HIV-infected person of the same or opposite sex.
- receiving a blood transfusion, especially prior to April 1985.
- using therapeutic blood products, especially prior to April 1985 (this specifically places people with hemophilia at risk for HIV infection).
- having been born to an HIV-infected mother.
- Having an opportunistic infection or other signs or symptoms of HIV-related illness.
- having sexual intercourse with multiple partners. *Note:* Every time one repeats high-risk behaviors, one multiplies the odds of contracting HIV. However, it is important to recognize that *even one time* of engaging in a high-risk behavior puts one at risk of contracting HIV. For example, having sexual intercourse only once with an HIV-infected person can lead to infection.

A person may also be at high risk for HIV infection if he or she has had a sexually transmitted disease, especially one that causes a sore or ulceration of the skin (e.g., syphilis, herpes, and chancroid). Skin is generally an effective barrier to most types of infection, but cuts and sores create openings for HIV to get into or from which HIV can be transmitted. Take care to shield broken skin from other people's body fluids.

If there is no cure for HIV/AIDS, why get tested?

1. If a person has engaged in high-risk behavior but is found *not* to be infected, he or she can:
 - ♥ be relieved of the anxiety of *not* knowing.
 - ♥ learn, through counseling, how to continue to avoid infection.
2. If a person *is* infected with HIV, he or she can:
 - ♥ be relieved of the anxiety of *not* knowing.
 - ♥ seek early health care & treatment that can help a person with HIV live longer by avoiding certain infections & by slowing the progression to AIDS
 - ♥ make an informed choice about life decisions—for example, the education or career choice decisions, making a will, making child custody arrangements, and making other survival plans for children and/or other family members.
 - ♥ inform sexual partner(s) about any exposure to HIV and the need for protection.
 - ♥ make responsible decisions about future sexual intercourse and then need for protection.

How does HIV antibody testing work?

A small sample of blood is tested for antibodies to HIV. The most commonly used test is an ELISA test (ELISA stands for Enzyme-Linked ImmunoSorbent Assay). If the ELISA test reveals the presence of antibodies to HIV, a follow-up test such as the Western Blot is done to confirm the results.

There is a “window period” from the time of infection to the time when sufficient antibodies appear to enable the test to reveal HIV infection. This window period is usually six months, but in some cases, may be longer. For this reason, a person who receives a negative test result can only be *certain* of its accuracy if she or he:

- ♣ received a negative test result & repeated the test 6 months later; *and*
- ♣ has abstained from behaviors associated with risk for HIV transmission since the time of testing.

Why is counseling before and after HIV testing required?

HIV testing is a very emotional experience for most people. A counselor can:

- ⊕ help people cope with feelings, such as anxiety and fear.
- ⊕ explain how HIV is transmitted and how to prevent infection, or, if already infected, how to avoid transmitting the virus to others.
- ⊕ help people decide how they can reduce their risk for HIV.
- ⊕ help people evaluate whether they are at risk of infection.
- ⊕ help people decide if they should be tested.
- ⊕ help people decide if they want confidential or anonymous HIV testing.
- ⊕ explain HIV testing and results.
- ⊕ refer people for health care or other services, as necessary.
- ⊕ discuss how to communicate with family, friends, sexual partner(s) about HIV.
- ⊕ help people decide whether and when to get re-tested to confirm a previously negative test, if there is a chance that a significant quantity of antibodies had not yet developed at the time of the first test.
- ⊕ discuss how to live with HIV, should the test reveal HIV antibodies.
- ⊕ discuss how to prevent HIV.
- ⊕ support one’s decision to remain or become abstinent, or to practice safer sex
- ⊕ explain means of sexual expression that do not put oneself or one’s partner(s) at risk for HIV infection.

Do I have to be tested if I don’t want to be tested?

- ◇ In most states, HIV testing is a voluntary personal choice. Even if a person visits a testing site, she or he can leave after the pre-counseling and think about the decision.
- ◇ In some instances, HIV testing **is** mandated. For example, testing is required for entrance into the armed services, the Peace Corps, the Job Corps, and certain other government jobs. People in federal prisons are also tested, regardless of their wishes. Some insurance companies require HIV testing before they will cover applicants.

Where do I get tested?

There are many agencies and/or organizations that provide HIV counseling and testing services. Contact your local health department or hospital for places that provide services for adolescents.

What is the difference between anonymous and confidential testing?

Voluntary counseling and testing may be either anonymous or confidential, although a choice between the two may not be available at each site.

Δ Anonymous testing is when no one (including the counselor) knows the name of the person who has come in for testing; the person is identified only through the use of a code number. The person being tested returns to the site after the mutually agreed-upon time/date, submits a number card, and is then given the test results.

Δ Confidential testing is when the counselor or agency knows the name of the person being tested and promises to keep the test results confidential. It is hoped that staff members can use this information to develop ongoing supportive relationships with clients, providing not only medical referrals and services, but also a trusted person to talk to over a period of time.

Regulations may require the agency to disclose results to doctors and other caregivers, government programs, such as Medicaid, medical insurance companies, etc. Test results are supposed to be kept confidential, but there is the risk that someone will disclose results by accident. *Although it is true for adults that no test results can be revealed to others without the affected person first signing a release form, it is not always true for adolescents, e.g., youths in foster placement, incarcerated youths, etc.*

For statistical purposes, there is a reporting requirement for the health care provider who initially concludes that the individual is HIV+. In some states, it is now required that the number, *not the names*, of persons who are HIV+, as well as the number of AIDS cases, is reported to the state Department of Health. These numbers are then reported to the Centers for Disease Control (CDC), who track the numbers of HIV and AIDS cases nationwide to help plan strategies for fighting the disease.

Common STDs

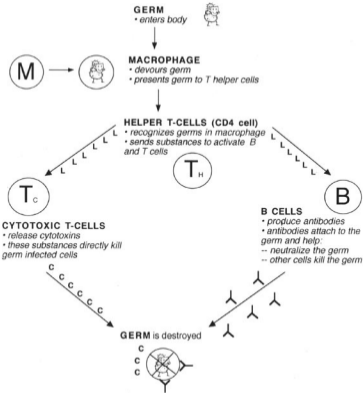
Disease	How it's transmitted	Signs/Symptoms	Treatment
HPV Genital Warts Condyloma	Direct contact with genital warts or skin that contains HPV (Human Papilloma Virus) Many people show no external signs or warts, but still transmit this virus.	Soft, painless, fleshy growths around the vaginal area, anus, penis, or urethra. Growths may appear several months or up to one year after contact.	Removal of warts with chemical, laser, or surgical procedures. Partners need exam. Use of condoms until controlled.
Chlamydia	Contact with the organism <i>Chlamydia trachomatis</i> in the vagina or penis. Transmission can occur even if there are no signs or symptoms of infection, which may persist for years.	MEN: Burning or painful urination; thin, watery discharge from the penis. WOMEN: Often no symptoms until PID* develops. May be tested during GYN exams.	Infected persons and their sexual partners must be tested and/or treated with antibiotics.
Herpes	Contact with herpes sores at any stage in their development. Transmission can be genital-genital or genital-oral. Asymptomatic transmission (without signs of infection) is rare but cannot be ruled out.	1-6 weeks after contact, sores appear around the mouth, genitals, or anus, often with small painful blisters. Have any suspicious sore cultured while it's an open sore to determine if it is herpes.	Avoid genital-genital or oral-genital contact while sores exist. Oral drugs or ointment may help relieve pain but will not cure herpes.
Crab lice	Generally requires close genital contact or close contact with bedding, undergarments, towels, or hairbrush used by an infected person.	Itching, especially at night. Visible lice in pubic hair and eggs (nits) attached to hair shafts.	Medicated lotion or shampoo. Partners should be treated. Wash bedding and clothes in HOT water.
AIDS HIV-infection	Virus is transmitted by blood-to-blood contact, exposure to semen or vaginal fluids, or mother to fetus/infant. Infected persons may show no symptoms for many years but are still	Positive HIV test. Unusual susceptibility to common infections and unusual cancers. Significant unexplained prolonged fever, weight loss, diarrhea, and/or swollen glands.	No current proven cure for AIDS. Some treatments prolong the symptom-free period or reduce the symptoms of infections.

<p>Gonorrhea</p>	<p>infected and can transmit the virus. Through vaginal, anal, or oral-genital contact with an infected person. <i>Many people have no symptoms but still transmit Gonorrhea,</i> especially when it occurs in the throat or rectum. Women often have no symptoms until PID*.</p>	<p>1-14 days after sexual contact, a yellow-green discharge from the penis or vagina may occur. Burning or painful urination or bowel movement; fever; testicular pain in men; painful irregular periods in women; painful intercourse; lower abdominal cramps.</p>	<p>Infected persons and their sexual partners must be tested and treated with antibiotics. Follow-up cultures and exam are necessary.</p>
<p>Hepatitis B most common contagious liver disease</p>	<p>By direct contact with the <i>blood or body fluids</i> of an infected person, through oral, vaginal, or anal intercourse, through open wounds, or through body fluids present on shared needles, razors, nail clippers, pierced earrings, or toothbrushes.</p>	<p>1-6 months after exposure to the virus, symptoms appear. Nausea, vomiting, diarrhea, lack of appetite, dark urine, yellowing of skin or eyes, low-grade fever or malaise are most common. 50% of those infected do not get symptoms.</p>	<p>No specific treatment. Rest and a good diet are recommended. Avoid alcohol and/or medications metabolized by the liver. BE SAFE—GET VACCINATED!</p>
<p>Syphilis</p>	<p>Close intimate or sexual contact with fluid from a syphilitic sore. During pregnancy, an infected mother may transmit it to a fetus.</p>	<p>Painless sore at point of contact; usually the penis, anus, rectum, vagina, cervix, or mouth. Second stage may include rash and swollen lymph nodes.</p>	<p>Infected persons and their sexual partners must be tested and treated with antibiotics.</p>

*PID = Pelvic Inflammatory Disease—an infection of the fallopian tubes. Symptoms include fever, abdominal pain, heavy vaginal bleeding, and excessive discharge. PID can lead to infertility.

**UTI = Urinary Tract Infection-- burning, frequency, and urgency with urination are common. May have blood in urine or fever. These symptoms require immediate treatment with an antibiotic.

How the Immune System Works



If **GERM** enters the body again, **B-CELLS** and **T-CELLS** have a **MEMORY** and they will recognize the **GERM** and make **ANTIBODIES** and **CYTOTOXIC T-CELLS** to destroy it.

HIV/AIDS Word Search

Find the following words in the *HIV/AIDS Word Search*. The words may appear horizontally, vertically, or diagonally, and may be spelled backwards. A single letter may be used in more than one word.

ABSTINENCE
BEHAVIOR
DECISION
INFECTION
MACROPHAGE
SEMEN
TRANSMIT

AIDS
BLOOD
DRUGS
INJECT
OPPORTUNISTIC
STD
VAGINAL FLUIDS

ANTIBODY
COMPASSION
HIV
INTERCOURSE
PREGNANCY
T-CELLS
VIRUS

B-CELLS
CONDOM
IMMUNE
JUDGMENT
RISKY
TESTING

Q A L V A G N I A L F L U I D S A V B T I A B C D K
C N A M B H I L N O P P O R T U N I S T I C P D S I
R T E S T I N G P F H E A L L A Z R X T X N T I T Y
L I V O E E W A C F E G R I P P Y U D R C P J R K T
Z B S T O P B B R K H C S J O Y S S N A R T Y E I S
R O G L V C P L R P I I T S G C E D T N F F E S C F
E D R L E O H P O V C A D I F N E I O S S O S C X T
A Y D L G O A S E O C A L L O A E S A M T V O T Y T
L I L Z B A G I N T D D S M M N A M E I R Y S X S O
I S R A D S E D T R D S K A M G A E L T X T R U Y R
T T E S M I O T A A I T C C X E A K K I X I P Y T S
E A A M T M M E T N S R Y R S R T S R P R Y C R K S
I J B T E S X I N G O B T O I P I I O I C O O S I D
M U S N A N T I B P L E I P A P T T I E M B M U P I
M D T O L L E B H D A N F H I C Y P V P R A R E T U
U G I I C R A A H E A L G A T P R B R A H S S A I P L
N M G S Q U G M A C R O V G S K P S H K I O S D P F
E E L I F E L T H O S D I A Q I S R E T O T I R T L
A N A C R E L H R J D R H U G I S E B A U R O A A A
C T A E G X E N O I K E J C O C I S P E I P N P S N
H L F D R U G S O Q S S A N O E S R U O C R E T N I
B E H A V E O O P Q I K K R P K S U T U J H R U P G
U X C E L M P E D O U N Y U N T P T T S T I J L E A
T C E L L S D E I I B C E A B S T I N E N C E G O V