

HIV and Homeless Shelters

Policy and Practice



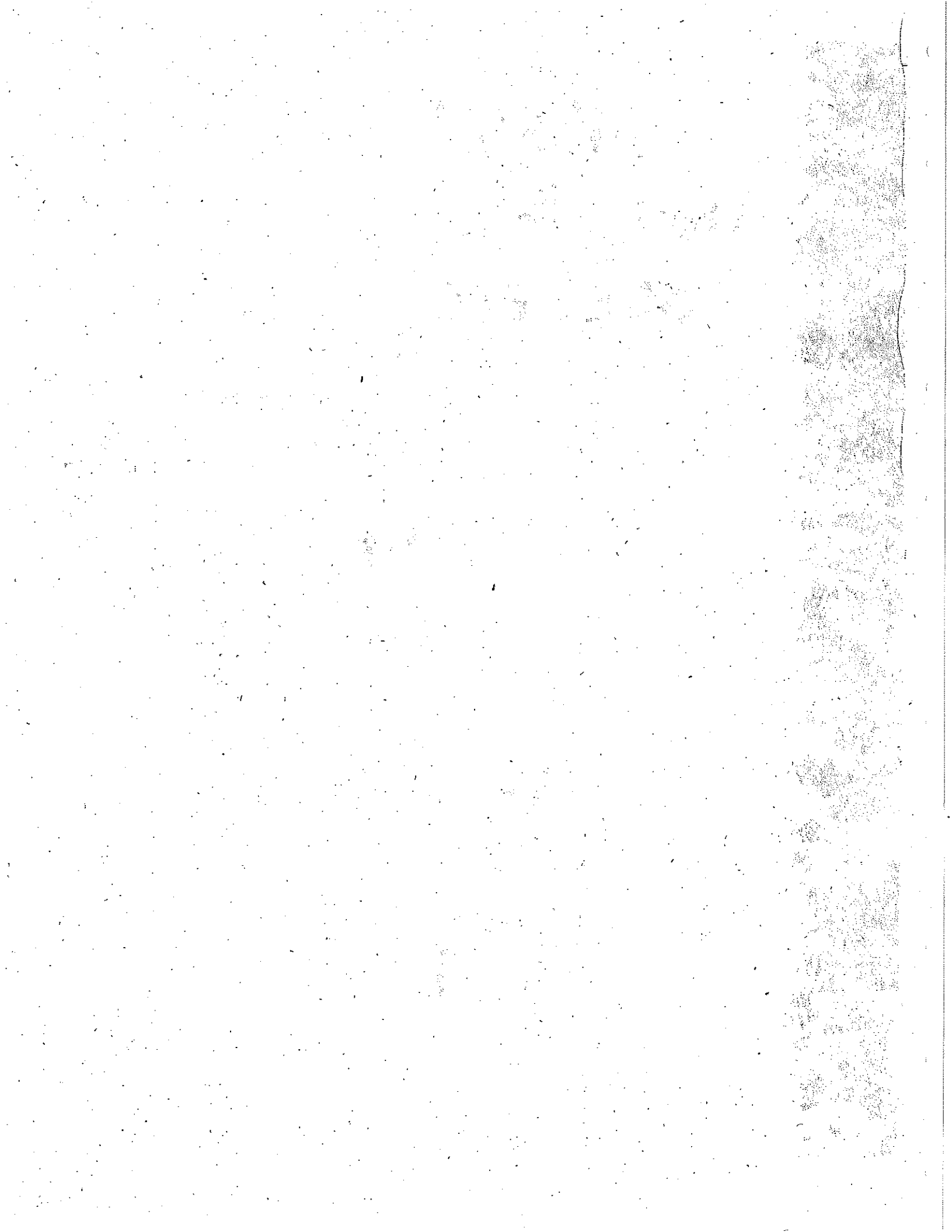
**American Civil Liberties Union
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HIV and Homeless Shelters:

Policy and Practice

by Michael Adams

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HIV and Homeless Shelters: Policy and Practice

December 1999

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Director, AIDS Project

Founded in 1986, the AIDS Project of the ACLU works to protect the civil liberties of people with HIV and AIDS.

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Part I: An Introduction

HIV And Homelessness: The Connection

The crises of homelessness and HIV are two of our country's greatest challenges. Rather than existing independent of each other, they are inextricably interwoven. It is estimated that between one third and one half of people living with AIDS in the United States are either homeless or at imminent risk of homelessness.¹ This means that a disproportionate number of homeless individuals are infected with HIV. A study tracking the spread of HIV in the late '80's and early '90's in 16 U.S. cities reported a median HIV seroprevalence of 3.4% for homeless adults, compared to less than 1% for the general population.²

In more recent studies of urban centers with high HIV seroprevalence, rates of HIV among homeless persons are even higher (8.5% among homeless adults in San Francisco; 19.4% among homeless mentally ill men in New York City).³

These figures are not surprising, given that homelessness frequently occurs in combination with substance abuse, unsafe sexual behavior, and/or chronic mental illness, all factors that heighten the risk of HIV infection.⁴ A recent survey of homeless adults found that 69% were at risk for HIV infection from either unprotected sex with multiple partners, injection drug use, sex with IDU partners, or exchanging unprotected sex for money or drugs.⁵

Homeless women and adolescents are especially at risk. Homeless women frequently associate with men for protection and end up being sexually abused; they are four times as likely as domiciled women to be raped.⁶ Homeless adolescents engage in especially high levels of both unsafe sex and substance abuse. They are raped and sexually abused in large numbers and engage in "survival sex" that sometimes leads to systematic prostitution.⁷ In addition, it is estimated that between seventy and eighty five percent of homeless youth abuse substances.⁸

The Links That Bind Prevention, Care And Discrimination

As this stark reality makes apparent, homeless people are in desperate need of HIV-related prevention services and, in many cases, care. Prevention is critical to encourage behavioral changes that will reduce the risk of HIV infection among homeless persons; those who are already infected with HIV must be encouraged to avoid behavior that puts others at risk. And in an era of promising, if imperfect medical treatments, access to care and support services is critical.

But homelessness itself infinitely complicates care and prevention. The lack of housing makes it even more difficult to maintain what are already complicated treatment regimens, not to mention the dangers of medication being stolen or lost on the streets.⁹ And effective prevention, which involves far more than giving people information about how HIV is transmitted,¹⁰ is hard to provide to a population that has no safe place for sleep and meals, much less education.

Shelter settings provide critical opportunities to provide homeless people with HIV prevention services and referrals for care. To be sure, shelter-based approaches to HIV are no panacea. Shelters should always be seen as a temporary resource in times of emergency; they are not an acceptable replacement for permanent housing, which must remain the goal for all people. This is especially true for people with HIV, for whom shelters pose inherent dangers.¹¹ But compared to the streets, the safer space of the shelter offers the best chance to provide prevention services and links to care to many.¹² It is therefore extremely important to make shelters welcoming places for homeless people who have HIV or are at risk for infection.

Stigma against people with HIV is on the rise again, and shelters are not immune from this problem. In a recently published national telephone survey, approximately one third of those interviewed expressed discomfort and negative feelings toward people with HIV. The number of individuals who overestimated the risks of HIV transmission through casual contact and who perceived people with HIV as deserving their condition was higher than those reporting the same beliefs in a similar survey conducted in 1991.¹³

Besides creating additional stressors and emotional trauma for people with HIV, stigma leads to reduced social support.¹⁴ The social crises of HIV and homelessness each have their own stigma attached to them. Combining the two together creates a level of social marginalization for homeless people with HIV that "has profound consequences for their psychological state and their willingness to comply with treatments."¹⁵ While people with HIV are fre-

quently stigmatized as being to blame for their illness,¹⁶ homeless people with HIV are additionally branded as dangerous and unproductive members of society.¹⁷ Ironically, this stigma and branding occurs even in settings which are designed to serve homeless persons. As a result, homeless men and women with HIV repeatedly have been barred from shelters.¹⁸ It was one such incident that motivated this report.

A True Story

In December 1997, Patrick Biggers took up temporary residence at the Emmaus Center in Ellsworth, Maine. Although the quality of Emmaus' work with the homeless is in general highly respected, it quickly became clear that the shelter was not a safe place for people with HIV. Within a few days of Patrick's arrival, both staff and residents at the shelter were up in arms about his presence, and two days before Christmas Patrick was forced out of the shelter and into a local motel. He spent the holidays alone, cut off from the only social support structure that had been available to him.

In response to a complaint filed with the Maine Human Rights Commission by the ACLU on Patrick's behalf, Emmaus argued that it had evicted Patrick not because he has HIV, but because of his "dangerous behavior." Emmaus went on to explain that Patrick's "dangerous behavior" included telling other shelter residents that he had HIV, holding a baby, handing a resident a cup of coffee, drinking out of a cup, and touching dishes in the shelter's kitchen. Shelter residents were afraid to eat at the same table with Patrick; some of them start-

ed sleeping outside the building. Shelter staff complained that Patrick should not be talking about his health status and that he was putting staff and residents at risk of HIV transmission via saliva. After Patrick was transferred to the motel, the shelter director ordered that "everything on the sink counter should be run through the dishwasher."

When the Maine Human Rights Commission indicated it intended to find probable cause that Emmaus had broken the law, the shelter entered into negotiations with the ACLU. Ultimately, the shelter agreed to adopt a clear and detailed non-discrimination policy to protect people with HIV, to conduct a series of HIV training workshops for staff and residents, and to issue a written apology to Patrick.

Patrick's story has a somewhat happy ending. But the fact remains that a homeless man was discriminated against, the support system through which he accessed care was shattered, and an opportunity to provide prevention education to shelter residents and to reinforce the behavior modification of a homeless man with HIV was lost the day Patrick was kicked out of Emmaus.

Part II: A Primer on HIV and Homeless Shelters

HIV is not easily transmissible. It is spread by direct contact with infected body fluids: blood, semen, vaginal secretions and breast milk. This means that HIV contained in one of these fluids must get into the bloodstream by direct entry into a vein or a break in the skin or mucous linings (the eyes, mouth, nose, vagina, rectum or penis). HIV is not contained in body fluids like urine, saliva, sweat and vomit, unless blood is present. It cannot be transmitted through air, water, food or casual contact such as handshaking. Nor can it be transmitted through sneezing, coughing, eating or drinking from common utensils, sitting on a toilet seat, or merely being around a person with HIV.

People get HIV from unprotected sex and from needles. Sex and needle sharing is prohibited in shelters. Each may occur from time to time despite the rules, but neither poses a greater threat inside a shelter than exists anywhere else. The bottom line is that there is no real threat of HIV transmission in a homeless shelter unless people are having unprotected sex or sharing needles.

HIV And The Shelter Setting

The shelter setting is not a breeding ground for HIV transmission, but it should

be a safe place for HIV prevention education. Too often, however, the shelter is instead a place of indifference or outright hostility for people who have HIV or are at risk for infection. Although this is tragic, it is not entirely surprising. Indeed, many of the characteristics of shelter life are conducive to an atmosphere of fear and intolerance. Homeless people staying in shelters have no private space and are forced to share close living quarters with people whom they do not know and who often exhibit anti-social behavior. Fear and mistrust of others is common in this environment.

When it comes to HIV, these attitudes are exacerbated by lack of information, misinformation, homophobia¹⁹ and addict-phobia.²⁰ Homeless people are relatively well-informed about those activities that pose a high risk of HIV transmission, like unprotected sex and injection drug use. Unfortunately, studies show that homeless persons frequently do not differentiate these high risk activities from others that pose no risk of transmission, such as sharing eating utensils and sitting on toilet seats.²¹ Such misunderstandings frequently correlate with discriminatory attitudes.²² And as the story of Patrick Biggers demonstrates, shelter staff can be equally misinformed and saddled with HIV-related bias.

Ironically, while people with HIV are often treated as a health threat in shelters, in reality it is the shelter that presents a health threat to the person with HIV. Once a person's immune system is weakened by HIV, both the risk of contracting infections and the damage caused by any infection increases. And shelter conditions often pose serious health risks to individuals with compromised immune systems. Thanks to

scarce resources, high turnover rates, and the sheer number of people served, unsanitary conditions are common in the shelter setting. These conditions lend themselves to the spread of infectious diseases. In fact, infectious diseases such as Hepatitis A, bronchitis, pneumonia and skin infestations (such as lice and scabies) are rampant in many shelters.

Currently, the most serious infectious diseases commonly found among homeless persons in shelters are tuberculosis (TB), Hepatitis C, and HIV. People with HIV are highly susceptible to TB. Homeless people with HIV who sleep in shelters are twice as likely to have TB as shelter residents who are HIV-negative, and the impact of TB is far more severe on immuno-compromised individuals.²³

The health threats to homeless people with HIV are exacerbated by delays in diagnosis of medical problems and inadequate follow-up. In addition, homeless people with HIV who need treatment are more likely to face hospitalization rather than outpatient care since they have no appropriate setting in which to recuperate.²⁴ While outpatient care often better serves the emotional health of people with HIV,²⁵ hospitalization is often preferable to a shelter when it comes to recuperating from an infection. Shelter living requires sharing rooms, bathrooms, and the like, depriving people with HIV of the option of attending to their medical needs in private. Additionally, many shelters close their doors during the day, leaving a homeless person with HIV no place to rest and recuperate and adding the additional burden of carrying belongings throughout the day.²⁶

Shelters pose special challenges for peo-

ple with HIV even when they are relatively healthy because HIV-related drug regimens are so demanding and rigorous. Many HIV-related drugs must be refrigerated and/or taken with food, and all must be taken on strict time schedules. The failure to administer medications according to proper scheduling can result in the development of resistance to the drugs. While adherence to medical regimens is certainly easier in shelters than on the street, even in the shelter setting refrigeration is not always available and coordination of drug and food requirements is often difficult. For example, meal schedules may not coincide with the prescribed schedule for taking medications.

Part III: What the Law Requires

Homeless shelters are subject to the requirements of the federal Americans with Disabilities Act (ADA), which forbids discrimination against all people with disabilities in any public accommodation.²⁷ People with HIV are protected against discrimination under this law, and homeless shelters are public accommodations.

The ADA imposes two requirements on shelters. First, they may not discriminate against people with HIV. This means that they must afford all people with HIV the opportunity to use all the services of the shelter on an equal basis – i.e. the same as everyone else. They may not forbid people with HIV from being a part of any of the regular services or programs of the shelter. As part of that equal treatment, shelters must make services available in an integrated way – in other words, shelters may not segregate people with HIV. They may not house them in a different section of the shelter (or at some location outside the shelter), require that people with HIV eat at a separate table or use a separate bathroom, or ask them not to use the same cups and dishes as the rest of the client population. Shelters may not single out someone whom they suspect may have HIV and require them to be tested in order to stay in the shelter.

Non-discrimination also means that shelters cannot tolerate harassment of people with HIV. If shelter staff treat somebody

worse because they have HIV, or if staff turn a blind eye to residents mistreating people with HIV, the shelter could be liable for discrimination.

The other requirement that the ADA imposes on shelters is a requirement of "reasonable accommodation" for people with HIV. "Reasonable accommodation" means that where it is necessary for a shelter to modify its program or practices to allow people with HIV to participate equally, they must make that modification. For example, if a shelter allows clients to store and take medication, then it must do what is necessary to make sure clients with HIV can store and take their medication also. If clients with HIV need to refrigerate their medication, then refrigeration must be provided. If clients with HIV need to take their medication with food, then access to food must be provided.

Finally, most shelters are also bound by state laws concerning the confidentiality of medical information in general, and HIV information in particular. These laws vary from state to state, but generally require that health care workers, and often others who have information on HIV status, keep that information confidential. Frequently, a general authorization to give out medical information is not enough to permit health care workers to disclose HIV information. Most states also impose strict conditions on when individuals may be tested for HIV, and in some there are criminal penalties for testing an individual for HIV without their express consent.

If a consumer or provider believes that the ADA has been violated by a shelter or other public accommodation, the victim of discrimination can sue or, in some cases,

complain to the U.S. Department of Justice (DOJ). The best thing to do is to call a lawyer or an AIDS service organization. Information can also be obtained from an ADA specialist at DOJ by calling (202) 514-0301. In addition, many states have administrative agencies that will investigate violations of state laws protecting people with HIV.

Part IV:

How to Make Shelters Safer Spaces for HIV Prevention & Care

While the combined crises of HIV and homelessness present tremendous challenges, shelters can take a number of steps to eliminate discrimination against people with HIV and create a safe space for prevention and links to care.

1. **Adopt a non-Discrimination policy** which clearly prohibits all discrimination, including discrimination on the basis of HIV, AIDS and sexual orientation.²⁸ Make the policy as detailed as possible, so that staff and residents understand how it applies in the shelter setting. Distribute the policy broadly and post it in visible locations. Require staff to review and sign the policy as a pre-requisite of employment. While some people may have religious or other beliefs that affect their views on HIV and AIDS, emphasize the fact that public health policy, services provision, and the law cannot be based on these private beliefs.

Consult with local human rights officials or AIDS organizations to help you develop an appropriate non-discrimination policy. A model policy developed by the ACLU for the Emmaus Center is found at Appendix A.

2. **Provide mandatory staff training on HIV-related issues.** Educate staff about what HIV is, how it is transmitted, how it is treated, the need for universal precautions, the importance of ensuring that discrimination does not occur, and the resources available in your community. Local AIDS service organizations can be called on to provide these trainings. Information may also be obtained from your local or State Department of Health or the federal Centers for Disease Control and Prevention.

Residents should be encouraged to attend similar programs, particularly as part of any informational sessions the shelter provides on topics such as substance abuse, tuberculosis, health and hygiene. Sessions should include information about HIV transmission, how to avoid becoming infected with HIV and universal precautions. Set guidelines about respectful treatment of other residents. Emphasize tolerance and cultural sensitivity and make it clear that verbal and physical abuse will not be tolerated. Consider using peer educators.²⁹ Programs targetting residents should be brief, intensive, and cycle repeatedly.³⁰

HIV curricula should be tailored to the population served by a shelter. A sample curriculum for residents, provided by Health Care for the Homeless, Inc., is found at Appendix B. A sample curriculum for shelter staff, developed by the Down East AIDS Network of Ellsworth, Maine for the Emmaus Center, is found at Appendix C.

3. **Take steps to maintain the confidentiality of all individuals' HIV status.** Establish a confidentiality policy which ensures that no person is forced to disclose his or her HIV status, or has it disclosed without his or her consent. The confidentiality policy should cover conversations between shelter staff and staff of other service providers. Ensure that all records are kept confidential and that any services provided to individuals with HIV do not single them out such that their status is unnecessarily disclosed. If possible, allow unrestricted, private bathroom access.
4. **Establish non-discriminatory intake procedures that are sensitive to the needs of people with HIV.** Intake procedures should be based on the assumption that any person might have HIV and require confidentiality, respect and information about available HIV-related services. The shelter's confidentiality and non-discrimination policies should be explained during intake.
5. **Treat everyone the same, except where different treatment is necessary to accommodate the medical needs of a person with HIV or another disability.** People with HIV should not be distinguished from other residents. They should not be segregated into separate programs or facilities or served by separate staff members, except when HIV-specific services are being provided. Nor should they be treated any differently than other residents when it comes to casual touching, food preparation, or participation in shelter activities. Any policy that is promulgated with the interests of people with HIV in mind should be incorporated into the procedures and services available to all residents. For example, if medication calls are provided, these should apply to people with HIV just as they do to any other resident taking medication. If presentations are made about HIV, these should be open and advertised to all residents, in the same manner as presentations on other topics like domestic violence and drug abuse.
6. **Provide a "Consumer Bill of Rights" detailing the rights and privileges all residents can expect to receive while in the shelter.** These often include statements of non-discrimination and confidentiality, the consumer's right to receive competent and respectful services, the consumer's ability to make informed decisions about their services, and the consumer's responsibilities and obligations while staying at the shelter. A "Consumer Bill of Rights" must be written at a reading level and in languages that are accessible to homeless people, many of whom have limited formal education and do not speak English as a first language. Because some homeless people are pre-literate, providers should consider making the "Consumer Bill of Rights" available in non-written media, like video.
7. **Make the shelter a safe space for people with HIV by actively discouraging discrimination; by posting "safe zone" stickers which state that the shelter is a safe space for all, regardless of age, sex, race, sexual orientation, ability or HIV status; and by providing HIV-related**

materials and programs like those discussed above. Residents should know that there are supportive staff who they can talk to about HIV-related issues.

8. **Maintain clean and sanitary conditions at the shelter** to reduce the risk of infections to all residents. Encourage good hygiene and health and safety among residents.
9. **Introduce universal precautions into shelter safety procedures.** Universal precautions are procedures used to handle the blood, body fluids, open skin or mucous membranes (e.g. inside of the mouth or nose) of all individuals, regardless of whether they are known to have HIV or hepatitis. Such precautions allow the isolation of potentially harmful fluids, without isolating individuals.

Universal precautions include 1) treating all blood and body fluids as if they are infected with HIV or hepatitis, 2) wearing latex gloves when touching blood or body fluids, 3) using bleach to clean up any blood spillages, 4) washing hands with soap and running water after removal of gloves, and 5) disposing of latex gloves by rolling them up and placing them in plastic bags. Universal precautions can be posted above sinks and in other locations in shelters for all staff and residents to follow. Ask a local AIDS service organization or contact the federal Centers for Disease Control for more detailed information or pamphlets about universal precautions.

10. **Allow access to refrigerators and meal-time flexibility** to accommodate those individuals taking medications which require refrigeration and/or eating with medications. Provide clean drinking water – sometimes several pints a day are required for HIV-related medications. Help residents maintain their medication schedules by providing individual medications supervision. Medication storage, access and supervision must maintain the confidentiality of individuals with HIV. Ensure that medications are safe from theft and abuse.
11. **Connect residents to HIV-related services in the community.** Establish links with local AIDS service organizations, treatment centers, and community based organizations that can provide residents with access to medical treatment, counseling, family planning, more permanent housing and other services. Information about these organizations can be obtained from the Centers for Disease Control (CDC), the Health Resources and Services Administration (HRSA), or your local or state department of health. If possible, provide transportation to these organizations, clinics, medical appointments, pharmacies, and the like.

Resources

(in alphabetical order)

ACLU AIDS Project
 125 Broad St., 18th floor
 New York, NY 10004
 tel. (212) 549-2627
 fax (212) 549-2650
 lgbthiv@aclu.org
www.aclu.org/issues/aids/hmaids.html

AIDS Housing Washington
 2025 First Avenue, #420
 Seattle, WA 98121
 tel. (206) 448-5242
 fax (206) 441-9485
 info@aidshousing.org
www.aidshousing.org

Bailey House, Inc.
 275 Seventh Avenue, 12th Floor
 New York, NY 10001
 tel. (212) 633-2500
 fax (212) 633-2932
 RRQBH@aol.com

CDC National AIDS Clearinghouse
 P.O. Box 6003
 Rockville, MD 20849-6003
 tel. (800) 458-5231

CDC National AIDS Hotline
 1-800-342-AIDS (2437)
 Spanish: 1-800-344-SIDA (7432)
 Deaf: 1-800-243-7889
www.ashastd.org/nah/nah.html

Health Resources and Services Administration
www.hrsa.dhhs.gov

Housing Works
 594 Broadway, Suite 700
 New York, NY 10012
 tel. (212) 966-0466
 fax (212) 966-0869
www.housingworks.org

National AIDS Housing Coalition
 c/o Gina Quattrochi
 Bailey House, Inc.
 275 Seventh Avenue, 12th Floor
 New York, NY 10001
 tel. (212) 633-2500
 fax (212) 633-2932
 RRQBH@aol.com

National Alliance to End Homelessness
 1518 K St., NW, Suite 206
 Washington, D.C. 20005
 tel. (202) 638-1526
 fax (202) 638-4664
 naeh@naeh.org
www.naeh.org

National Clearinghouse on Families and Youth
 PO Box 13505
 Silver Spring, MD 20911-3505
 tel. (301) 608-8098
 fax (301) 608-8721

National Coalition for Homeless Veterans
331 Pennsylvania Ave., SE
Washington, DC 20003-1148
tel. (800) 838-4357
fax (800) 233-8582
nchv@nchv.org
www.nchv.org

National Coalition for the Homeless
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fax (202) 737-6445
nch@ari.net
nch.ari.net

**National Health Care For
The Homeless Council**
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fax (615) 226-1656
network@nhch.org
www.nhchc.org

**National Law Center on Homelessness
and Poverty**
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Washington, DC 20005
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fax (202) 628-2737
nlchp@nlchp.org
www.nlchp.org

National Network for Youth
1319 F Street NW, Suite 401
Washington, DC 20004-1113
tel. (202) 783-7949
fax (202) 783-7955
nn4youth@worldnet.att.net
nn4youth.org

**National Resource Center on Homelessness
and Mental Illness**
262 Delaware Avenue
Delmar, NY 12504-1123
tel. (800) 444-7415
fax (518) 439-7612
nrc@prainc.com
www.prairie.com/nrc

New York City AIDS Housing Network
475 Riverside Drive
New York, NY 10025
tel. (212) 870-3303
fax (212) 870-3334
Flynn@dtinet

Office of AIDS Housing
Dept. of Housing and Urban Development
451 7th St., S.W., Room 712
Washington, D.C. 20410
tel. (202) 708-1934

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Endnotes

- 1 S. Goldfinger, et al., HIV, Homelessness, and Serious Mental Illness: Implications for Policy and Practice, paper prepared for the National Resource Center on Homelessness and Mental Illness (March 1998).
- 2 D. Allen, et al., HIV Infection Among Homeless Adults and Runaway Youth, United States, 1989-1992, *AIDS* 1994 8:1593-1598.
- 3 A.R. Zolopa, et al., HIV and Tuberculosis Infection in San Francisco's Homeless Adults, *JAMA* 1994, 272:455-461; E. Susser, et al., Prevalence of HIV Infection Among Psychiatric Patients in a New York City Men's Shelter, *American Journal of Public Health* 1993, 83:568-570.
- 4 J.S. St. Lawrence and T. Basfield, HIV Risk Behavior Among Homeless Adults, in *AIDS Education and Prevention*, 7(1), 22-31, 1995.
- 5 Id. HIV is also transmitted perinatally, an important consideration for homeless women of child-bearing age.
- 6 B. Fisher, et al, Risks Associated With Long-Term Homelessness Among Women: Battery, Rape, and HIV Infection, in *International Journal of Health Services*, 25(2), 351-369, 1995.

- 7 J. Athey, HIV Infection and Homeless Adolescents, in *Child Welfare*, LXX(5), 517-528, 1991.
- 8 Id.
- 9 J. Raba, et al, Homelessness and AIDS, in *Under The Safety Net: The Health and Social Welfare of the Homeless in the United States*, 217-233 (1990).
- 10 The evidence suggests that most homeless people are already aware of what behaviors present a high risk of HIV infection, but have not been provided with education that has resulted in changes in behavior. Goldfinger, *supra* note 1.
- 11 The dangers that people with HIV confront in homeless shelters were well-documented by the Coalition for the Homeless in their legal challenge to New York City's practice of requiring an AIDS diagnosis in order to provide persons with HIV with non-shelter housing. In that case, the Supreme Court of New York found that forcing a person with HIV to stay in a "barracks type shelter" may well involve irreparable danger to his health...
Mixon v. Grinker, 595 N.Y.S. 2d 876 (1993). Indeed, the appellate court in the case ruled that moving people with HIV from barracks-type shelters to four person rooms did not meet "minimum standards of sanitation, safety and decency" because it did not protect people with HIV from contagious diseases. *Mixon v. Grinker*, 627 N.Y.S. 2d 668 (1995).
- 12 In addition, HIV education offered in shelter settings is only a partial solution because shelters fail to reach many homeless adults, the stays of shelter residents is limited, and the extent of contact with shelter residents is unpredictable. Lawrence and Bradford, *supra* note 4.
- 13 G. Herek, AIDS and Stigma, in *American Behavioral Scientist*, 42(7), 1108-1116 (1999) (Herek I).
- 14 C. Winkle & D. Ward-Chene, Power, Social Support and HIV-Related Service Use: The Roles of Community and Homelessness, in *Journal of Health & Social Policy*, 4(2), 1992.
- 15 Goldfinger, *supra* note 1 at 19-20.
- 16 G. Herek and J. Capitanio, AIDS Stigma and Sexual Prejudice, in *American Behavioral Scientist*, 42(7) 1130-1147 (1999) (Herek II).
- 17 L. Takahashi, The Socio-Spatial Stigmatization of Homelessness and HIV/AIDS, in *Social Science Medicine*, 45(6) 903-914 (1997).
- 18 Raba, *supra* note 9; M. Stoner, Interventions and Policies to Serve Homeless People Infected by HIV and AIDS, in *Journal of Health & Social Policy*, 7(1), 1995.

ENDNOTES

- 19 Numerous studies demonstrate that much of the stigma attached to AIDS and HIV reflects longstanding hostilities toward gay men specifically, and the lesbian and gay community more generally. See Herek II, *supra* note 16.
- 20 J. Capitanio & G. Herek, AIDS-Related Stigma and Attitudes Toward Injection Drug Users Among Black and White Americans, in *American Behavioral Scientist*, 42(7), 1148-1161 (1999).
- 21 Goldfinger, *supra* note 1 at 11, 13.
- 22 Herek I, *supra* note 13 at 1108-1109.
- 23 Goldfinger, *supra* note 1 at 22-23; Stoner, *supra* note 18 at 58-59.
- 24 Raba, *supra* note 9 at 223.
- 25 Raba, *supra* note 9; Stoner, *supra* note 18.
- 26 Shelter living and shelter hours unacceptably deprive all homeless persons, regardless of health status, of privacy and rest. The problems that result from this can be especially grave for people with HIV.
- 27 State law may provide similar or additional protections to disabled people, including people with HIV.
- 28 HIV-related bias is frequently motivated by discriminatory attitudes about sexual minorities. Herek II, *supra* note 16. Therefore, combatting HIV-based discrimination will frequently mean combatting sexual orientation discrimination.
- 29 Evidence suggests that homeless peers or "natural opinion leaders" are often more credible as educators and can avoid the often conflicting interactive styles of professional staff and homeless people. Lawrence, *supra* note 4 at 28-29.
- 30 Lawrence, *supra* note 4 at 28.

APPENDIX A

H.O.M.E. \ EMMAUS \ SR. BARBARA HANCE H.O.M.E.

Model Non-Discrimination Policy

HIV/AIDS Policy and Procedures

This policy is being written in order to affirm the value of all human beings and as a way of welcoming people who seek employment or shelter at any of H.O.M.E.'s shelters or transitional houses. HIV/AIDS is a communicable disease (i.e. an infectious disease). However, unlike staph or strep or flu, fellow workers and people sharing living spaces are not exposed to the risk of infection in any casual way or from any type of casual contact. There is no evidence of casual transmission of HIV from handshakes, toilet seats, door knobs, hugs, sharing food and beverages, living in the same household, playing together, sharing toys, and so on. Research resoundingly affirms that there is no risk of casual transmission to household members or co-workers. Instead, the only significant risk of HIV transmission comes from unsafe sex or needle-sharing. At present, there are more effective medical treatments for HIV and AIDS. But it is a disease that sometimes leads to unfair stigma and discrimination. Like any disease, it calls for our understanding, knowledge and compassion.

HIV and AIDS do not present serious risks to those who use or work at H.O.M.E.'s shelters and transitional housing. However, because HIV and AIDS frequently lead to more stigma and discrimination than other health conditions, H.O.M.E. is adopting this Policy.

Policy Statement

Purpose: To establish guidelines and policies for staff, volunteers and clients in order to protect the human rights of each individual. Also to promote an educational program whose goals are reducing the risk of transmission of HIV and the stigma and discrimination associated with HIV and AIDS.

Policy: AIDS and HIV education will be a regular and integral part of our training and counseling programs for clients, volunteers and staff, in order to allay fear, misconceptions or prejudice about AIDS and HIV and to encourage personal behavior that helps prevent transmission of HIV. This education will ensure that proper and current information is available. We understand that some staff members, volunteers and clients may raise some objections related to their fear of contact with a person who has HIV or AIDS. Sensitivity will be shown and education will be provided to deal with these concerns, since one of the main goals of the education program is to combat these types of baseless fears. Prejudicial or discriminatory behavior, isolation, ridicule or inappropriate actions or comments based on irrational fear, directed at anyone with AIDS or HIV infection, will not be tolerated and appropriate disciplinary actions will be undertaken. The guidelines will be individually applied, consistent with legal requirements, taking into consideration the psychological, physical and behavior characteristics of the individuals involved.

Guidelines:

1. Staff members or clients who know or suspect that they are infected with HIV are encouraged to seek medical testing and treatment. The administration will make every reasonable effort to provide assistance.
2. Routine screening of staff or clients to determine HIV status will not occur. It is also illegal.
3. All staff members, volunteers and clients will be treated the same, regardless of their sexual orientation.
4. Kitchen Procedures: Food handlers, staff, clients, volunteer cooks and anyone who prepares food in H.O.M.E.'s kitchens must abide by the following:
 - a. Food handlers who have HIV or AIDS shall not be restricted from using the kitchen, equipment or utensils unless they have a medically verified illness for which restrictions would be warranted based on health concerns. (e.g. active tuberculosis)
 - b. All food handlers should follow the recommended standards and practices of personal hygiene and food sanitation. Frequent training will be given regarding these standards.
 - c. All food handlers should attempt to avoid personal injuries during food handling. Foods tainted with blood or other body fluids must be discarded, irrespective of whether or not the handler has HIV.
 - d. A disinfectant solution (1:10 household bleach and water) should be available for treating any equipment contaminated by blood or other body fluids, irrespective of whether or not the food handler has HIV.
5. Universal Precautions: The practice known as Universal Precautions will be adhered to strictly. In any incidents of possible exposure of an individual or equipment to blood, vomit, or other body fluids latex gloves will be used and waste will be disposed of properly. Disinfecting any exposed surfaces with a 1:10 bleach solution as well as hand washing with warm water and soap will be necessary.
6. Confidentiality: The right of an individual client, staff member or volunteer to confidentiality with regard to his/her HIV antibody status or AIDS diagnosis will be respected by the administration and staff of H.O.M.E. and all related agencies. We will comply with Maine Law (5 MSRA, Part 23, Chapter 501, 19203) and with federal law, including but not limited to the Americans with Disabilities Act.
 - a. Information that is shared with a staff member or volunteer regarding an individual's antibody status must be held in the strictest confidence and shared only with the Executive Director or Administrator if necessary for pur-

poses of supervision, and then only after obtaining the written consent of the individual in question. No mention of an individual's HIV status will be made in the files or other written records, except that any individual's written consent to waiver of his or her right to confidentiality will be kept on file.

- b. The sharing of information about an individual's HIV status with other clients, volunteer or staff members is the exclusive right of the individual with HIV or AIDS.
- c. H.O.M.E. personnel may share information about an individual's HIV antibody status only with the specific written consent of the individual with HIV or his/her legal guardian. The only legitimate context for such disclosures will be that of providing comprehensive services to the infected individual.
- d. Disciplinary action will be taken against any employee who inappropriately discloses medical information about any client, volunteer or staff person.
- e. These guidelines shall be reviewed periodically and revised as necessary to reflect new medical information regarding HIV and AIDS and to be consistent with legal requirements.

H.O.M.E. and its related shelters are unique in that we are open to people from all over the State of Maine, the country and, in fact, the world. People come to us for a variety of reasons and with a variety of problems. Many parts of the U.S. and the world have been deeply affected by the epidemic of AIDS and HIV. The key to ending this epidemic lies in education and we will strive to provide the necessary education to everyone, clients, staff and volunteers alike. We must always remember to be open and welcoming and to be mindful of the humanity and rights of all individuals.

APPENDIX B

HEALTH CARE FOR THE HOMELESS, INC.

Training Module

Objectives & Evaluation	Outline of Content	Activities & Teaching Aids
<p>Objectives: Upon completion of this module, the participant will be able to:</p> <ol style="list-style-type: none"> 1. Identify components of product labels as "effective" or "less effective" in acting as a barrier to STD's. 2. Demonstrate proper technique for applying a condom. 3. Recognize any attitudinal barriers that may discourage him from using a condom. <p>Evaluation:</p> <ol style="list-style-type: none"> 1. Post-Test (paper and pencil). 2. Return demonstration of condom technique. 3. Self-report of attitude assessment. 	<p>III. Breaking the links of Mode of Escape, Transfer, and Entry "How can you reduce the risk of transmission to you?"</p> <p>A. Reducing transmission that occurs through sexual contact:</p> <p>Types of sexual contact: Penile-anal Penile-vaginal Penile-oral Mutual masturbation</p> <p>Barriers: Male condoms Female condoms Latex condoms Nonoxynol-9 Water-based vs. Oil-based condoms Method of using condoms "Pulling out"</p>	<p>Review of "Chain of Events..."</p> <p>Sample condoms & Dental Dams Read labels Demonstration on penis model</p> <p>"Touch sensitivity through condoms:" differentiate between three items while blind-folded and wearing latex gloves</p> <p>Discussion: "How does the use of a condom, by yourself or your partner, make you feel?"</p> <p>"What prevents you from using a condom?"</p> <p>Role play: <i>Cast:</i> Two partners of either gender <i>Scene:</i> Sex is demanded in exchange for a place to stay for the night <i>Questions:</i> How do you introduce the idea of using a condom?</p> <p>Role play: <i>Cast:</i> Two partner of either gender <i>Scene:</i> One partner is encouraging the other to go for HIV testing and Counseling <i>Question:</i> How does the "knowledgeable" partner introduce the subject?</p> <p>Solicit other ideas for role plays from group participants</p> <p>Brochures: "Apply News," "Worth Waiting," "Saying No to Sex"</p>

Objectives & Evaluation	Outline of Content	Activities & Teaching Aids
<p>Objectives: Upon completion of this module, the participant will be able to:</p> <ol style="list-style-type: none"> 1. State the address of the Needle Exchange Program. 2. Demonstrate cleaning a syringe and needle with bleach solution. <p>Evaluation:</p> <ol style="list-style-type: none"> 1. Report of session facilitators. 2. Return demonstration of needle-cleaning technique. 	<p>B. Reducing the Risk of Transmission through needles and other paraphernalia</p> <ol style="list-style-type: none"> 1. Obtaining new needles 2. Needle exchange 3. Preparing the 1:10 bleach solution 4. Cleaning needles/works with bleach solution 5. Safe disposal of needles 	<p>Information about Needle Exchange Program</p> <p>Demonstration of needle cleaning</p> <p>Role Play: <i>Cast:</i> Two IVDUers <i>Scene:</i> One set of works <i>Question:</i> How does the "knowledgeable" user introduce the idea?</p> <p>Role Play: <i>Cast:</i> IVDU and Worker at Needle Exchange <i>Scene:</i> 601 N. Caroline Street <i>Question:</i> What happens when you go there?</p> <p>Solicit other ideas for role plays from group participants</p>

APPENDIX B

Objectives & Evaluation	Outline of Content	Activities & Teaching Aids
<p>Objectives: Upon completion of this module, the participant will be able to:</p> <ol style="list-style-type: none"> 1. List at least five health promotion/disease prevention activities (interventions). 2. State the rationale, as related to HIV, for following health promotion/disease prevention advice. <p>Evaluation:</p> <ol style="list-style-type: none"> 1. Report of session facilitators. 	<p>IV. The Susceptible Host “How can you keep yourself healthier so you aren’t as likely to get any infectious diseases?”</p> <p>A. Regular medical appointments</p> <ul style="list-style-type: none"> • take care of minor illnesses before they become major. • detect any “hidden” illness so you can get proper care <p>B. Influenza vaccine</p> <p>C. Pap smears</p> <p>D. Don’t use drugs (include judgement factors)</p> <p>E. Good nutrition</p> <p>F. Adequate rest/sleep</p> <p>G. Physical activity</p> <p>H. Good body hygiene</p> <p>I. Good dental hygiene</p> <p>J. Pneumovax (If HIV+)</p> <p>K. TB testing</p> <p>L. Take appropriate measures to avoid STD’s</p>	<p>Review the “Chain of Events...”</p> <p>Answer the question “Where can I get that?” for each of the interventions discussed</p> <p>Discuss how each intervention could raise one’s defenses against HIV (if one is HIV-) or against other illnesses (if HIV+)</p> <p>Role Play: HIV Testing and Counseling (Pre and Post) <i>Cast:</i> Nurse and client <i>Scene:</i> IVDU going for T&C for 1st time <i>Question:</i> What happens at these sessions?</p> <p>Discuss HCH Plan of Care for HIV+ client</p> <p>List of Testing and Counseling sites</p> <p>Role Play: Partner and Family Notification <i>Cast:</i> IVDU and his female partner <i>Scene:</i> Her place. He’s just come from T&C, where he was told he’s HIV+ <i>Questions:</i> How do you share this news? With whom should you share it? When should you share it?</p> <p>Solicit other ideas for role plays from group participants</p> <p>Brochures: “What Everyone Should Know about HIV Testing,” “About Living with HIV,” “So You’re HIV negative”</p>

List of Supplies Needed for Group Sessions

1. "Chain of Events" Cards
2. Flip Chart and Paper
3. Personal Assessment of Risks
4. Sample Condoms
"How to use a condom" pamphlet
5. Penis Model
6. Latex Gloves
7. Three items for touch-sensitivity exercise
8. Bleach
9. Large (60cc) syringe for demonstration
10. Flyers with Needle Exchange information
11. List of HIV Testing and Counseling Sites
12. Incentive Packs
13. Pre/Post Tests (parts I, II, and III)
14. Statistical Reporting Forms

Personal Assessment of Risks

From each column, select the statement (and the card under it) that best describe your behavior within the past three months. Put the cards together to make a Poker hand. The Joker is WILD! What can you do to improve your hand?

I have not used drugs.	I have one steady partner.	My sex partner doesn't have sex with anyone but me.	I don't drink alcohol.	I haven't been tested for HIV.
I use the Needle Exchange Program.	I always use condoms.	I know my partner has had no STD's (VD, gonorrhea, syphilis, herpes, etc.)	I occasionally drink alcohol but I don't get drunk.	I've been tested for HIV within the past six months.
I buy new needles for my own use.	I have no STD's (VD, gonorrhea, syphilis, herpes, etc.)	(VD, gonorrhea, syphilis, herpes, chlamydia, etc.)	I lose control when I drink alcohol.	I have talked with my partner (either sex or needle-sharing) about our risks for HIV.
I clean my needles with bleach.	I have multiple partners and don't use condoms.	It could be that my partner has sex with people besides me.	I abuse alcohol and I have blackouts.	
I share needles with other users.		My partner is HIV+.		

APPENDIX C

Down East AIDS Network

Basic Curriculum for Homeless Shelters in Rural Areas

**Compiled by Mary Harney BA (Human Ecology)
HIV Prevention Education Coordinator**

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A BASIC HIV PREVENTION CURRICULUM FOR HOMELESS SHELTERS IN RURAL AREAS

Compiled by Mary Harney BA (Human Ecology) : HIV Prevention Education Coordinator

Introduction

In 1997 a resident of a homeless shelter in rural Maine was asked to leave the shelter because of his HIV+ status. The resident took his case of discrimination to the American Civil Liberties Union (ACLU.) As part of an out of court settlement the ACLU requested that Down East AIDS Network (DEAN) train the staff of local homeless shelters in basic HIV information. DEAN compiled a curriculum addressing issues involving HIV transmission, current therapies, medications, sexuality, and the law as it pertains to people living with HIV. DEAN presented a six week, one hour session pilot program to the staff of the homeless shelter. At the beginning and end of the program we administered a simple pre- and post- test on knowledge, attitudes, beliefs, and behaviors (KABB.) Once the pilot scheme was completed DEAN examined what had been learned, the strengths and weakness of the program, and the learning abilities and needs of the participants. This curriculum is the result. It was extended by four hours and includes more participant interactive exercises.

DEAN asks you, the reader, to bear in mind that DEAN is a three person AIDS Service Organization covering ninety six thousand square miles of rural Maine. The majority of the population DEAN serves is white. DEAN understands that this curriculum may be read by people living in inner city areas with a large, racially diverse, population. DEAN adapted information and exercises from the many HIV training's we attended here in Maine. For the most part the exercises are generic, however in Session Four, the exercise on homophobia is taken from Tackling Gay Issues In School with permission from the editor Leif Mitchell and adapted to suit the needs of this program. DEAN invites you to adapt this curriculum to suit the needs of the population you serve.

Thank You

Staff at Down East AIDS Network (DEAN)

Ron King, LSW	Director
Debby Parker, RN LSW	Support Services Coordinator
Mary Harney, BA	Education Coordinator

HIV Prevention Education for Homeless Shelter Staff

This is a curriculum guide for a 12 hour, 5 session HIV/AIDS awareness program. We recommend Homeless Shelter agencies contact their local AIDS Service Organizations for assistance in putting this training into practice. We further recommend trainer's review entire curriculum before beginning sessions as the content may impact who is selected to lead the sessions and some trainer's may want to seek additional resources/background.

This curriculum was developed with the assistance of three rural Homeless Shelters in Maine. As a result of that experience here are some tips for a successful program.

- Conduct the training sessions in a space away from the Homeless Shelter.
- Ensure the space has comfortable seating arrangements (a classroom is not an ideal site).
- Make time for adequate stretch breaks (you know your participants and their comfort level).
- After each break ask the group if they have any questions they would like answered.
- At the beginning of each training session post a chart of the overall goal and objectives at the front of the room. Explain the importance of goals and objectives at the beginning of each session.

Overall goal of training

- To provide basic information of transmission, progression, and treatments for HIV/AIDS so that discriminatory practices may be avoided in Homeless Shelters.

Objectives of overall training : By the end of the training participants will be able to:

- identify modes of transmission for HIV.
- understand why it is important for shelter staff to deliver HIV medications at stated times.
- understand the challenges faced by people who are living with HIV.
- understand why clear guidelines and policies regarding people with HIV are necessary for shelter staff and residents.

TIMELINE

The timeline for the five sessions is a guide. As a result of the pilot program and consequent evaluations We concluded that three hours and thirty minutes is the minimum time required to complete the first session. The timeline for sessions 2-5 are also based on the pilot program, however, all of the sessions can be divided into time blocks according to the needs of participants.

EVALUATION TOOLS

Administer a simple Pre- and Post questionnaire on knowledge, attitudes, beliefs, and behaviors (KABB) around issues of HIV/AIDS to modify and adapt the program for the learning needs of the participants.

(see sample questionnaire in resource section.)

OUTLINE OF SESSIONS

SESSION ONE-HIV 101 : Time : Three hours and thirty minutes.

Throughout the program remember the trainer's mantra - "Tell them what you are going to tell them, tell them, and tell them what you have told them"

Objectives of Session 1 : At the end of this session the participants will be able to:

- define terms related to HIV/AIDS
- define HIV transmission
- define HIV Risk Reduction
- define and introduce universal precautions to their work place

1) Introductions

Time : 10 minutes

Trainer introduce self
Explain the overall goal and objectives of training

GROUP INTRODUCTIONS AND GROUP AGREEMENTS

Time : 30 minutes

Materials : Blank sheets of flip-chart paper.
Markers and tape.
Flip-chart with the HIV transmission outline prepared in advance.
(see trainer's outline Appendix A at back of this session)

The purpose of the icebreaker exercise and group agreements is to allow participants to introduce themselves and, because they will be discussing sensitive issues, to ask them to identify their needs for creating a safe space for the training.

ICEBREAKER : Ask the participants to choose a partner, allow 2 ½ minutes for each person to ask the following questions:

1. Name
2. What was the most exciting part of their last vacation
3. What special skills do you bring to the group. (One person may be a good listener, another may be a good organizer, etc.)

When the time is up ask partners to introduce each other to the group. This exercise is a good method of practicing listening skills.

GROUP AGREEMENTS:

Explain to the group that the training will bring up mixed emotions; For some people it may be a remembrance of family or friends who are living with, or have died from HIV/AIDS related illnesses. For others it may be that they are afraid of coming into contact with people living with HIV. Whatever the emotion, we all need to be sensitive of each others feelings. The group agreement is a positive tool to ensure group safety for sharing feelings or expressing an unpopular belief. However, it is also important for the trainer to keep the training session on track and not allow it to become a therapy session or a support group session.

EXAMPLES OF GROUP AGREEMENTS:

Respect - It is important that one person speaks at a time and that members of the group give their undivided attention to the speaker. *Confidentiality* - What is shared in the group remains in the group. Ask the group to add to the list and record responses on the flip-chart. Display the list in a prominent

place before each session, refer to the agreements as necessary, review the agreements at each session, and add to them as necessary.

BREAK : 10 MINUTES

2) Introduction to HIV/AIDS-Transmission -

Time : 50 minutes

Materials : Flip-chart with outline of HIV transmission and timeline taken from trainer's outline. (Appendix A at back of this session.)
Markers.
Blank training outline handout. (For participants to fill in as the trainer goes through the exercise - Appendix A1 see back of session 1)
CDC handout entitled "HIV/AIDS PREVENTION" (See resources section back of manual.)
"Test Tube" handout illustrating "Average number of HIV particles in 1 cc of these body fluids" (see resources section)

The purpose of this exercise is to help participants understand the transmission of HIV, its progression to AIDS and to demonstrate how small volumes of body fluids can have large amounts of HIV in them. At the beginning of this session, pass-out handouts relevant to the session. Ask the group to fill in the blank HIV transmission training outline as you explain it from the flip-chart and the trainer's outline.

Transmission of HIV

Using the trainer's HIV/AIDS guideline (Appendix A back of session 1) work through the Outline on the flip-chart, allow time for questions from group members. Explain the timeline with emphasis on the fact that **exposure does not always equal infection: infection is dependent on amount of virus in the body fluid and other variables at the time of exposure.** It is also necessary to clarify the difference between HIV and AIDS (see trainer's outline) When you get to the HIV and Body Fluids section of the outline, pass out the dice and the "Test Tube" handouts for people to note how much of the virus is contained in small amounts of body fluids. Continue with the outline through to the end of the transmission section. At this point review the CDC handout entitled "HIV/AIDS Prevention."

BREAK FOR 5 MINUTES:

After the break ask the group if they have any questions on transmission of HIV and answer them in the shortest time possible. The trainer may also want to evaluate how the information is being received by the group, an easy evaluation is to ask questions on topics discussed before the break.

Continue the training outline on HIV prevention. Inform the group there are some exercises involved in this section. To assist the instructor in "fleshing out" the training, following suggestions are offered as part of the outline.

3) HIV Infection Prevention and Risk Reduction

a) **Abstinence**-The only 100% safe option for preventing HIV infection? What does abstinence mean to you? The purpose of this exercise is to help participants define abstinence for themselves and identify difficulties associated with expectations related to maintaining abstinence.

Exercise-have group break into smaller groups of 3-4. Allow five minutes for groups to define abstinence and to identify potential difficulties that may confront them and their clients as they attempt to practice abstinence. After five minutes bring the groups together. Ask for responses to the exercise, record responses on the flip-chart and ask participants to explain the ease or difficulties they

experienced in defining abstinence. Lead a discussion related to the responses. Emphasize that abstinence is an ideal difficult to reach for some people. Maintaining abstinence requires strong communication, negotiation skills, self-esteem, and self-worth. Point out to the group that if a person is unable to feed their children, if they are in an abusive relationship or dependent on Homeless Shelters for housing, then their self esteem may be negligible, and abstinence may be a concept they do not understand.

Continue to follow each section of the trainer's outline:

b) Reduce The Risks :

- Sexual activity without exchange of body fluids
- drug and alcohol awareness
- setting limits with sexual partners and drug buddies (IV drug users)
- know yourself and partner's(s)-drug and alcohol use history; sexual history

c) Safer Sex : The correct use of latex barriers

Demonstrate correct usage of male condoms, female condoms, latex barriers, lubricants, and spermicides. Discuss safer sex options as listed on trainer's outline (the options should also be printed on the flip-chart prior to the session)

Traffic Light Exercise- The purpose of this exercise is to illustrate low, medium and higher HIV risk infection activities. Using traffic lights as an analogy, have group rate the risk for HIV infection. Ask group to line up on one side of room. Place three squares of paper, one green, one yellow and one red, on the floor in a row. Announce to the group that you will be reading descriptions of activities.

Example:

Green light - no risk
holding hands

Orange Light - medium/low risk
intercourse with a condom
Caution-condom may break

Red Light - High risk
unsafe- sharing needles
for IV drug use with
HIV infected person

Have a prepared list of four or five activities. As the trainer reads through the list ask members of the group to respond to the level of risk by standing near the correct "light" in relation to the risk. Ask for volunteers to explain their choices. Lead discussion regarding levels of risk for HIV infection and ask the group to brainstorm ideas for reducing those risks.

d) Blood Awareness-Review danger factors on trainer's outline.

BREAK : 5 MINUTES

Allow at least 35 minutes for the following exercise.

Syringe Exercise-illustrates the ability and ease with which HIV can be passed by an infected IV drug user who shares needles. Ask the group to gather around a table. Fill a syringe with red dye or cranberry juice (the dye represents blood drawn into the needle by IV drug users when they engage in "booting") Now, empty the dye into a clear plastic or glass container. Invite the group to check the syringe for fluid retained in the syringe, then draw clean water into the syringe to show that the water becomes clouded and colored from the juice/dye left in the syringe. This demonstrates how HIV infected fluid can be passed to the next user if the needle is shared without cleaning it. For many IV drug users the process of cleaning needles with bleach and water is not a viable option, often the cleaning products are not readily available, and given the nature of addiction, drug users are not going to spend time cleaning equipment

when they need a "fix". The most effective HIV prevention method for IV drug users is a needle exchange program.

Universal Precautions:

Universal precautions is a method of infection control that treats all human blood and some human body fluids as if they are infected with HIV or other bloodborne diseases.

Reduce your risk : Wear latex gloves any time there is direct contact with human blood or broken skin. (if you have an allergy to latex, polyurethane gloves are now available.)

Clean with bleach : Use a mixture of one part bleach to nine parts water to clean blood spillage. Keep your gloves on when cleaning up blood or body fluids.

Wash your hands : Wash your hands with soap and running water after removal of gloves.

Dispose of gloves : Dispose of latex gloves by rolling them up and placing them in plastic garbage bags.

HIV Antibody Testing :

Testing for HIV is a method of prevention, in addition to knowing status it provides an opportunity for the person being tested to reduce their risk for infection. Testing also allows a person to enter treatment early. Early intervention and treatment offers a better outcome for health and quality of life.

Explain that the HIV test is a test for antibodies to HIV not for AIDS. It can take up to six months from infection for the HIV antibodies to show up on the test. This six months is called the "window period." If a person was infected with HIV six months ago (or longer) it will show up on the test, if they became infected in the past six months it may not show up on the test. If, during the past six months the person being tested has done things that put them at risk for HIV infection they will need to be tested again after the "window period." (Refer to prepared flip-chart with the timeline of HIV transmission.) In addition to knowing HIV status and reducing risks for transmission, testing for HIV allows a person to enter treatment early. Early treatment can result in a better outcome such as an extended lifespan. The most common test for HIV antibodies is a blood test. Testing is carried out at health clinics, or at anonymous test sites. Many test sites offer pre and post HIV testing counseling to help people make the best decisions. There are also a number of home test kits on the market. The results are anonymous, but no counseling is offered and for many people the cost is prohibitive. When going for an HIV test it is important for people to remember the following:

Anonymous Test - no name given, name is never associated with test or results, testing is carried out at anonymous test sites.

Confidential : test is carried out in doctor's office, clinic, hospital etc. name is known and associated with test.

Check your state laws on this topic before addressing it in the training. Provide details of local testing sites, optional methods of testing i.e. home test kits, and the costs of testing.

AIDS HOTLINES Local and national telephone numbers should be written on flip-chart.

(see resources)

SUMMARY AND CLOSURE : 30 MINUTES

At the end of the session summarize the main points of the session. Allow time for participants questions and for some activity that is not a "test" but allows participants to see what they have learned. The activity could be:

- Participants pair up with their partners from the introduction
- Cards with questions with answers are handed out to each pair
- Partners quiz each other and give answers where necessary

It is a good idea to follow up with a check-in from participants who want to share on the events of the training. End the session with an overview of topics to be covered at the next training.

APPENDIX A

TRAINERS HIV TRAINING OUTLINE

HIV/AIDS

- H uman (not in dogs, cats, etc.)
- I mmunodeficiency (attacks immune system, making it unable to fight off infection)
- V irus (disease causing agent)

- A cquired (not genetic or hereditary--one gets it, does not "catch it")
- I mmune
- D efficiency
- S yndrome (not one disease but a collection of characteristics)

Most people without HIV disease have about 800-1200 CD4 cells (helper cells or T cells) These cells keep illness at bay by attacking infections that enter the body. The effect of HIV is to destroy the CD4 cells so they no longer protect the body from viruses and infections.

TIMELINE:

Exposure to HIV does not always equal infection. However if a person is infected the following is a guide to the timeline of the progression of the virus.

Exposure/Infection	Asymptomatic/no symptoms	Symptomatic	AIDS **
--2 wks-6 months	-----few months-years-----	-months-years-	-1 of 26 O.I--
HIV antibodies form	virus is working on the body	night sweats diarrhea, etc.	opportunistic infections/T cell count below 200
SEROCONVERSION			

****AIDS DIAGNOSIS:** The Center for Disease Control case definition or diagnosis as the presence of HIV plus one of 26 opportunistic infections

(such as Pneumoyistis Carinii Pneumonia--PCP; Kaposi's Sarcoma; Tuberculosis; Invasive cervical cancer, etc.)

or T-cell count below 200.

STATISTICS - State :

National :

HIV AND BODY FLUIDS

(average amount in infected fluids)

- BLOOD:** 1 cc - 18,000 particles, HIV
- SEMEN:** 1 cc - 11,000 particles, HIV
- VAGINAL FLUIDS:** 1 cc - 7,000 particles, HIV
- BREAST MILK:** trace quantities
- SALIVA:** (without blood, trace amounts)

APPENDIX A

NOT: sweat, urine, tears, saliva, etc.

TRANSMISSION:

1. Congenital/perinatal: either in womb, or during delivery – blood present
2. Blood to Blood: sharing needles for IV drugs, steroids, ear piercing or tattooing, through open sores or cuts (including blood brother/sister rituals). Transfusions or blood clotting factors (before 1985).
3. Unprotected sexual intercourse: exchange of sexual fluids (semen, vaginal secretions) and/or blood

Most risky: Unprotected anal; **Risky:** Unprotected vaginal especially for woman;
Lesser Risk: Unprotected oral sex.

NOT: Giving blood, sharing utensils, kissing, sharing toilet seat, shaking hands, mosquitoes

PREVENTION OF HIV:

A.) ABSTINENCE: Only 100% safe option...How to say "No"...self esteem...

B.) REDUCE RISK: set limits...sexual without exchanging fluids... drug/alcohol stuff... know self and partner

C.) SAFER SEX: including the correct way to use latex barriers.

a) **ORAL** intercourse (mouth to penis, anus, vagina)—latex square... condom... Saran wrap

For added comfort, put lubricant on the side of the barrier facing the vagina or anus. ..water-based lubricant!

b) **ANAL** intercourse –condom (some say 2)... spermicides... water-based lubricants (KY or WET) or lubricated condoms.

c) **VAGINAL** intercourse – condom... spermicides... water-based lubricant

D. BLOOD AWARENESS: Most dangerous when wet and warm

a. needlesticks use latex gloves

b. blood splashes use soap, bleach, alcohol

c. tattooing clubs and jails use single-use needles and latex gloves

HIV antibody testing : A test for antibodies to HIV—not for AIDS or the virus itself

INFORMED CONSENT: Person must be informed that they are getting tested, what the test is for and what it means.

ANONYMOUS : Anonymous – no name given, no one asks, name is never associated with test or results, anonymous test sites.

CONFIDENTIAL: Doctors office, clinic, hospital, etc. Name is known and associated with test.

PREVENTION OF HIV:

A.) ABSTINENCE:

B.) REDUCE RISK:

C.) SAFER SEX:

a.

b.

c.

D. BLOOD AWARENESS

a.

b.

HIV antibody testing :

INFORMED CONSENT:

ANONYMOUS

CONFIDENTIAL:

HOW, WHERE, AND COST:

AIDS HOTLINES:

MISC. NOTES:

**PARTICIPANT'S TRAINING NOTES
TRAINING OUTLINE**

HIV/AIDS

**H
I
V**

**A
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D
S**

TIMELINE:

AIDS DIAGNOSIS:

STATISTICS - State :
National :

HIV AND BODY FLUIDS
(average amount in infected fluids)

BLOOD:

SEMEN:

VAGINAL FLUIDS:

BREAST MILK:

SALIVA:

NOT:

TRANSMISSION:

1)

2)

3)

NOT:

SESSION TWO

HIV "202"

Objectives of Session 2 : At the end of this session participants will:

- have basic knowledge of current therapies for HIV
- understand the importance of adherence to HIV medications, early intervention treatment, and medical treatment plans.

Time : 2 hours.

Materials: Group agreements posted in prominent place.
flip-chart, markers, tape,
Handouts "Daily Dosing Of Available Antiretroviral Agents." (see resources)

Purpose of this session is to learn how the new drug therapies work on the HIV virus. To avoid misinformation about the new medications and their side effects; it is very important to invite a case manager from the local AIDS Service Organization, (ASO) case manager, nurse, MD or other community based organization dealing with HIV+ clients. One of the most effective parts of this session is to invite a guest speaker, someone who is living with HIV to present this part of the training. Most ASOs employ trained case managers. Case managers help people living with HIV access medications, deal with the Health Department, access a good physician, and find support groups. Case managers are also trained to explain the effects of the new drug therapies on the immune system and the necessity for adherence to the medication regimens for someone living with HIV. The guest speaker will provide an authentic account of living with HIV and daily life on medication and HIV therapies. The speaker will relate from experience the emotional, psychological and social impact of living with HIV/AIDS. It is vital that staff of homeless shelters understand the importance of dispensing medication on time to their HIV positive clients, and the results of missed or delayed doses of HIV medications.

1) HIV 101 Review : (10 minutes)

Review the transmission of HIV and the risk factors involved. Review the section on the immune system, and the effects of the virus on the CD4 cells (helper cells.)

2) Introduction of Case Manager. (50 minutes including question and answer time)

The case manager will explain the following:

How HIV attacks the body.

The meaning of viral load and its effects on the body. The meaning of CD4 counts

Opportunistic infections that attack a weak immune system.

The current treatments being used to suppress the effects of HIV in the body. The side effects of anti-viral medications.

The importance of providing medications at the proscribed times.

BREAK FOR 10 MINUTES

3) Introduction of Guest Speaker (40 Minutes including question and answer time)

The speaker should be prepared to share her/his story of living with HIV and taking medications on a daily basis. If the speaker agrees to show a day's worth of medication to the group, it is an effective method of demonstrating the importance of strict adherence to medication regimens.

Allow for response time.

SUMMARY AND CLOSURE

Summarize the salient points of the session. Closure time may be group sharing time, or pairs of participants asking each other pre-written questions on information presented during the session.

SESSION THREE

Repeat goal of training.

Hepatitis A, B, C,

Objectives of Session 3: At the end of this session the participants will be able to

- define transmission of the Hepatitis Viruses and current therapies
- Examine the similarities for transmission of some Hepatitis and for HIV.
- Start a dialogue on why there is a stigma attached to HIV, and not to Hepatitis viruses which have similar modes of transmission. This is a preparation for Session 4.

Time : 2 hours

Materials : Brochures on the Hepatitis Viruses can be obtained from the state Health Department
Flip-chart of HIV/AIDS transmission outline from first session.
Blank flip-chart paper, and markers.
“Hepatitis A, B and C: The Basics” (see resources) The trainer should utilize this handout in creating a flip-chart similar in layout to the HIV chart before the session. Once again, We recommend that trainers seek assistance from local health agencies before presenting this material.

1) HIV 101 Review : (10 minutes)

It is important to reiterate the modes of transmission for HIV at the start of every session.

2) Introduction of the Hepatitis Viruses (“HEPS”) 50 minutes

Refer to your prepared flip-chart to show the transmission for each hepatitis virus. Ensure that participants understand that all hepatitis virus cause liver disease. When you get to hepatitis B note that : The hepatitis B virus (HBV) can be transmitted through blood and other body fluids like semen, vaginal fluids, breast milk, saliva, and urine. Ask the group to look at the similarities in the fluids that transmit HIV. Refer back to the HIV chart. Be sure to point out that HIV is not generally transmitted through urine, (unless it contains infected blood) and is not generally transmitted through saliva unless HIV infected blood is present. At this point ask the group to consider why people with HIV often suffer discrimination yet the same is not true for people with HBV. This discussion is usually lively and it creates a good lead for the next session on homophobia and discrimination.

BREAK FOR 10 MINUTES

3) Continue working through the prevention and treatment for the hepatitis viruses. 50 minutes

At the end of the “HEPS” session, review the universal precautions from the first session and confirm that protections are identical for all bloodborne viruses.

SUMMARY AND CLOSURE

Summarize the main points of transmission modes of the Hepatitis viruses. For closure break into smaller groups, ask the participants to brainstorm ideas for putting their new knowledge into practice in their shelters. Bring the group together and discuss the ideas presented, write responses on flip-

chart. Remind the group of the topic for the next session. Trainer's may also close the session with a meditation, or a yoga exercise.

SESSION FOUR

Repeat the goal of training

Values Clarification on issues of AIDS and Sexuality

Objectives of Session 4 : At the end of this session the participants will be able to

- listen to opinions that are different from their own.
- discuss the stigma attached to HIV
- offer people an opportunity to share their values in a non-judgmental setting.

Time : 2 Hours

Materials : 3 Cards with the words "AGREE" "DISAGREE" "NOT SURE" (one word per card)
Flip-chart, markers, and tape

Remind participants of the group agreements and make sure the agreements are prominently posted.

1) **HIV 101 Review :** (10 minutes)

2) **"I agree" exercise :** (50 minutes)

Talking about values can be a sensitive issue. Explain to the group that in this exercise they will be asked to share their feelings about their values. Review the group agreements to ensure safety for members of the group to express differing opinions. Remind the group it is okay to disagree with someone but not to put them down or judge them. If people express an unpopular opinion it is important for the trainer to support their willingness to stand up for their values. When expressing your own viewpoint be clear that this is a personal point of view, not a policy statement.

Explain that you are going to place the "Agree" "Disagree" and "Not sure" cards in different parts of the room. Once you have placed the cards tell the group you are going to read a list of value statements. As you read each statement ask them to think carefully about the feelings each statement creates as it is read. Then suggest they stand near the card that reflects their opinion. Ask for volunteers to share their feelings about the statement. Remind the group that it is okay to pass and there are no right or wrong answers only opinions. Everyone is entitled to hold their own opinions but not to put other people down for having a different opinion. Once a person has shared their opinion and everyone has heard it, some people may want to change their position. This may be because they received more information about the statement. For whatever reason it is okay for people to change positions. Allow time for discussion on the statements.

Examples of some statements. (You may add your own or think up new ones)

I would not eat food cooked by someone with AIDS

I think giving clean needles to drug users is a good way to halt the spread of HIV

Gay people are responsible for the spread of AIDS.

The information about HIV is changing all the time and I don't trust that HIV is not spread by casual contact or by mosquitoes.

I think it should be a crime for people infected with HIV to have sex without telling their partner.

(Discussion point - What is the difference between someone who knowingly engages in high risk activity, and does not get tested for HIV as opposed to someone who gets tested finds out they are HIV+ and does not tell their sex partners or needle sharing friends??) This exercise usually engenders a lively debate.

BREAK FOR 10 MINUTES

3) Discussion on Homophobia and the stigma of HIV. 50 minutes

Place the flip-charts of the HIV transmission outline and the Hepatitis transmission routes on the wall side by side. Ask the group to note the similarities for risk and infection. Then ask them to discuss the reasons why there is a greater stigma attached to people who are HIV positive than to people who are hepatitis B positive. Discuss the origins of HIV in America and how the health departments and media contributed to the myth that HIV was a Gay Related Immune Disease. (GRID) Identify the word homophobia as being a fear and sometimes a hatred of people who are gay/lesbian/bisexual or transgender. Ask the group to relate their own experiences of what it is like to be seen as "different" either because of race, class, color, gender, or religion.

At the end of the discussion ask the group to count off in numbers 1 and 2. Then ask the number 1s to stand in a circle, number 2s will form an outer circle facing a partner. Ask the number 1s to relate to their number 2 partner their earliest memories of hearing about lesbians. This can include messages picked up from peers, parents, jokes, teachers, books, religious teachings, etc. Give the group two minutes to do this and call a halt. Now ask the number 2s to relate to their number 1 partner their earliest messages about gay men. When the two minutes are up ask for volunteers to share their messages. Write some of the key statements on a flip-chart and ask people if they remember the feelings these messages created at the time. Ask about feelings created today as they listened again to those messages. Point out to the group how these messages are included in our upbringing and in our culture, and how many of us do not realize that the messages are hurtful and often destroy the self esteem of the person who is gay/lesbian/bisexual or transgender.

Reassure the group that the purpose of the exercise is not to blame or judge people for holding certain beliefs. It is to help the group explore where the beliefs came from and to examine how we, as a society, can change those beliefs to celebrate and honor diversity in all people. The dignity of all people must be affirmed and respected.

SUMMARY AND CLOSURE:

Example of a summary question to pose to the group

How did this exercise show you the value of different beliefs? Use some examples of other issues - gender, race, color, religion. Close with group sharing or meditation.

HIV Curriculum for Homeless Shelters

SESSION FIVE

Repeat the goal of training

Laws and Policies relating to HIV, infectious diseases and reporting.

Objectives of Session Five : At the end of this session participants will

- understand the rights, entitlements and legal protections under Federal and State law for HIV+ people.

Time : 2 hours

Materials : Flip-chart, markers, and tape
Sample Policy from the Emmaus Homeless Shelter (see resources)

1) **HIV 101 Review : 10 minutes**

2) **Federal/State/Local laws and policies relating to HIV, infectious diseases and reporting.**

We recommend a State representative from the State Health Department present the portion on Federal and State laws relating to infectious diseases and requirements for reporting.

In relation to creating or updating current policies for Homeless Shelters the trainer may consider inviting a local ACLU lawyer or policy maker to present the second part of the session. Use the policy in the resources as a guide for policy making in homeless shelters. Stress the practical application of laws and policies. Remind participants the final application of this training amounts to RESPECT and CIVILITY for all.

SUMMARY AND CLOSURE:

Summary question : How prepared do trainees feel after the program to communicate on these issues with their clients?

Closure : Administer post measuring tool (KABB) and present participants with certificates of completion of training. It is a good incentive for participants if trainers offer Continued Education Units (CEUs) for the program. The CEUs may be obtained from the DHS office of social work. Finish the session by affirming and honoring the group for their participation in the training program.

RESOURCES

For the following statements please circle one 5=strongly agree, 4= agree, 3 = I neither, agree or disagree, 2 = disagree, 1 = strongly disagree.

I wouldn't mind being in the same room with someone who has AIDS	5	4	3	2	1
A centralized file containing the names of all people known to have AIDS virus should be created	5	4	3	2	1
If I found out a friend has AIDS I would be afraid to hug him/her	5	4	3	2	1
I would object to sending my non-infected child to school with a child who has AIDS	5	4	3	2	1
I believe public officials when they say AIDS cannot be transmitted through casual contact	5	4	3	2	1
I am afraid that I will get AIDS	5	4	3	2	1
Compared with other public health problems, I think AIDS is a minor problem.	5	4	3	2	1
If I found out my lover/partner/husband/wife had AIDS , I would still have sex with him/her.	5	4	3	2	1

HIV BEHAVIOR and KNOWLEDGE

Below are several questions about AIDS and HIV. Answer each question either True, False or Don't Know (DK) to the best of your knowledge.

1. Condoms make intercourse completely safe	T	F	DK
2. When people become sexually exclusive with one another, they no longer need to follow safer sex guidelines.	T	F	DK
3. Oral sex is safe if partners do not swallow	T	F	DK
4. The AIDS virus does not penetrate unbroken skin.	T	F	DK
5. Intravenous drug users become exposed to the AIDS virus because the virus is often contained in injected drugs.	T	F	DK
6. Donating blood carries no AIDS risk for the donor.	T	F	DK
7. A great deal is known about how the AIDS virus is transmitted.	T	F	DK
8. It is more important to take precautions against AIDS in a large city.	T	F	DK
9. Coughing does not spread the AIDS virus.	T	F	DK
10. By reducing the number of sexual partners, you are effectively protected from AIDS.	T	F	DK

AIDS
Prevention

SAVES LIVES

HIV and Its Transmission

Research has revealed a great deal of valuable medical, scientific, and public health information about the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). The ways in which HIV can be transmitted have been clearly identified. Unfortunately, false information or statements that are not supported by scientific findings continue to be shared widely through the Internet or popular press. Therefore, the Centers for Disease Control and Prevention (CDC) has prepared this fact sheet to correct a few misperceptions about HIV.

How HIV is Transmitted

HIV is spread by sexual contact with an infected person, by sharing needles and/or syringes (primarily for drug injection) with someone who is infected, or, less commonly (and now very rarely in countries where blood is screened for HIV antibodies), through transfusions of infected blood or blood clotting factors. Babies born to HIV-infected women may become infected before or during birth or through breast-feeding after birth.

In the health care setting, workers have been infected with HIV after being stuck with needles containing HIV-infected blood or, less frequently, after infected blood gets into a worker's open cut or a mucous membrane (for example, the eyes or inside of the nose). There has been only one instance of patients being infected by a health care worker in the United States; this involved HIV transmission from one infected dentist to six patients. Investigations have been completed involving more than 22,000 patients of 63 HIV-infected physicians, surgeons, and dentists, and no other cases of this type of transmission have been identified in the United States.

Some people fear that HIV might be transmitted in other ways; however, no scientific evidence to support any of these fears has been found. If HIV were being transmitted through other routes (such as through air, water, or insects), the pattern of reported AIDS cases would be much different from what has been observed. For example, if mosquitoes could transmit HIV infection, many more young children and preadolescents would have been diagnosed with AIDS.

All reported cases suggesting new or potentially unknown routes of transmission are thoroughly investigated by state and local health departments with the assistance, guidance, and laboratory support from CDC. *No additional routes of transmission have been recorded*, despite a national sentinel system designed to detect just such an occurrence.

The following paragraphs specifically address some of the common misperceptions about HIV transmission.

HIV in the Environment

Scientists and medical authorities agree that HIV does not survive well in the environment, making the possibility of environmental transmission remote. HIV is found in varying concentrations or amounts in blood, semen, vaginal fluid, breast

CDC
CENTERS FOR DISEASE CONTROL
AND PREVENTION

milk, saliva, and tears. (See page 3, *Saliva, Tears, and Sweat*.) To obtain data on the survival of HIV, laboratory studies have required the use of artificially high concentrations of laboratory-grown virus. Although these unnatural concentrations of HIV can be kept alive for days or even weeks under precisely controlled and limited laboratory conditions, CDC studies have shown that drying of even these high concentrations of HIV reduces the amount of infectious virus by 90 to 99 percent within several hours. Since the HIV concentrations used in laboratory studies are much higher than those actually found in blood or other specimens, drying of HIV-infected human blood or other body fluids reduces the theoretical risk of environmental transmission to that which has been observed—essentially zero. Incorrect interpretation of conclusions drawn from laboratory studies have unnecessarily alarmed some people.

Results from laboratory studies should not be used to assess specific personal risk of infection because (1) the amount of virus studied is not found in human specimens or elsewhere in nature, and (2) no one has been identified as infected with HIV due to contact with an environmental surface. Additionally, HIV is unable to reproduce outside its living host (unlike many bacteria or fungi, which may do so under suitable conditions), except under laboratory conditions, therefore, it does not spread or maintain infectiousness outside its host.

Households

Although HIV has been transmitted between family members in a household setting, this type of transmission is very rare. These transmissions are believed to have resulted from contact between skin or mucous membranes and infected blood. To prevent even such rare occurrences, precautions, as described in previously published guidelines, should be taken in all settings—including the home—to prevent exposures to the blood of persons who are HIV infected, at risk for HIV infection, or whose infection and risk status are unknown. For example,

- Gloves should be worn during contact with blood or other body fluids that could possibly contain visible blood, such as urine, feces, or vomit.
- Cuts, sores, or breaks on both the care giver's and patient's exposed skin should be covered with bandages.
- Hands and other parts of the body should be washed immediately after contact with blood or other body fluids, and surfaces soiled with blood should be disinfected appropriately.
- Practices that increase the likelihood of blood contact, such as sharing of razors and toothbrushes, should be avoided.
- Needles and other sharp instruments should be used only when medically necessary and handled according to recommendations for health-care settings. (Do not put caps back on needles by hand or remove needles from syringes. Dispose of needles in puncture-proof containers out of the reach of children and visitors.)

Businesses and Other Settings

There is no known risk of HIV transmission to co-workers, clients, or consumers from contact in industries such as food-service establishments (see information on survival of HIV in the environment). Food-service workers known to be infected with HIV need not be restricted from work unless they have other infections or illnesses (such as diarrhea or hepatitis A) for which any food-service worker, regardless of HIV infection status, should be restricted. CDC recommends that all food-service workers follow recommended standards and practices of good personal hygiene and food sanitation.

In 1985, CDC issued routine precautions that all personal-service workers (such as hairdressers, barbers, cosmetologists, and massage therapists) should follow, even though there is no evidence of transmission from a personal-service worker to a client or vice versa. Instruments that are intended to penetrate the skin (such as tattooing and acupuncture needles, ear piercing devices) should be used once and disposed of or thoroughly cleaned and sterilized. Instruments not intended to penetrate the skin but which may become contaminated with

blood (for example, razors) should be used for only one client and disposed of or thoroughly cleaned and disinfected after each use. Personal-service workers can use the same cleaning procedures that are recommended for health care institutions.

CDC knows of no instances of HIV transmission through tattooing or body piercing, although hepatitis B virus has been transmitted during some of these practices. One case of HIV transmission from acupuncture has been documented. Body piercing (other than ear piercing) is relatively new in the United States, and the medical complications for body piercing appear to be greater than for tattoos. Healing of piercings generally will take weeks, and sometimes even months, and the pierced tissue could conceivably be abraded (torn or cut) or inflamed even after healing. Therefore, a theoretical HIV transmission risk does exist if the unhealed or abraded tissues come into contact with an infected person's blood or other infectious body fluid. Additionally, HIV could be transmitted if instruments contaminated with blood are not sterilized or disinfected between clients.

Kissing

Casual contact through closed-mouth or "social" kissing is not a risk for transmission of HIV. Because of the potential for contact with blood during "French" or open-mouth kissing, CDC recommends against engaging in this activity with a person known to be infected. However, the risk of acquiring HIV during open-mouth kissing is believed to be very low. CDC has investigated only one case of HIV infection that may be attributed to contact with blood during open-mouth kissing.

Biting

In 1997, CDC published findings from a state health department investigation of an incident that suggested blood-to-blood transmission of HIV by a human bite. There have been other reports in the medical literature in which HIV appeared to have been transmitted by a bite. Severe trauma with extensive tissue tearing and damage and presence of blood were reported in each of these instances. Biting is not a common way of transmitting HIV. In fact, there are numerous reports of bites that did *not* result in HIV infection.

Saliva, Tears, and Sweat

HIV has been found in saliva and tears in very low quantities from some AIDS patients. It is important to understand that finding a small amount of HIV in a body fluid does not necessarily mean that HIV can be *transmitted* by that body fluid. HIV has *not* been recovered from the sweat of HIV-infected persons. Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV.

Insects

From the onset of the HIV epidemic, there has been concern about transmission of the virus by biting and bloodsucking insects. However, studies conducted by researchers at CDC and elsewhere have shown no evidence of HIV transmission through insects—even in areas where there are many cases of AIDS and large populations of insects such as mosquitoes. Lack of such outbreaks, despite intense efforts to detect them, supports the conclusion that HIV is not transmitted by insects.

The results of experiments and observations of insect biting behavior indicate that when an insect bites a person, it does not inject its own or a previously bitten person's or animal's blood into the next person bitten. Rather, it injects saliva, which acts as a lubricant or anticoagulant so the insect can feed efficiently. Such diseases as yellow fever and malaria are transmitted through the saliva of specific species of mosquitoes. However, HIV lives for only a short time inside an insect and, unlike organisms that are transmitted via insect bites, HIV does not reproduce (and does not survive) in insects. Thus, even if the virus enters a mosquito or another sucking or biting insect, the insect does not become infected and cannot transmit HIV to the next human it feeds on or bites. HIV is not found in insect feces.

There is also no reason to fear that a biting or bloodsucking insect, such as a mosquito, could transmit HIV from one person to another through HIV-infected blood left on its mouth parts. Two factors serve to explain why this is so—first, infected people do not have constant, high levels of HIV in their bloodstreams and, second, insect mouth parts do not retain large amounts of blood on their surfaces. Further, scientists who study insects have determined that biting insects normally do not travel from one person to the next immediately after ingesting blood. Rather, they fly to a resting place to digest this blood meal.

Effectiveness of Condoms

Condoms are classified as medical devices and are regulated by the Food and Drug Administration (FDA). Condom manufacturers in the United States test each latex condom for defects, including holes, before it is packaged. The proper and consistent use of latex or polyurethane (a type of plastic) condoms when engaging in sexual intercourse—vaginal, anal, or oral—can greatly reduce a person's risk of acquiring or transmitting sexually transmitted diseases, including HIV infection.

There are many different types and brands of condoms available—however, only latex or polyurethane condoms provide a highly effective mechanical barrier to HIV. In laboratories, viruses occasionally have been shown to pass through natural membrane ("skin" or lambskin) condoms, which may contain natural pores and are therefore not recommended for disease prevention (they are documented to be effective for contraception). Women may wish to consider using the female condom when a male condom cannot be used.

For condoms to provide maximum protection, they must be used *consistently* (every time) and *correctly*. Several studies of correct and consistent condom use clearly show that latex condom breakage rates in this country are less than 2 percent. Even when condoms do break, one study showed that more than half of such breaks occurred prior to ejaculation.

When condoms are used reliably, they have been shown to prevent pregnancy up to 98 percent of the time among couples using them as their only method of contraception. Similarly, numerous studies among sexually active people have demonstrated that a properly used latex condom provides a high degree of protection against a variety of sexually transmitted diseases, including HIV infection.

For more detailed information about condoms, see the CDC publication "*Facts about Condoms and Their Use in Preventing HIV Infection and Other STDs.*"

CDC's Response

CDC is committed to providing the scientific community and the public with accurate and objective information about HIV infection and AIDS. It is vital that clear information on HIV infection and AIDS be readily available to help prevent further transmission of the virus and to allay fears and prejudices caused by misinformation. For a complete description of CDC's HIV/AIDS prevention programs, see "*Facts about CDC's Role in HIV and AIDS Prevention.*"

For more information...

CDC National AIDS Hotline:

1-800-342-AIDS (2437)

Spanish: 1-800-344-SIDA (7432) (HIV and STDs)

Deaf: 1-800-243-7889

CDC National Prevention Information Network:

P.O. Box 6003

Rockville, Maryland 20849-6003

1-800-458-5231

Internet Resources:

DHAP: <http://www.cdc.gov/hiv>

NCHSTP: <http://www.cdc.gov/nchstp/od/nchstp.html>

NPIN: <http://www.cdcpin.org>

NATIONAL HOTLINES

AIDS Clinical Trials Information Service.....1-800-TRIALS-A
 CDC Hearing Impaired AIDS Hotline (TTY)1-800-243-7889
 CDC Labor Responds to AIDS Resource Service.....1-800-458-5231
 CDC National AIDS Hotline.....1-800-342-AIDS
 CDC National AIDS Hotline (Classroom Calls).....1-800-342-AIDS
 CDC Spanish AIDS Hotline.....1-800-344-7432
 CDC National Prevention Information Network.....1-800-458-5231
 CDC National STD Hotline.....1-800-227-8922
 CDC—Recorded information:
 AIDS Statistical Information Line.....1-888-232-3299
 Fax Information Service Line.....1-888-232-3299
 General Info. (including info. on HIV/AIDS).....1-888-232-3299
 Center for Substance Abuse Prevention (CSAP)
 Nat'l Clearinghouse for Alcohol & Drug Info....1-800-729-6686
 Children of the Night
 (help hotline for people of all ages).....1-800-551-1300
 Hepatitis and Liver Disease Hotline.....1-800-223-0179
 HIV/AIDS Treatment Information Service.....1-800-HIV-0440

National Child Abuse Hotline.....1-800-422-4453
 Nat'l Cocaine Hotline (Chemical Dependency).....1-800-COCAINE
 Nat'l Drug & Alcohol Treatment Routing Service....1-800-662-HELP
 National Herpes Hotline.....1-919-361-8488
 Recorded information on herpes.....1-800-653-4325
 Project Inform (HIV Treatment Hotline).....1-800-822-7422
 Rape Abuse and Incest Nat'l Network (RAINN).....1-800-656-HOPE

HOTLINES SPECIFIC TO YOUNG PEOPLE

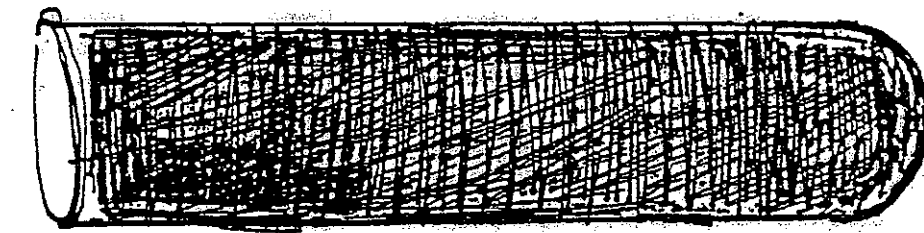
Boystown National Hotline1-800-448-3000
 Covenant Hse Nineline/Crisis Intervention Cntr..1-800-999-9999
 HIPS Hotline (for adolescent prostitutes).....1-800-676-4477
 National Gay & Lesbian Youth Hotline1-800-347-TEEN
 National Pediatric HIV Resource Cntr (NPHRC) ..1-800-362-0071
 Nat'l Runaway Switchboard (adolescent crisis line) 1-800-621-4000
 TEENS TAP (Teens Teaching AIDS Prevention)....1-800-234-TEEN
 The Teen AIDS Hotline1-800-440-TEEN

AIDS HOTLINES BY STATE AND TERRITORY

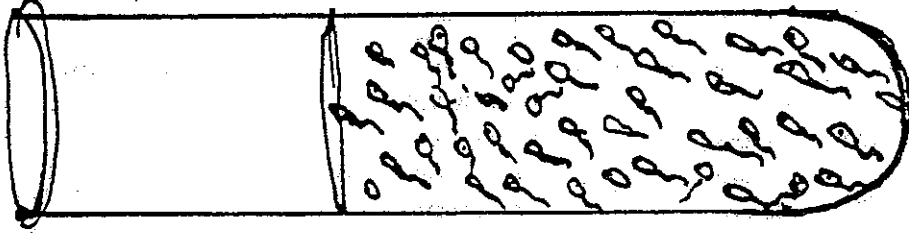
Alabama1-800-228-0469	Iowa1-800-445-AIDS	(TDD)1-800-369-AIDS
Alaska1-800-478-AIDS	Kansas *	North Carolina *
Arizona1-800-334-1540	Kentucky1-800-840-2865	North Dakota1-800-472-2180
Arkansas1-800-364-AIDS	Louisiana1-800-992-4379	Ohio1-800-332-AIDS
California (Northern)	Maine1-800-851-AIDS	(TTY/TDD)1-800-332-3889
Sp. & Eng.1-800-367-AIDS	Maryland1-800-638-6252	Oklahoma1-800-535-AIDS
(Tagalog)1-800-345-AIDS	(TTY/TDD)1-800-553-3140	(TTY)1-800-535-AIDS
(TDD)1-888-225-AIDS	(VA/Metro DC area)....1-800-322-7432	Oregon1-503-223-AIDS
California (Southern)	Massachusetts1-800-235-2331	(TTY/TDD)1-503-223-AIDS
(English)1-800-922-AIDS	(TTY/TDD)1-617-437-1672	(available in area codes
(Spanish)1-800-400-SIDA	Michigan1-800-872-AIDS	503, 206, 208)1-800-777-AIDS
(TTY/TDD)1-800-553-AIDS	(teen line)1-800-750-TEEN	Pennsylvania1-800-662-6080
Colorado1-800-252-AIDS	(Spanish)1-800-826-SIDA	Puerto Rico1-800-981-5721
(TTY/TDD)1-303-691-7719	(TTY/TDD)1-800-332-0849	Rhode Island1-800-726-3010
Connecticut1-800-203-1234	(health care workers) 1-800-522-0399	South Carolina1-800-322-AIDS
Delaware1-800-422-0429	Minnesota1-800-248-AIDS	South Dakota1-800-592-1861
District of Columbia1-202-332-AIDS	Mississippi1-800-826-2961	Tennessee1-800-525-AIDS
(TTY/TDD)1-202-797-3575	Missouri1-800-533-AIDS	Texas1-800-299-AIDS
Florida1-800-352-AIDS	Montana1-800-233-6668	(TTY/TDD)1-800-252-8012
(Spanish)1-800-545-SIDA	Nebraska1-800-782-AIDS	Utah1-800-366-AIDS
(Haitian Creole)1-800-AIDS-101	Nevada1-800-842-AIDS	Vermont1-800-882-AIDS
(TTY)1-888-503-7118	New Hampshire1-800-752-AIDS	Virgin Islands1-809-773-AIDS
Georgia1-800-551-2728	New Jersey	Virginia1-800-533-4148
(TTY/TDD)1-404-876-9950	(Sp. & Eng.)1-800-624-2377	(TTY/TDD)1-800-533-4148
Hawaii1-800-321-1555	(TTY/TDD)1-201-926-8008	(Spanish)1-800-322-SIDA
Idaho *	New Mexico1-800-545-AIDS	Washington1-800-272-AIDS
Illinois	New York	West Virginia1-800-642-8244
(Sp. & Eng.)1-800-243-AIDS	(Sp. & Eng. info)1-800-541-AIDS	Wisconsin1-800-334-AIDS
(TTY/TDD)1-800-782-0423	(counseling)1-800-872-2777	In Milwaukee414-273-AIDS
Indiana1-800-848-AIDS	(Spanish)1-800-233-SIDA	Wyoming1-800-327-3577
(TTY/TDD)1-800-972-1846		

* indicates state without an organized hotline. Please refer to CDC National AIDS Hotline 1-800-342-AIDS

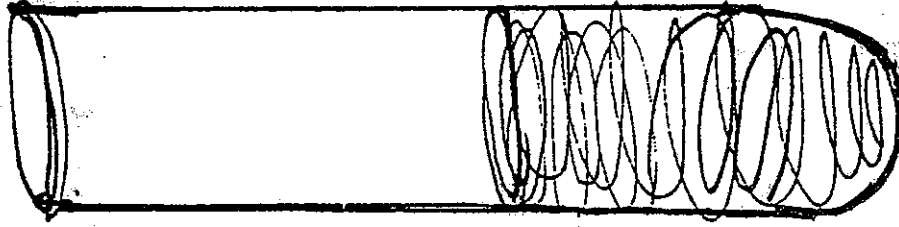
These are average numbers of HIV particles in 1 cc* of these body fluids



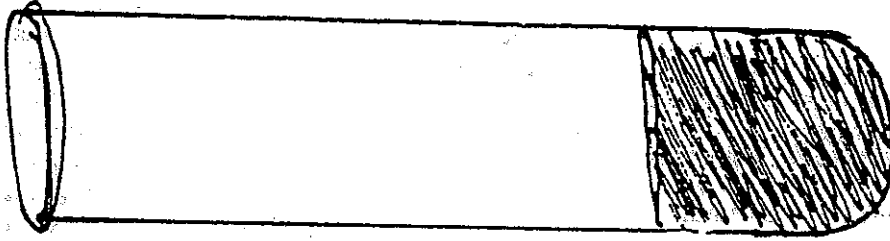
BLOOD
18,000 HIV particles



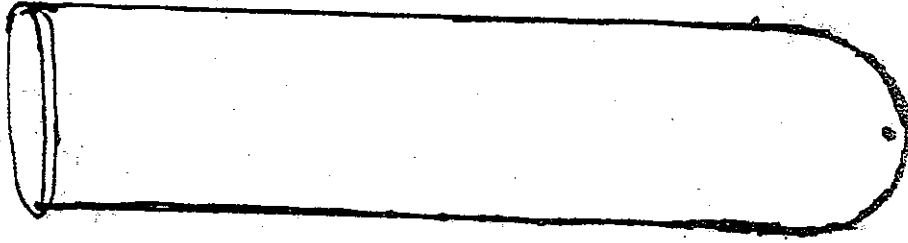
SEMEN
11,000 HIV particles



VAGINAL FLUIDS
7,000 HIV particles



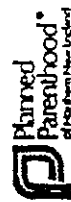
AMBIOTIC FLUIDS
4,000 HIV particles



SALIVA
less than 1 HIV particle

* 1 cc of fluid is much smaller than the size diagrammed here

Source: Michael Domin of C. Everett Koop's original task force

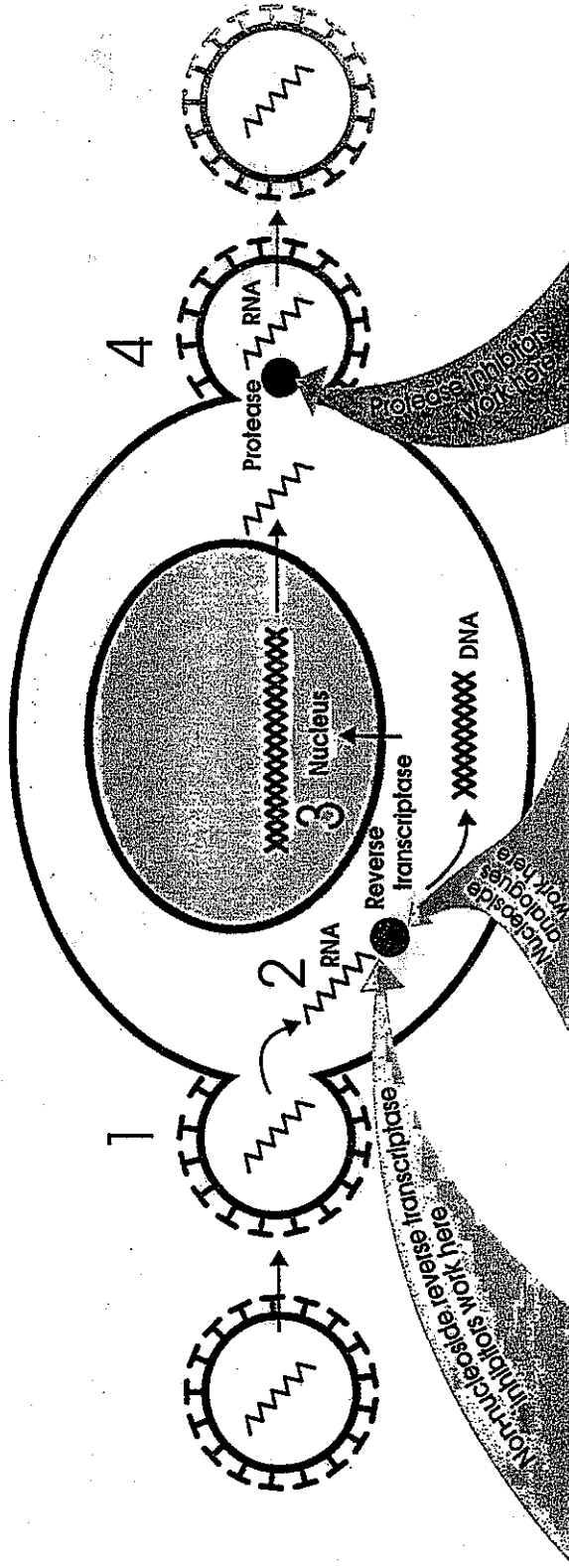


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ANTIRETROVIRAL AGENTS FOR HIV

Stages of HIV reproduction

- 1 HIV enters a CD4+ cell.
- 2 HIV is a retrovirus, meaning that its genetic information is stored on single-stranded RNA. Instead of the double-stranded DNA found in most organisms, HIV uses an enzyme known as reverse transcriptase to convert its RNA into DNA.
- 3 HIV DNA enters the nucleus of the CD4+ cell and inserts itself into the cell's DNA. HIV DNA then instructs the cell to make many copies of the original virus.
- 4 New virus particles are assembled and leave the cell, ready to infect other CD4+ cells.



Non-nucleoside reverse transcriptase inhibitors

The newest class of antiretroviral agents, non-nucleoside reverse transcriptase inhibitors (NNRTIs) stop HIV production by binding directly onto reverse transcriptase and preventing the conversion of RNA to DNA. These drugs are called "non-nucleoside" inhibitors because even though they work at the same stage as nucleoside analogues, they act in a completely different way.

VIRAMUNE® (nevirapine)
Rescriptor® (delavirdine mesylate)
Sustiva™ (efavirenz)

Nucleoside analogues

The first effective class of antiretroviral drugs was the nucleoside analogues. They act by incorporating themselves into the DNA of the virus, thereby stopping the building process. The resulting DNA is incomplete and cannot create new virus.

Zidovudine (abacavir sulfate)
Retrovir® (zidovudine - also known as ZDV or AZT)
Epivir® (lamivudine - also known as 3TC)
Videx® (didanosine - also known as ddI)
Hivid® (zalcitabine - also known as ddC)
Zeffix® (stavudine - also known as d4T)
Combivir™ (lamivudine/zidovudine)

Protease inhibitors

Protease inhibitors work at the last stage of the virus reproduction cycle. They prevent HIV from being successfully assembled and released from the infected CD4+ cell.

Invirase® (saquinavir mesylate)
Crixivan® (indinavir)
Norvir™ (ritonavir)
Viracept® (nelfinavir mesylate)
Fortovase™ (saquinavir)

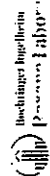
Note: This information is provided for background only.

DAILY DOSING OF AVAILABLE ANTIRETROVIRAL AGENTS*

CLASS/DRUG	USUAL ADULT DAILY DOSING†	SPECIAL CONSIDERATIONS
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
VIRAMUNE® (nevirapine)	1 x 200 mg tablet 2 times a day	Lead-in dosing for first 14 days of therapy: 1 x 200 mg tablet once a day.
Sustiva™ (efavirenz)	3 x 200 mg capsules 1 time a day	To improve tolerability of nervous system side effects, bedtime dosing is recommended during the first 2-4 weeks of therapy and in patients who continue to experience these symptoms. High fat meals should be avoided.
Rescriptor® (delavirdine mesylate)	4 x 100 mg tablets 3 times a day	Should be taken at least 1 hour apart from didanosine and from antacids.
NUCLEOSIDE ANALOGUES		
Combivir™ (lamivudine/zidovudine)	1 x 150 mg/300 mg tablet 2 times a day	Should not be prescribed for patients requiring dosage adjustments.
EpiVir® (lamivudine-also known as 3TC)	1 x 150 mg tablet 2 times a day	
Zerit® (stavudine-also known as d4T)	1 x 40 mg capsule 2 times a day	
Ziagen™ (abacavir sulfate)	1 x 300 mg tablet 2 times a day	
Hivid® (zalcitabine-also known as ddC)	1 x 0.75 mg tablet 3 times a day	Should not be used concomitantly with didanosine. Do not take simultaneously with magnesium/aluminum containing antacids.
Videx® (didanosine-also known as ddI)	2 x 100 mg tablets 2 times a day	Take on empty stomach. Alcohol may exacerbate toxicity.
Retrovir® (zidovudine-also known as ZDV or AZT)	2 x 100 mg capsules 3 times a day	
PROTEASE INHIBITORS		
Crixivan® (indinavir)	2 x 400 mg capsules every 8 hours	Take on empty stomach 1 hour before or 2 hours after a meal. Drink at least 1.5 liters of liquid daily.
InVirase® (saquinavir mesylate)	3 x 200 mg hard gelatin capsules 3 times a day	Take within 2 hours after a full meal. Saquinavir taken without food may have less bioavailability. Take with a meal or light snack.
Viracept® (nelfinavir mesylate)	3 x 250 mg tablets 3 times a day	Should be refrigerated. Take with meals. Titrated lead-in dosing: start at no less than 300 mg bid; increase by 100 mg increments bid up to 600 mg bid.
Norvir™ (ritonavir)	6 x 100 mg capsules 2 times a day	Take within 2 hours after a full meal. Saquinavir taken without food may have less bioavailability.
Fortovase™ (saquinavir)	6 x 200 mg soft gelatin capsules 3 times a day	

*Agents are administered as shown by the manufacturer.
 †Based on full prescribing information for VIRAMUNE® (nevirapine).
 ‡Based on manufacturer's prescribing information.
 †Based on adults weighing ≥60 kg.

Rescriptor is a registered trademark of Pharmacia & Upjohn Company. EpiVir and Retovir are registered trademarks and Combivir and Ziagen are trademarks of Glaxo Wellcome Inc. Zerit and Videx are registered trademarks of Bristol-Myers Squibb Company. Hivid and InVirase are registered trademarks and Fortovase is a trademark of Roche Laboratories. Crixivan is a registered trademark of Merck & Co., Inc. Viracept is a registered trademark of Abbott Laboratories. Norvir is a trademark of Abbott Laboratories.



Hepatitis A, B and C: The Basics

June 1998

Reprinted from the March 1998 issue of *Positive News* (415/487-8063), which was adapted by Christopher Gortner from the article "Hepatitis" by Liz Highleyman in the January 1998 issue of *BETA*. Both are published by the San Francisco AIDS Foundation.

What is Hepatitis?

Hepatitis is a disease that affects the liver. The liver is a large organ located under the ribcage that helps clean the body of substances like drugs and toxins (poisons). Hepatitis can be caused by different factors, including viruses and toxins. This article is about hepatitis A, B and C. Hepatitis is usually called acute (short-term) or chronic (long-term). Acute hepatitis is the first stage of the illness. Hepatitis B and C can become chronic. Chronic hepatitis can last for many years and can result in permanent liver damage.

Hepatitis A

Hepatitis A is also called infectious hepatitis. It is the most common type of hepatitis, and is caused by a virus called the hepatitis A virus, or HAV. This virus usually infects a person through oral contact with contaminated food or water. HAV can also be passed from person to person when changing an infected baby's diapers or during oral/anal sex. Household contact with an infected person (such as sharing spoons, forks or knives) may also transmit HAV.

The symptoms of hepatitis A usually develop quickly, within 10 to 50 days. The first symptoms include fever, pain in the stomach, nausea and fatigue (feeling tired). People with hepatitis A can infect others during the first 10 days of their illness. Some people with HIV, especially young children, do not develop symptoms, but can still pass the virus on to others. Hepatitis A usually cures itself. Some people may take 6 to 12 months to completely recover. Hepatitis A does not become chronic.

People who have been exposed to HAV and have developed antibodies against the virus, and people who have already had hepatitis A, cannot develop the disease again.

Prevention of Hepatitis A

The first way to avoid being exposed to, or infected by, HAV is to practice good hygiene. Always wash your hands after using the toilet and before preparing food, and be careful about possibly contaminated food and water, especially when traveling.

Hepatitis A can be prevented with a vaccine. The vaccine is safe for adults and children, and involves one injection followed by a booster (a second injection) 6 to 18 months later. Protection from the vaccine lasts at least 4 years. The vaccine is recommended for all men who have sex with men, international travelers, injection drug users, people in the military, day-care center workers, and children living in areas with high rates of hepatitis A. The HAV vaccine is also recommended for all HIV positive people who have never had hepatitis A.

Treatment for Hepatitis A

There is no effective treatment for hepatitis A. If a person has been exposed to HAV, an injection of immune globulin (antibodies) can help prevent the disease from developing, or reduce the length or severity of the disease. This treatment is called post-exposure prevention. It should be given within 2 weeks after a person has been exposed to the virus.

Hepatitis B

The hepatitis B virus (HBV) causes hepatitis B. Hepatitis B can be transmitted through blood and other body fluids like semen, vaginal fluid, breast milk, saliva, and urine. It can also be transmitted by sharing needles with an infected person or through the use of unsterilized needles for tattoos or body piercing. Sharing toothbrushes or razors, and having unprotected sex with an infected person, can also transmit the virus. Mothers can transmit HBV to their babies late in pregnancy or during birth. HBV is easier to transmit than HIV, and harder to kill. It can live in dried blood for as long as 10 days, and on some kinds of surfaces, it can live for as long as 30 days.

The symptoms of hepatitis B can develop as early as 40 days after infection or as late as 180 days after infection. People with HBV can transmit the virus for 50 to 60 days after infection. The first symptoms of hepatitis B include fever, stomach cramps, nausea, vomiting, loss of appetite and muscle aches.

Almost all babies infected with HBV become chronic carriers of the virus. Carriers may or may not develop symptoms of the disease, but can still infect others. Some people never develop hepatitis B symptoms. Other people develop chronic hepatitis B. People with chronic hepatitis B may suffer from permanent liver damage called cirrhosis, or from liver cancer. Hepatitis B is life-threatening.

Prevention of Hepatitis B

To avoid HBV exposure or infection, it is important to not share needles, cocaine straws, crack pipes, or personal items like toothbrushes and razors. It is also important to use sterilized needles for tattoos, body piercing, and acupuncture. Because HBV and other viruses can be transmitted by unsafe sex, it is important to use condoms and dental dams.

Hepatitis B can also be prevented with a safe and highly effective vaccine. The HBV vaccine is given in 3 injections; the second injection is given 1 month after the first, and the third is given 5 months later. Today, the HBV vaccine is recommended by doctors as part of standard childhood vaccinations. It is also recommended for teenagers not vaccinated as children, HIV positive people, healthcare workers, men who have sex with men, and injection drug users.

Post-exposure prevention using immune globulin can help prevent a person from developing hepatitis B disease. Immune globulin plus the first of the 3 vaccine injections should be given no later than 72 hours after the person is first exposed to HBV. This procedure can also help prevent the transmission of HBV from a woman with hepatitis B to her newborn baby.

Treatment for Hepatitis B

The only approved treatment for hepatitis B is interferon alfa. Interferon alfa is a drug that reduces virus reproduction in the body and stimulates the immune system. Interferon alfa is an effective treatment in about half of all hepatitis B cases.

Interferon alfa is injected under the skin 3 days a week for 12 months. The treatment works better in people with low HBV virus loads, and in people without permanent liver damage. Side effects of interferon alfa include flu-like symptoms. Experimental treatments are being tested.

Hepatitis C

Hepatitis C is caused by a virus called HCV. HCV is usually transmitted through blood and other body fluids, and people get infected in many of the same ways as with HBV (sharing needles, etc.). Sexual transmission of HCV is not common.

Hepatitis C is more common among injection drug users who share contaminated needles, and hemophiliacs who received contaminated blood products. An accurate test to detect HCV in donated blood became available in the U.S. in 1992. Anyone who received a blood product transfusion before 1992 should be tested for HCV.

The first symptoms of hepatitis C include a flu-like illness that usually develops 1 to 3 months after infection. Many people infected by HCV only develop mild symptoms of the disease. Other people have no symptoms at all. The symptoms of hepatitis C are usually less severe than the symptoms of hepatitis B or A, but hepatitis C disease can be more serious. Almost 85% of people infected with HCV develop chronic hepatitis C. Chronic hepatitis C can cause permanent liver damage, liver cancer, and death.

Prevention of Hepatitis C

No vaccine is available to prevent hepatitis C. To prevent HCV exposure or infection, it is important to not share needles, cocaine straws, crack pipes, or personal items like toothbrushes and razors. It is also important to use sterilized needles for tattoos, body piercing, and acupuncture. Although HCV is not often transmitted through sex, condoms and dental dams can reduce the risk of exposure to HCV.

Treatment of Hepatitis C

Interferon alfa is the only approved treatment for hepatitis C. Relapses of the disease after treatment are common. Some experimental treatments are being tested.

Toxic and drug-induced hepatitis

The liver's main job is to clean the body of toxic substances. In some cases, the liver can become overworked if the level of toxins in the body gets too high.

Many drugs, including anti-HIV drugs, anti-tuberculosis drugs, sulfa drugs, and pain relievers with acetaminophen (such as Tylenol) strain the liver. Excessive levels of natural or artificial hormones like testosterone can damage the liver and cause drug induced hepatitis.

Some herbs, poisonous mushrooms and industrial products can also cause toxic hepatitis.

Different drugs and toxins cause different kinds of liver damage. Damage can develop immediately after exposure or as long as 6 months later. Heavy, short-term use of alcohol can cause hepatitis; long-term alcohol abuse can cause cirrhosis of the liver and death.

In some cases, if the toxic substance is discontinued, the liver will recover. In other cases, the damage is permanent.

Acute Hepatitis

Acute hepatitis usually starts with a flu-like illness. Symptoms can include fever, nausea, vomiting, loss of appetite, fatigue, and muscle aches. Some people have pain in the upper part of the abdomen and itchy skin. People with acute hepatitis also usually have high levels of two liver enzymes in their blood.

The flu-like symptoms usually disappear in a few weeks. After that, some people develop jaundice, or yellowing of their skin and the whites of their eyes. Jaundice is a sign that the liver is not working properly.

Most people with acute hepatitis enter a recovery period that can last from 2 to 12 weeks or longer, during which a person may still feel tired and have a tender abdomen.

Chronic hepatitis

Some people with hepatitis B or C do not recover completely from the disease. Hepatitis B and C can become chronic. Long-term effects include cirrhosis, liver cancer, and fatal liver failure.

About 5 to 10% of people infected with HBV develop chronic hepatitis B. Chronic hepatitis B is more likely in people who were infected during childhood—up to 90% of these people become chronic carriers.

More people infected by HCV develop chronic hepatitis C—nearly 85%, say experts. Although some people with chronic hepatitis C do not show any signs of liver damage, they can still infect others. Other people suffer liver damage, and the disease worsens as time goes on. Chronic hepatitis B and C are more likely in people with weakened immune systems, like HIV-positive people.

Chronic hepatitis can damage the liver

so much that it can no longer function properly. This condition is called liver failure. Liver failure caused by chronic hepatitis is the major reason for liver transplants in the U.S. Untreated liver failure is fatal.

Diagnosis of Hepatitis

A doctor usually makes a diagnosis of hepatitis after looking at different factors. Because the flu-like symptoms are common to many other diseases besides hepatitis, relying on just these symptoms is not the best way to diagnose hepatitis.

Besides flu-like symptoms, a person with hepatitis may have jaundice (yellowing of the skin), dark-colored urine, and visible masses of blood vessels under the skin called spider angiomas. A person with hepatitis may also feel tenderness or pain in the upper right part of the abdomen.

A physical exam of the abdomen may reveal an enlarged (swollen) liver, or small (shrinking) liver. In some cases, an ultrasound scan (a computerized exam of the body) may be done to find out the size and shape of the liver. In other cases, a biopsy (removing a piece of liver tissue with a needle so that it can be examined under a microscope) may be necessary.

The most reliable signs of hepatitis show up in blood tests. Blood tests to detect hepatitis include liver function tests that measure liver enzyme levels in the blood, and tests to detect hepatitis antibodies in the blood.

Hepatitis is a serious disease. Preventing infection is easier and more effective than treating the disease itself. Vaccines can prevent both hepatitis A and B. Good hygiene and safe drug and sex practices can help reduce the risk of being exposed to hepatitis viruses. Vaccination against hepatitis is strongly recommended for all HIV-positive people.

Hepatitis Resources

- San Francisco Department of Public Health: 415/554-2830
- Centers for Disease Control & Prevention: 888/232-3328
- American Liver Foundation Hotline: 800-GO-LIVER
- Hepatitis B Foundation: 800/891-8786
- Hepatitis C Foundation: www.hepcfoundation.org

H.O.M.E./EMMAUS/SR. BARBARA HANCE H.O.M.E.

POLICY AND PROCEDURES

FOR

HIV/AIDS

OCTOBER, 1998

H.O.M.E.\EMMAUS\SR. BARBARA HANCE H.O.M.E.

HIV/AIDS POLICY AND PROCEDURES

This policy on HIV/AIDS is being written in order to affirm the value of all human beings and as a way of welcoming people who seek employment or shelter at any of H.O.M.E.'s shelters or transitional houses. HIV/AIDS is a communicable disease (i.e., an infectious disease). However, unlike staph or strep or flu, fellow workers and people sharing living spaces are not exposed to the risk of infection in any casual way or from any type of casual contact. There is no evidence of casual transmission of HIV from handshakes, toilet seats, door knobs, hugs, sharing food and beverages, living in the same household, playing together, sharing toys, and so on. Research resoundingly affirms that there is no risk of casual transmission to household members or co-workers. Instead, the only significant risk of HIV transmission comes from unsafe sex or needle-sharing. At present, there are more effective medical treatments for HIV and AIDS. But it is a disease that sometimes leads to unfair stigma and discrimination. Like any disease, it calls for our understanding, knowledge and compassion.

HIV and AIDS do not present serious risks to those who use or work at H.O.M.E.'s shelters and transitional housing. However, because HIV and AIDS frequently lead to more stigma and discrimination than other health conditions, H.O.M.E. is adopting this Policy.

POLICY STATEMENT:

PURPOSE: To establish guidelines and policies for staff, volunteers and clients in order to protect the human rights of each individual. Also to promote an educational program whose goals are reducing the risk of transmission of HIV and the stigma and discrimination associated with HIV and AIDS.

POLICY: AIDS and HIV education will be a regular and integral part of our training and counseling programs for both clients, volunteers and staff, in order to allay fear, misconceptions or prejudice about AIDS and HIV and to encourage personal behavior that helps prevent transmission of HIV. This education will ensure that proper and current information is available. We understand that some staff members, volunteers and clients may raise some objections relating to their fear of contact with a person who has HIV or AIDS. Sensitivity will be shown and education will be provided to deal with these concerns, since one of the main goals of the education program is to combat these types of baseless fears. Prejudicial or discriminatory behavior, isolation, ridicule or inappropriate actions based on irrational fear, directed at anyone with AIDS or HIV infection, will not be tolerated and appropriate disciplinary actions will be undertaken. The guidelines will be individually applied, consistent with legal requirements, taking into consideration the psychological, physical and behavioral characteristics of the individuals involved.

GUIDELINES:

1. Staff members or clients who know or suspect that they are infected with HIV are encouraged to seek medical testing and treatment. The administration will make every reasonable effort to provide assistance.
2. Routine screening of staff or clients is not recommended.
3. All staff members, volunteer and clients will be treated the same, regardless of their sexual orientation.
4. Kitchen Procedures: Food handlers; staff, clients, volunteer cooks and anyone who prepares food in H.O.M.E.'s kitchens must abide by the following:
 - a. Food handlers who have HIV or AIDS shall not be restricted from using the kitchen, equipment or utensils unless they have a medically verified illness, or signs or symptoms of an illness, for which restrictions would be warranted, based on health concerns (e.g. active tuberculosis).
 - b. All food handlers should follow the recommended standards and practices of personal hygiene and food sanitation. Frequent training will be given regarding these standards.
 - c. All food handlers should attempt to avoid personal injuries during food handling. Foods tainted with blood or other body fluids must be discarded, irrespective of whether or not the handler is infected with HIV.
 - d. A disinfectant solution (1:10 household bleach and water) should be available for treating any equipment contaminated by blood or other body fluids, whether or not the food handler has HIV.
5. Universal Precautions: The practice known as Universal Precautions will be adhered to strictly. In any incidents of possible exposure of an individual or equipment to blood, vomit or any other body fluids, latex gloves will be used and waste will be disposed of properly. Disinfecting any exposed surfaces with a 1:10 bleach solution, as well as hand washing with warm water and soap, will be necessary.
6. Confidentiality: The right of an individual client, staff member or volunteer to confidentiality with regard to his/her HIV antibody status or AIDS diagnosis will be respected by the administration and staff of H.O.M.E. and all related agencies. We will comply with Maine Law (5 MSRA, Part 23, Chapter 501, 19203) and with federal law, including but not limited to the Americans With Disabilities Act.

- a. Information that is shared with a staff member or volunteer regarding an individual's antibody status must be held in the strictest confidence and shared only with the Executive Director or Administrator if necessary for purposes of supervision, and then only after obtaining the written consent of the individual in question. No mention of it is to be made in the files or other written records, except that any individual's written consent to waiver of his or her right to confidentiality.
- b. The sharing of this information with other clients, volunteers or staff members is the exclusive right of the infected individual.
- c. H.O.M.E. personnel may share information about an individual's HIV status with other agencies or individuals only with the specific written consent of the individual with HIV or his/her legal guardian. The only legitimate context of such disclosures will be that of providing comprehensive services to the infected individual.
- d. Disciplinary action will be taken against any employee who inappropriately discloses medical information about any client, volunteer or staff person.
- e. These guidelines shall be reviewed periodically and revised as necessary to reflect new medical information regarding HIV and AIDS and to be consistent with legal requirements.

H.O.M.E. and its related shelters are unique in that we are open to people from all over the State of Maine, the country and, in fact, the world. People come to us for a variety of reasons and with a variety of problems. Many parts of the U.S. and the world have been deeply affected by the epidemic of AIDS and HIV. The key to ending this epidemic lies in education and we will strive to provide the necessary education to everyone, clients, staff and volunteers alike. We must always remember to be open and welcoming and to be mindful of the humanity and rights of all individuals.



