

AN ABSTRACT OF THE THESIS OF

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Title: A Survey of Oregon College and University Health
Service AIDS-Related Priorities and Policies: A
Replication of the Caruso and Haig Philadelphia
Study

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/ Margaret M. Smith

The literature asserts that both the medical and educational communities have forecast a potential for an AIDS epidemic on college and university campuses. The experts warn that without either a cure or a vaccine for AIDS, it is only through education of "risk behaviors" that devastation can be avoided.

A previous study of AIDS-related programs, policies, and services was conducted in 37 Philadelphia area colleges and universities to determine ideal priorities for AIDS-related issues on campuses, and to assess the programs, policies, and services that were currently in place. In order to replicate the previous study, the original five-part questionnaire was used in the current study.

Questionnaires were sent to 36 Oregon colleges and universities in Oregon that offered either two-year

associate degree programs, four-year general baccalaureate degree programs, or colleges and universities with general post-baccalaureate programs. Speciality schools were excluded in order to replicate the Philadelphia study. Twenty-eight Oregon colleges and universities responded to the survey.

The data for research questions 1, 3, and 4 were reported in percentages. Non-parametric statistics were used to analyze data regarding current and ideal programming. Chi square statistic was used to analyze research question 2. Because of unusually small cell size, data for research question 5 was also reported in percentages.

It was found that the programs, policies, and services that are currently in place on the sampled campuses are congruent with the respondent's conceptualized ideal programming in the areas of the development of institutional guidelines, adjustment in counseling services, and the distribution of written AIDS-related information. It was also reported that none of the Oregon institutions had allocated any funds for the hiring of new personnel to address the problems of AIDS on campus. There appeared to be a definite trend for the larger schools, (> 3,000) to have more AIDS-related programs, policies and services in place than did the smaller colleges and universities.

The Oregon study showed a higher percentage of AIDS-related campus activities in place than did the earlier

Philadelphia study, however, the results indicated there is still a serious lack of focus on the issues surrounding AIDS on campus.

Educational recommendations were offered in the areas of guideline development, mandatory staff training, and providing AIDS-related information to students. Recommendations for future research should also focus on evaluation of the effectiveness of programs, policies, and services currently in place on college and university campuses.

A SURVEY OF OREGON COLLEGE AND UNIVERSITY HEALTH
SERVICE AIDS-RELATED PRIORITIES AND POLICIES:
A REPLICATION OF THE CARUSO AND HAIG
PHILADELPHIA STUDY

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A SURVEY OF OREGON COLLEGE AND UNIVERSITY HEALTH SERVICE
AIDS-RELATED PRIORITIES AND POLICIES: A REPLICATION
OF THE CARUSO AND HAIG PHILADELPHIA STUDY

I. INTRODUCTION

Background of the Problem

Less than two years have passed since the Department of Health and Human Services (DHHS), released a report constructed from a colloquium held by eighty-five Acquired Immune Deficiency Syndrome, (AIDS), experts and health care administrators. At that time the DHHS did not predict an increase in the proportion of AIDS transmission among the heterosexual population (Seligmann, Hager, Springen, 1986). However, the onslaught of AIDS has reduced the focus on "risk groups" and heightened attention has now been directed toward "risk behaviors." Estimates are that over 59,000 people in the United States now have AIDS with the number of newly diagnosed cases doubling approximately every thirteen months (Oregon State Health Division, 1988). These estimates are indicative of the potential threat that is presented by risk behaviors, and these behaviors occur in the college population as well as many other populations (Biemiller, 1985).

Foresighted experts warned of the significant risk factor of heterosexuals who have multiple sex partners (Biemiller, 1985; Seligmann, et. al., 1986; Solomon, DeJong, 1986; Wheeler, 1987) and their predictions have been validated. The heterosexual, non-intravenous (IV)

drug user population now has as many cases of AIDS as did the homosexual and IV drug user population five years ago (Koop, 1987).

With neither a vaccine nor a cure for AIDS being available within the foreseeable future, public health officials and health educators have identified a critical need for readily available AIDS information that clearly targets individuals who participate in risk behaviors.

Statement of the Problem

The focus of the problem derives from an extensive review of the literature which consistently indicates the need for AIDS-related education among the college population. The need for these resources is heavily documented, however, the literature reports regarding AIDS-related programs that are currently in place on college and university campuses, are very limited.

Purpose of the Study

The major goal of this study was to replicate a survey of Philadelphia colleges and universities by B. A. Caruso and J. R. Haig which was done in 1987. The present study was intended to identify the AIDS-related policies and programming currently in place on Oregon college and university campuses. In accordance with the Philadelphia study, the following objectives were established:

- (1) to determine if there is a difference in AIDS-related priorities and programming according to the institution's enrollment size.
- (2) to identify discrepancies between the respondent's conceptualizations of effective AIDS-related programs and services, and what has actually taken place on these campuses.
- (3) to replicate a study conducted in the Philadelphia area, and compare the results of the two studies.

Research Question

In order to meet the objectives of this study, the following questions were posed:

- (1) What importance is given to AIDS-related programs and services by college and university student health services officials?
- (2) What AIDS-related program are currently in place in Oregon campuses?
- (3) Has funding been budgeted to provide education, services, and personnel?
- (4) Does the enrollment size of the institution have a bearing on the programs and services currently in place?
- (5) Are student health services currently implementing the highly rated programs and services of surveyed officials?

Justification of the Study

Justification for this study is well-documented. The United States Centers for Disease Control, (CDC), the National Academy of Sciences, (NAS), and the United States Surgeon General have reported that without vaccine or cure for AIDS, education is, at the present time, the only

means of preventing the spread of AIDS (Fulton, Metress, Price, 1987; Koop, 1987). Emphasis on education is the common theme throughout the professional literature (Biemiller, 1987; Bowen, 1987; Dan, 1987; DiClemente, Zorn, Temoshok, 1986; Fulton, et. al., 1987; Lewis, 1987; Solomon, et. al., 1987; Wark, 1988; Wheeler, 1986; Windom, McGinnis, 1986).

The risk behavior of having multiple sex partners is not uncommon among the college and university population (Widen, 1987). Because of the prevalence of risk behaviors by students, colleges and universities have been identified as major targets for AIDS-related education and programming (Biemiller, 1987; Keeling, 1986; Lewis, 1987; Solomon, et. al., 1987).

Dr. Richard B. Keeling, editor of a is a special report entitled AIDS ON THE COLLEGE CAMPUS (1986), wrote:

There have been a few cases of AIDS itself among college and university students so far... On the other hand, the incubation period... may be quite long; what someone does now in college may not result in recognizable AIDS until long after commencement. Students are commonly experimental and may exercise inconsistent judgment in their selection of sexual partners.

AIDS has been given "epidemic" status by health officials including the United States Surgeon General, C. Everett Koop. Yet, the National Health Interview Survey, (NHIS) of August 1987 reported that most adults believe that they and the people they know are at little or no

risk of contracting AIDS. Sixty percent of the sample population felt they had no chance of AIDS infection, and 30 percent reported a low chance of contracting AIDS themselves. Only 10 percent of the sample population identified AIDS as a personal threat. Sixty percent of the sample indicated that the chance of someone they know getting AIDS is either non-existent or low. The NHIS report is indicative of the Surgeon General's concern that by emphasizing "risk groups," (IV drug users, homosexuals), rather than "risk behaviors," the threat of AIDS to people not in the "risk groups" will be underestimated (Koop, 1987; Krim, 1986).

With the reported rate of teen pregnancy higher in the United States than any other developed country (Planned Parenthood, 1986) it must be understood that American adolescents must be considered primary targets for AIDS education. The possibilities for transmission among this population are great. Because of the possible asymptomatic nature of the HIV infection, an adolescent may carry the infection and transmit it to numerous sexual partners throughout several years prior to showing any symptoms.

The need for institutional AIDS-related policies has also been addressed in the literature (Fulton, et. al., 1987; Gerberding, 1986; McMillin, 1986). Clearly establishing policies and guidelines can prevent panic and a sense of urgency in decision-making. Position

statements regarding students and staff who are HIV positive have been issued by several nationally known organizations as well as numerous state health department these factions have encouraged immediate and thorough efforts directed toward development of guidelines and policies in all schools (Fulton, et. al., 1987).

This study examines the AIDS-related education and policies of Oregon college and universities. It also reports the priority levels placed on AIDS-related programs and services by the student health service officials.

Definition of Terminology

The AIDS crisis has brought with it a particular vernacular used to described AIDS-related terminology. In this section, the terms, "at-risk groups," "at-risk behaviors," "AIDS," "HIV positive," "seropositive," "asymptomatic carriers," and "ARC," are defined according to their current use in the literature.

"At-risk" is an epidemiological term meaning an individual has an increased probability of developing the disease over a specific period of time. "At-risk groups" were originally thought to include mainly homosexuals and Haitians (Leishman, 1987) because the disease was first identified within these two populations. As the disease spread, IV drug users were given "risk group" status because of the tendency for sharing contaminated needles,

thus providing a very direct route for transmission of the virus.

As more and more cases of AIDS developed, it became apparent that the virus was not limited to the groups originally identified as "high risk." Those who received blood transfusions prior to April 1985 when the blood supply was not screened for the AIDS virus, prostitutes, sexually active men and women with multiple sex partners, and children born to infected mothers have all been cited as "risk groups" for the AIDS virus (Traux, 1987).

The literature has recently changed the focus from "risk groups" to "risk behaviors", indicating that it is the actual behavior that puts the individual at risk for contracting AIDS. The Surgeon General and the medical community have called for a campaign of information and education regarding these high risk behaviors as a primary means of AIDS prevention (Keeling, 1986; Koop, 1987; Lewis, 1987). At the present time based on known modes of transmission, risk behaviors include: 1.) unprotected or ineffectively protected sexual contact with an infected individual 2.) blood exchange from an infected individual, and 3.) transmission from an infected mother to an unborn fetus during pregnancy or during childbirth.

The letters A-I-D-S stand for acquired immune deficiency syndrome. AIDS is the final stages of a series of health problems caused by a virus which compromises the immune system's ability to fight diverse opportunistic

illnesses. This virus is human T-lympho-tropic virus-type III/lymphadenopathy, which has been designated "human immunodeficiency virus", (HIV), (Fulton, et. al., 1987). AIDS is a result of destruction of the immune system. It is characterized by the development of a combination of diseases known as opportunistic infections. Opportunistic infections commonly associated with fully developed AIDS cases in the United States include Kaposi's Sarcoma, (skin tumors), and pneumocystis carinni pneumoma, (lung infection). The AIDS virus can also cause dementia by damaging the nervous system and brain (Koop, 1987). The AIDS virus has been identified in blood, semen, saliva, breastmilk and tears.

A seropositive test indicates that the blood of an individual, more likely than not, contains antibodies to HIV. A person may test positive for HIV, (seropositive), and not show any visible signs or symptoms of the disease. At the present time, according to Surgeon General Koop (1987) there are no certain projections of the number of persons testing seropositive. It has been established, however, that these "asymptomatic carriers" of the HIV, can and do pose a threat of transmission through risk behaviors (Koop, 1987).

AIDS-Related Complex, (ARC), is a condition caused by the AIDS virus in which the individual both tests positive and presents a specific set of clinical problems caused by the HIV infection damage to the immune system. These

people however, are without the opportunistic infections and cancers associated with AIDS. Health problems typically associated with ARC include night sweats, weight loss, skin rashes, general lack of resistance to infection, diarrhea, fevers, tiredness, and/or swollen glands (Koop, 1987).

Summary

This chapter addressed the epidemic status of AIDS. It also discussed the emphasis on education as a means of prevention. The research questions were posed and justification of the study was discussed. Current AIDS-related terminology was defined.

II. REVIEW OF THE LITERATURE

Introduction

This chapter discusses professional literature in four AIDS-related areas: A Brief History and Future Forecast of AIDS, Risk Behaviors Among College and University Students, A Case For Education, and A Philadelphia Study.

Brief History and Future Forecast of AIDS

The first case reports of AIDS appeared in 1979, but AIDS was not identified "as an entity" until 1981 (Widen, 1987). In 1979 it was considered to be a risk to only the homosexual, Haitian, and IV drug user populations. At the present time over 59,000 people in the United States have AIDS and the number of new cases doubling every twelve months (Oregon State Health Division). It is estimated that between 1.5 million and 5 million people in the United States are now infected with the HIV, but have no symptoms (Biemiller, 1987). By the year 1991, it is estimated that there will be a minimum of 270,000 cases of AIDS (Drotman, 1987). The CDC in Atlanta estimates that 5 percent to 20 percent of those infected with the virus will develop AIDS. However, many researchers now estimate a higher percentage, as high as 50 percent or more (Traux, 1987). The accuracy of AIDS data regarding the current prevalence of AIDS and projected future AIDS cases have

recently come into question (The Monthly Vital Statistics Report, September, 1987). There is a concern that the true cause of death may be underreported in many cases. A physician may want to shield the family of an AIDS patient from emotional pain or social embarrassment by not listing the primary diagnosis on the death certificate. A secondary problem such as "brain lymphoma" or "pneumonia" may be listed as the cause of death. Each time this takes place, the accuracy of current and project AIDS-related estimates becomes compromised. Experts estimate that there may be as many as 100 persons infected with the HIV for each case of AIDS presently identified (Curran, 1985). Quite early in the short history of AIDS in the United States, it was suggested that asymptomatic carriers with positive HIV could pose a significant threat to the general, non-infected population. By being unaware of the condition, they are likely to pass the HIV infection to their unsuspecting sexual partners (Pitchenik, Fischi, Spira, 1983). It is now well-understood that seropositive asymptomatic carriers do present a risk of infection to their sexual partners (Fleming, Cochi, Steece, 1987).

With the current estimates of cases of AIDS and the projections for the future, it is clear that AIDS is a public health crisis. The expected loss of productivity resulting from AIDS-related morbidity and premature mortality is estimated to rise from \$3.5 billion in 1985 to \$44.6 billion in 1991. Projected medical care costs for

AIDS patients will also show a sharp increase from \$630 million in 1985 to \$8.5 billion in 1991 (Scitovsky & Rice, 1987). However, because these estimates were based on CDC data, one must consider the issue of underreporting as raised by The Monthly Vital Statistics Report (September, 1987).

Though the estimated numbers may vary, experts have reached consensus that AIDS is indeed, an epidemic. It is not the discriminating disease it was once thought to be.

Risk Behaviors Among College and University Students

Keeling (1986) identified the college student population as being "commonly experimental" which can result in high risk behavior. The population which is at risk for sexually transmitted diseases, (STD's), is also the population that is the most sexually active. In 1985 it was estimated that 60 million people between the ages of 15 and 34 were sexually experienced (Widen, 1987). And the trend for sexual activity at earlier ages continues, while the average age for marriage increases. This results in the potential for more young people having multiple sex partners, thus increasing the risk of contracting AIDS or other STD's (Widen, 1987). A recent survey of college students in Wisconsin reported an average of approximately three sexual partners per month (Dunwoody, 1987). Citing his studies of military recruits, Major Robert R. Redfield of the Walter Reed Army

Institute of Research concluded that "it is dangerous for a heterosexual to think that he or she ran (sic) a risk of getting AIDS only from bisexual men or intravenous drug abusers" (Drake, 1987). Redfield also reported that "Twenty-percent of young sexually active people over 25 have herpes simplex" (Drake, 1987). These numbers alone indicate a serious need for education regarding the risk of contracting STD's in generally with specific attention given to AIDS.

McDermott, Hawkings, Moore, and Cittadino (1987) reported that college and university students are important targets for AIDS education because studies have indicated that this population has a relatively high level of sexual activity and a potential for multiple partners. Yet, in a 20 item forced-choice inventory distributed in a general education course, university students selected in cluster sampling, 37% of the sample were unclear about AIDS' lethal potential. Nearly thirty-two percent, (31.7%), did not recognize the actual risk associated with casual sex. The student concluded that "though media attention given to AIDS abounds, certain misconceptions are still held by some young adults." This study further revealed that among the population sampled, over 44% of the students cited television as their primary source of AIDS information.

A recent survey conducted by SEXUALITY TODAY (November 16, 1987) of 40 participating marriage and family

therapists from every part of the United States found that single heterosexual females have made the greatest changes in behavior in light of the risk of AIDS. Living in geographically high or low risk areas was not linked to the initiation of behavior change. The therapists reported a trend for this population regardless of geographical location (Schmidt, Edel, Streaun, de Mause & Stein, 1987).

The male population sampled in the same study were slower to initiate behavior changes in regard to sexual activity. Even though this survey was not directed at the college or university population, it is relevant to the fact that college students do not always restrict their dating partners to those within the parameters of the college or university campus.

A recent study was conducted at John Hopkins Hospital Department of Emergency Medicine, a level one trauma center (Baker, Kelen, Sivertson, Quinn, 1987). During a 100-day period in 1986, all patients 15 years of age and older and who underwent any procedure related to the procurement of blood, were eligible for the study. Of the 203 samples drawn, six, (16%), were determined to be seropositive, carrying the HIV infection. All six were male and in the 25-34 year-old age group. None of the patients were previously aware they were seropositive. Two of the six patients showed evidence of IV drug use. The other four were not identified as belonging to any

recognized "risk groups." The 25-34 year-olds in this study were not representative of the college population, but with multiple sex partners, age groups are possibly a more common link than recognized. College students do not necessarily exclude non-students from their social lives.

The literature is very scant regarding AIDS and college students. Little has been reported on attitude or behavior change. There have been some reports focusing on current AIDS-related education, programs, and services now in place, but these reports are isolated, possibly because of the relative newness of the disease and because AIDS was at first thought to be a problem specific to mostly homosexuals and IV drug users. Initially AIDS may have been viewed more as a "moral" issue than a public health issue. Other than requesting a report from the Surgeon General, the White House initially did not respond to the warnings of the Surgeon General, Secretary of Education, or others who foresaw a crisis situation developing (Lewis, 1987). It was only after the disease left the confines of these initial risk groups that focus on information and prevention escalated.

A Case For Education

The medical community has warned the educational community of the potential destruction that can be caused by an AIDS epidemic. Medical leaders are strongly urging that educational leaders take action directed toward young

people (Lewis, 1987). The United States Surgeon General published his official report on AIDS on June 11, 1987. In this report he stated, "Only the control of certain behaviors can stop further spread of AIDS." (Koop, 1987).

Recent studies conducted among clients in inner-city public health clinics showed dramatic results using educational and social marketing efforts to reduce risk behaviors (Solomon, et. al., 1986). Analysis of the results showed that "education efforts can successfully motivate the adoption of key behaviors relevant to the control of a variety of sexually transmitted diseases".

Former executive editor of EDUCATION USA, Anne C. Lewis, (1987) has challenged the effectiveness of the information that is presently targeted toward the young population.

Information about sexually transmitted diseases has been inadequately conveyed to young people through the channels that now exist. According to the American Social Health Association, at least 2.5 million teenagers in the United States will contract a sexually transmitted disease this year.

Lewis concluded that only an intense and aggressive educational campaign and substantial funding for medical research will prevent catastrophe.

The need for information and education is strongly reiterated throughout the literature. Regardless of the main focus on each author, the information and education components of AIDS prevention is emphasized repeatedly.

The achievement of these components will be guided by the establishment of educational priorities and policies.

A Philadelphia Study

This present study was intended to replicate a 1986 study of 37 Philadelphia area colleges and universities conducted by Barbara A. Caruso and John R. Haig. The Philadelphia academic institutions were surveyed concerning how the student health service departments thought AIDS programs should be carried out on campus, and how the institution's current AIDS-related programming was being conducted. There were discrepancies between conceptualizations of ideal AIDS programming and actual programs in place. Seventy-six percent of the responding schools placed a high priority on special counseling services for individuals at risk for contracting AIDS, but only one-third of the institutions had actually adjusted their counseling services, and even less had appropriated funds for hiring new personnel, or for training existing personnel. The delivery system for AIDS education and information was generally agreed upon with 81% rating written pamphlets, and 78% rating establishing AIDS guidelines as top priority items. However, only 46% rated more aggressive means of disseminating information, such as seminars and workshops as high priority items.

Students were targeted as high priority for AIDS-related education by 75% of the respondents. Sixty-eight

percent cited faculty, staff, and administration as high priority, while only 27% rated parents as high priority for this information. The local community and media were rated high by only 11% of the respondents, as were trustees and alumni.

Seventy-six percent rated special counseling services as high priority, and 48% gave the lowest rating to making AIDS screening and testing available to students and staff. It was also found that larger institutions, (> 1,000 enrollment), were more likely to have active AIDS planning and policies in anticipation of the problems involved than were the smaller schools.

When surveyed concerning, 1) the establishment of AIDS guidelines, 2) the distribution of AIDS pamphlets, and 3) the desire to join an AIDS coalition, schools with enrollment of less than 1,000 gave a "no" response far more often than a "yes" response. The opposite was indicated by the schools with larger enrollment.

Using Chi-square analysis, the Philadelphia researchers found that the institutions that had received American Council of Education, (ACE), and/or American College of Health Association, (ACHA), guidelines were more likely to have an AIDS task force or committee in place and to have established AIDS guidelines. The receipt of the ACE/ACHA guidelines also had a significant impact on the distribution of pamphlets by the academic institutions. The study also showed significant discrepancies between the

respondent's conceptualized ideal programs and those which were actually in place. Four of the 37 institutions sampled (11%) reported cases of AIDS or ARC on campus. There was no way, of course, to determine the number of students or staff who are presently seropositive but asymptomatic.

Summary

This chapter addressed the epidemic status of AIDS. Research was presented which indicated the occurrence of risk behaviors by college and university students. Recent studies indicate that these same students often have misconceptions concerning AIDS-related issues.

Education has been cited as the only weapon available at this time to fight the AIDS epidemic. Educators and health officials, including the Surgeon General of the United States, have been very emphatic in their efforts to enlist the active support of the educational system in providing information and programming. Both information and educational programming will most easily be achieved if they are guided by established educational priorities and policies.

The present study is a replication of a Philadelphia study (Caruso, Haig, 1987). The authors surveyed 37 area colleges and universities regarding each student health service's ideal conceptualization of AIDS-related programming and programs currently in place.

III. METHODS AND PROCEDURES

This chapter considers issues related to the sample and the instrument used in the survey. The collection and treatment of the data are also discussed.

Population

The sample population included student health service departments of all Oregon two-year colleges offering Associate degrees, all four-year general baccalaureate institutions, and universities offering post baccalaureate degrees, (Appendix A). Specialty schools, (e.g. business, art, theology, medicine, etc.), were not included.

Selection of Subjects

The questionnaires were sent to a designated person at each of the thirty-six institutions. Prior telephone contact with each school provided the name of the target person who was knowledgeable in the areas addressed by the questionnaire. If the school had no official health services department, the survey was directed to the student services department. A total of thirty-six questionnaires were distributed.

A cover letter, and support letter, (Appendix B), accompanied the five section questionnaire, the support reinforced the request for participation in the survey and the anonymity of the respondent. An enclosed self

addressed, stamped envelope was included. A total of thirty-six questionnaires were distributed.

Instrument

Consent was given by the authors of the Philadelphia study to replicate the questionnaire used in the previous study. The questionnaire was comprised of five sections.

The first section of the two-page instrument was in two parts. The first part appraised the perceptions of priorities regarding how to provide target groups with AIDS-related information. Each potential target group was rated low/medium/high by each respondent. The second part of the first section asked the respondent to prioritize four potential campus-related resources and services according to the previously-mentioned scale. This section was included to assess the respondent's evaluations of services that they believe to be instrumental in effective AIDS-related services and programs.

Current programs and policies were addressed in the third section of the questionnaire. It included questions concerning AIDS-related information programs or campus activities which are currently in place. Section three also included questions concerning the receipt of guidelines distributed by ACE and/or ACHA.

Demographic characteristics of the institutions were identified in the fourth section. The questionnaire inquired about enrollment size, funding, (public or

private), and school program, (two-year college, four-year college, or university).

The fifth section of the instrument solicited expanded answers and/or comments for potential future research, (the questionnaire appears in Appendix C).

Data Collection

The Caruso and Haig questionnaire was used in order to replicate the Philadelphia study. The questionnaires were returned to the researcher at the Department of Health, Waldo Hall, Oregon State University. Each reply was opened by a second-party and each envelope was immediately destroyed to preserve the anonymity of the respondents.

Treatment of the Data

Data obtained from the respondents was nominally scaled correspondingly to response categories. The first two sections were scaled according to each response in each of three priority levels, low/medium/high.

The responses in section three assessed current programs. These data were also nominally scaled in "yes" or "no" categories and assessed by percentage where enrollment of the responding schools, (<1,000, 1,000-3,000, >3,000), created exceptional low cell sizes. Demographic information in section four intended to examine differences between ideal conceptualized programming and

priorities and enrollment size was also assessed by percentage due to low cell sizes. Chi-square analysis was used to determine if there was a significant difference between ideal programming and services actually in place, but this could not be evaluated according to enrollment size due to small cell sizes. Section five solicited open-ended comments from the respondents.

In order to replicate the Philadelphia study, the following method of analysis was used.

Chi square statistics to determine if a significant relationship exists between the receipt of ACE/ACHA guidelines, and 1) establishing an AIDS committee or task force, 2) the establishment of AIDS guidelines on campus. Chi square was also used to determine significance between conceptualized ideal AIDS-related priorities and program currently in place. Chi square is a non-parametric test used to compare independent groups of nominal data (Tai, 1978).

The questions regarding ACE/ACHA guidelines were transformed into a null hypothesis for application of the Chi square. The hypothesis thus predicted that there would be no significant difference between institutions that received ACE/ACHA guidelines and 1) have established an AIDS committee or task forcer, 2) have established AIDS guidelines on campus.

Questions assessing ideal AIDS-related programs and priorities, and programs that are currently in place were

also transformed into a null hypothesis to be analyzed by means of Chi square statistics using the .05 level of significance.

The null hypothesis for examining the questions regarding ACE/ACHA guidelines and ideal and current programs was retained if the Chi square value was equal to, or less than the table value, $p < 3.84$ (Tai, 1978) with one degree of freedom.

Statistical analysis were not used for demonstrating the percentage of preferred target groups, delivery systems for disseminating information, or medical and human services. Percentage tables were used to show similarities and dissimilarities in responses between the Philadelphia study and the present study. Factual data such as response rate, cases of AIDS and ARC on campus, budget issues, and relevant comments are also reported.

Summary

This chapter described methods and procedures used to attain the objectives, and to evaluate the research questions presented in Chapter I. These methods and procedures were instituted for the selection of the respondents, providing anonymity, and procedures for analysis of the collected data and for the reporting of statistical and nonstatistical information.

IV. RESULTS

Introduction

The source of data for this study were twenty-eight questionnaires which were returned by a respondent at each of the twenty-eight academic institutions that replied to this survey. Thirty-six questionnaires were originally sent to Oregon colleges and universities that met the same criteria as those in the Philadelphia study. This chapter discusses the sample and presents data related to the five research questions posed in Chapter I.

Sample

The sample for this study is described in terms of twenty-eight colleges and universities in Oregon. Thirty-six colleges and universities were asked to participate in the study, twenty-eight, (78%), responded. Prior telephone contact by the researcher to each college and university provided the name of a contact person at each school to target for participation in the survey. All twenty-eight questionnaires that were returned were usable.

Description of the Sample

The sample population consisted of seventeen public and eleven private colleges and universities, (Figure 1). Nine of the twenty-eight responding institutions reported

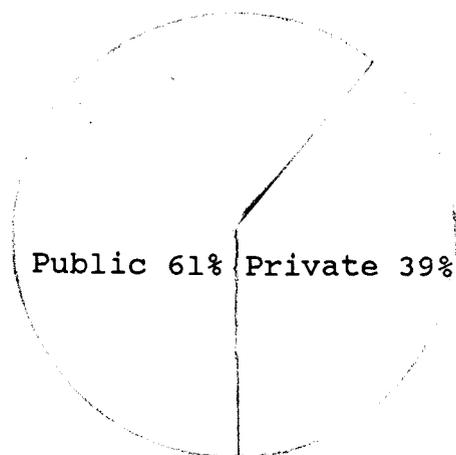


Figure 1. Percentage of responding public and private colleges and universities.

enrollment sizes of < 1,000; ten of the replies indicated enrollment size of 1,000 to 3,000 students; and nine reported enrollment sizes of > 3,000 students, (Figure 2). The respondents at each of the institutions completed questionnaires which addressed the perceived importance of AIDS-related programs, policies, and services on campus, and asked about programs, policies, and services currently in place.

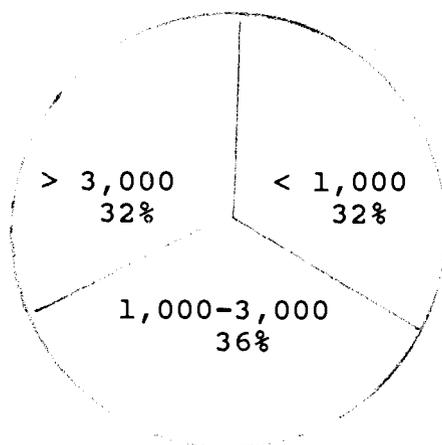


Figure 2. Responding colleges and universities, according to enrollment size.

Importance Given to AIDS-Related Programs

The responding institutions were highly consistent in their rating of who should be targeted for the receipt of AIDS-related information. Students were chosen as high priority group by 86% of the respondents. Fourteen percent of the sample placed a medium priority on providing AIDS-related information for students, and, unlike all the other categories, none of the respondents assigned a low priority to information services for this group.

The need to target parents for AIDS-related information was seen as a high priority by only 11% of the respondents, 38% assigned a medium priority to informing parents. The majority, (51%), rated parents as low priority. The percentages for priority levels for trustees and alumni were similar to priority levels given to parents by the respondents, (high, 14%; medium, 32%; low, 50%). Local communities and media were also rated consistent with the previous two categories, (high, 18%; medium, 29%; low, 50%). However, faculty was seen as a high priority target for AIDS-related information by 67% of the respondents. Only 3% assigned low priority to providing this information to faculty, (Table 1).

Seventy-nine percent of the respondents assigned a high priority to the distribution of AIDS-related pamphlets and to the establishment of campus AIDS

Table 1

Respondents' Assigned Priority Levels of
Groups to Target for AIDS-Related
Information on Oregon Campuses

	High %	Medium %	Low %
Students	86	14	0
Parents of Current Students	11	38	51
Trustees and Alumni	14	32	50
Local Community/Media	18	29	53
Faculty	67	30	3

guidelines. Seminars were seen as a high priority by 61%, and 54% of the respondents placed a high priority on both improving library holdings and referring to national/local agencies specializing in AIDS resources. Available screening and testing for AIDS was rated as a high priority by 32% of those surveyed. Fifty percent indicated a low priority, and 18% assigned a medium priority to screening and testing, (Table 2).

Thirty-two percent said group health insurance for the long-term treatment of AIDS is a high priority, while 39% placed insurance at a low priority level. Twenty-nine percent believed insurance is a medium priority issue.

Table 2

Percentages of Respondents Indicating a
High Priority for AIDS-Related Programs

Distribution of AIDS-Related Pamphlets	79%
Seminars and Workshops	61%
Improve Library Holdings	54%
Guidelines for Dealing with AIDS on Campus	79%
Referrals to National/Local Agencies	54%

Unlike all of the other priority questions, these responses were fairly evenly divided among the three levels. Counseling services directed toward persons "at risk" was seen as a high priority by 57% of the sample population. Twenty-nine percent rated counseling as a medium priority, and 14% rated this service low. Referrals to qualified medical centers was seen as a high priority by 79% of the sample population. Eleven percent cited this service as medium priority, and 10% responded that referrals should be assigned a low priority, (Table 3).

Table 3

Respondents' Assigned Priority Levels for
AIDS-Related Medical Services on Campuses

	High	Med.	Low
AIDS Screening and Testing	32%	18%	50%
Health Insurance - Long Term Medical Treatment	32%	29%	39%
Referrals to Qualified Medical Centers	79%	11%	10%
Counseling Services for Persons at Risk	57%	29%	14%

Programs Currently in Place

Responses to the questions addressing current AIDS-related campus activities are shown in Table 4. Institutional guidelines for AIDS-related issues are currently in place in 20, (71%), of the institutions surveyed. All nine, (100%), of the responding schools with enrollment of > 3,000 had AIDS guidelines in place. Four of the nine college and universities, (44%), with enrollment of < 1,000 to 3,000 had also developed AIDS guidelines.

Sixteen, (51%), of the responding institutions indicated that a task force or committee had been established on campus to deal with cases of AIDS. Once again, the institutions with enrollment of > 3,000 were more likely

to have an active task force or committee currently in place. Fifty percent of the schools with enrollments of 1,000 to 3,000 students, and 44% of the schools with enrollments of < 1,000 reported having a task force or committee as part of current AIDS programming.

Table 4

AIDS-Related Programs, Policies and Services
Currently in Place on Oregon Campuses
According to Institutional Enrollment Size

	<1,000	1,000- 3,000	>3,000
AIDS Guidelines Currently in Place	44%	70%	100%
Established AIDS Task Force/ Committee	44%	50%	64%
Distribution of Pamphlets	56%	100%	100%
Allocation of Budget for New Personnel	0%	0%	0%
Provided Training for Current Staff	22%	50%	33%
Interest in Joining an AIDS Coalition	67%	100%	88%
Adjustments in Counseling Services	40%	60%	67%
Received ACE/ACHA Guidelines	78%	80%	100%

Distribution of AIDS-related brochures/pamphlets took place on a major percentage of the responding campuses, (86%). All of the responding institutions with enrollments > 1,000 reported distributing some form of AIDS-related information. Fifty-six percent of the < 1,000 enrollment schools reported have distributed some form of AIDS-related printed material.

Funding to Provide Personnel

None of the responding schools reported an allocation of any budget for hiring new personnel, relating to AIDS programming, but 22% of the schools < 1,000; 50% of schools, 1,000 to 3,000; and 33% of the schools with enrollment of > 3,000 had provided time for training at least one staff person to provide AIDS-related services on campus. This was the only question regarding current AIDS-related programs in which the larger schools were less prepared for the issue of AIDS on campus than were the smaller colleges and universities.

Sixty-seven percent of the smaller schools indicated interest in joining an AIDS coalition, as did 100% of the schools with enrollment of 1,000-3,000, and 88% of the larger schools indicated interest in joining such a coalition. Forty percent of the smaller schools have made adjustments in counseling services in response to the AIDS problem. Sixty percent of the 1,000 to 3,000 enrollment size institutions, and 67% of the schools with > 3,000

enrollments had done likewise.

Eighty-two percent of the respondents indicated they had received either "AIDS ON CAMPUS" (American Council on Education), or "GENERAL STATEMENT ON INSTITUTIONAL RESPONSE TO AIDS", (American College Health Association), or both. Two institutions with enrollments of 1,000 to 3,000 indicated they did not receive these reports.

In order to determine if there was a significant relationship between conceptualized ideal AIDS-related priorities and programs currently in place on the sampled campuses, a Chi square statistic was applied to the data. For questions regarding counseling, guidelines, and distribution of written information, there was a significant relationship between conceptualized ideal programming and services and those currently in place, ($\chi^2 = 10.97$ at the .05 alpha level, $p = 5.99$). These data are also shown in percentages in Table 5.

Table 5

Current and Ideal AIDS-Related Policies
and Programs on Responding Oregon Campuses

	Current	Ideal
Adjust Counseling Services	53%	57%
Establishment of AIDS Guidelines	71%	79%
Distribution of Written Pamphlets	82%	79%

The Chi square statistic was also used to determine if a relationship exists between the receipt of ACE/ACHA guidelines, and 1) establishment of an AIDS committee or task force, 2) the establishment of AIDS guidelines on campus. The results showed there was no significant relationship in either area.

Oregon and Philadelphia Comparison

The Philadelphia and Oregon surveys showed both similarities and discrepancies in their results, (Table 6). The Philadelphia study had an initial response rate of 87%, however, the usable rate was 79% of the forty-seven institutions surveyed. Seventy-eight percent of the thirty-six Oregon colleges and universities contacted, responded. One-hundred percent of the returned questionnaires were usable. Eleven percent of the Philadelphia respondents reported known cases of AIRS or ARC on campus, in comparison with 18% of the Oregon respondents.

Approximately two-thirds of the Philadelphia respondents reported receiving ACE/ACHA guidelines, 82% of the Oregon respondents acknowledged receiving the same information. The Philadelphia study found a significant relationship between the receipt of these guidelines, and the development of institutional guidelines and the development of AIDS task force or committee. The Oregon study did not find a significant relationship between the

receipt of the ACE/ACHA guidelines and the development of either of these programs.

The Philadelphia study showed a significant discrepancy between ideal campus AIDS programs and what was actually taking place. The current study showed a significant relationship between ideal AIDS-related services and programs, and those currently in place regarding counseling services, the establishment of guidelines, and distribution of AIDS-related information.

As in the Philadelphia study, larger schools, (> 1,000 enrollments), were more likely to show interest in joining an AIDS coalition or establishing an AIDS task force. Unlike the Philadelphia study, no trend was seen in larger schools having established AIDS guidelines, or in distribution of AIDS-related written information.

The Oregon respondents were only slightly behind the Philadelphia respondents in two areas of AIDS services and programs. Thirty percent of the Philadelphia institutions reported having a gay caucus on campus, compared to only 23% of the Oregon sample. And 57% of the Philadelphia sample had established an AIDS task force/committee compared to 54% of the Oregon sample.

The largest discrepancy between the Philadelphia and Oregon responses to current AIDS-related programming was in the adjustment of counseling services. Only 32% of the Philadelphia respondents indicated any changes in their counseling services in response to the AIDS situation, and

Table 6

A Comparison of the ^{UNOJA SURVEY} Oregon and ^{Oral History Interviews} Philadelphia Studies

	^{UNOJA} Oregon 1987	^{ORAL HISTORY} Philadelphia 1986
1 Cases of AIDS-ARC on campus	18%	11%
2 Received ACE/ACHA Guidelines	82%	66%
3 Discussed Guidelines with Staff	78%	62%
4 Established AIDS Guidelines	67%	62%
5 Established Task Force/Committee	54%	57%
6 Training Staff	36%	11%
7 Distributed Pamphlets	79%	65%
8 Budgeted New Personnel	0%	0%
9 Gay Caucus on Campus	23%	30%
10 Want to Join AIDS Coalition	82%	59%
11 Adjusted Counseling	57%	32%
Significant Relationship Between Receipt of ACE/ACHA Guidelines and Development Task Force	No	Yes
Significant Relationship Between Receipt of ACE/ACHA Guidelines and Development of Institutional Guide.	No	Yes
Significant Discrepancy Between Ideal and Actual Programming	No	Yes

57% of the Oregon sample reported having made adjustments in this area.

Summary

Chapter IV described the sample population of this study and presented the results of the survey of the twenty-eight responding Oregon colleges and universities. Data regarding conceptualized ideal AIDS-related programs, policies, and services of the twenty-eight respondents was presented and compared to programs, policies, and services currently in place on the colleges and university campuses sampled.

The Oregon data was compared to the results of an earlier survey conducted in Philadelphia colleges and universities. Both similarities and discrepancies between the results in the two studies were presented.

V. DISCUSSION

The following chapter will address the three objectives of this study. It will also address additional findings, educational implications, and future research recommendations followed by a brief discussion of major conclusions.

Discussion and Conclusions

The ensuing discussion forms the recommendations which conclude this chapter. The discussions are presented under the following subheadings; Current AIDS-Related Programs, Policies, and Services, Perceptions of Ideal AIDS-Related Programs, Policies, and Services, Comparison of Current and Ideal AIDS-Related Campus Programs, Policies, and Services, Additional Findings, Replication of the Philadelphia Study, Educational Implications, Future Research, and Conclusions.

Current AIDS-Related Programs, Policies, and Services

In the evaluation of AIDS-related programs, policies, and services, there appeared to be a trend indicating more AIDS-related campus activities in place on the larger campuses. The larger colleges and universities consistently reported a high incidence of having AIDS guidelines, distribution of AIDS-related written material, and an AIDS task force or committee in place. They also

reported having made adjustments in counseling services more frequently than did the smaller schools. However, schools with enrollments of 1,000 to 3,000 responded that they had provided AIDS-related training for current staff more often than did either the schools with enrollments of < 1,000 or > 3,000. None of the sample population reported having allocated any budget for the hiring of new personnel to deal with the AIDS situations.

These results are not surprising. The larger schools would already have more available resources than would the smaller schools. Larger schools may quite likely be dealing with a more diverse group of students, and therefore, may have been more likely to anticipate the need for AIDS-related programs, policies, and services on campus. It was interesting to note however, that the mid-sized schools had more often provided staff training to deal with AIDS on campus.

Perceptions of Ideal AIDS-Related Programs, Policies, and Services

Responses to questions regarding priority levels of who should be targeted for receipt of AIDS-related information was fairly consistent, regardless of school enrollment size. Students were ranked as the number one, while faculty ranked as the second. All responding groups, (< 1,000, 1,000 to 3,000, > 3,000), assigned a low priority to local community and media, parents, and

trustees and alumni as targets for AIDS-related information. These low assignments could be considered disturbing. It would appear that respondents failed to recognize that parental influences do not necessarily cease when an adolescent reaches college age. Alumni and trustees may have a more indirect impact on AIDS-related campus issues, and a high priority rating of only 14% may be indicative of this. The modest 18% high priority rating assigned to local community/media is indicative of the tendency to consider students rather socially isolated from those outside the campus parameters. Students do not restrict their socializing to only other students, and any public health issue that is prevalent to a local community in general will also have an impact on the college or university population.

There was an apparent trend for the larger schools, (> 3,000) to have more AIDS-related programs and services in place. But there was no indication that conceptualized priority levels varied according to the institution's enrollment size in regard to target groups for AIDS-related information, modes of distributing the information, or human and medical services desired in light of the AIDS situation.

It is certainly a consideration that the larger schools, (especially those with student residents on campus), implemented AIDS-related programs, policies and

services secondary to media's initial concentration on "risk groups" rather than the current focus on "risk behaviors". Perhaps, as previously mentioned, the larger campuses were first responding to diverse groups of students on campus. The smaller, non-residential schools may have initially perceived less threat to students and they also may have felt less responsible to deal with the AIDS issue than did the residential campuses.

It is interesting to note, however, that at the time of this survey, responses to conceptualized ideal programming showed little variance according to the institution's enrollment size or whether it was residential or non-residential.

③ Current and Ideal AIDS-Related Programs, Policies, and Services

There was a significant relationship between current and ideal AIDS-related programs, policies, and services in regard to adjustments in counseling services, establishment of AIDS guidelines, and the distribution of written AIDS information. These three items showed very little discrepancy between the respondent's propensity toward these programs and what is actually taking place. It could be concluded from these responses that personnel directly involved with AIDS-related campus activities now recognize that AIDS can well become an issue on smaller campuses as well as the larger ones.

⊕ Additional Findings

Although only two schools reported no programs or services in place, a third questionnaire indicated that AIDS-related information on the particular campus was limited to "an article in the school newspaper." Therefore, this response was included in the category of having no AIDS-related programs or services in place.

Even though a significant relationship was found in conceptualized ideal programs, policies, and services and what is currently taking place in regard to adjustments in counseling services, distribution of AIDS-related information, and the development of institutional guidelines, these three issues cannot be the only areas of consideration. A strong majority, (93%), indicated an interest in developing AIDS programs, yet, none of the responding schools had budgeted any funds for the hiring of new personnel in light of the AIDS situation, and only 36% of the respondents indicated there had been some sort of staff training regarding AIDS. And of this 36%, only 10% had trained more than three people.

Slightly over half, (57%), of the responding schools had an AIDS task force or committee in place to deal with AIDS-related issues. Considering the potential impact of AIDS on campuses, and the dire warnings of the experts, this could be considered a very low percentage.

Because these issues were not addressed in the

priority level section of the questionnaire, it cannot be determined if the respondents would have given these issues a high, medium, or low priority. It can be said, however, that these areas have not been given a high priority by the sampled institutions.

A respondent at a small private college commented on the prohibitive cost of video tapes on AIDS. She reported that the price of these tapes are currently \$300 to \$500. With continual research, AIDS information is rapidly growing and expensive video tapes can quickly become outdated. The same respondent further questioned whether the larger colleges and universities could loan tapes and other resources for a small fee.

One institution reported a new policy which requires "all health education classes to reserve at least one class period to discuss AIDS", and that class must include a "qualified speaker". The same institution sponsored an all day community workshop on AIDS.

Several respondents indicated current activity directed toward AIDS-related issues on campus. According to the comments given in response to section five of the questionnaire, only a few of the Oregon colleges and universities sampled were not developing or increasing AIDS-related programs, policies, and services.

One small private college responded, "We are a private Christian college and we do not condone promiscuity," the comment went on to state that basic

AIDS-related information is taught in health and science classes. None of the other twenty-seven responding schools assigned any "moral" implication to the issue of providing AIDS-related information and services on campus.

⑤ Replication of the Philadelphia Study

Through replication of the earlier Philadelphia study it becomes apparent that even though the Oregon sample reported an increase in most areas of AIDS-related campus activities over the Philadelphia respondents, the Oregon schools are still behind in the establishment of an AIDS task force or committee, and the development of a gay caucus on campus. It is also important to note that the only areas which the Oregon sample showed a remarkable increase over the Philadelphia sample was in adjustment of counseling services, training of staff, and distribution of written material. More of the Oregon sample had received ACE/ACHA guidelines and had discussed them in staff meetings than had the Philadelphia sample. However, considering the continual increase in media attention and the escalating warnings by the experts of the potential epidemic status of AIDS, it is not unexpected that the present study would indicate an increase in AIDS-related programs and services on college and university campuses compared to the earlier Philadelphia study.

It could be speculated that the differences between the two studies does not indicate a major effort on the part of the Oregon institutions sampled to highly prioritize AIDS-related programs, policies, and services on college and university campuses.

Two of the Philadelphia respondents replied that because they were non-residential schools without student health services departments, AIDS education on campus was unnecessary. None of the Oregon respondents expressed a similar view. The Oregon sample indicated that schools with no formal student health services departments were providing AIDS-related services through the student affairs departments.

Both studies indicated only one student request for a change of dorm or roommate due to concern about AIDS. It is interesting to note that the only request for change indicated in the Oregon study was made at the college mentioned earlier, who chose not to offer readily available AIDS-related information because of concern about "condoning promiscuity".

⑥ Educational Recommendations

Many implications for education have become apparent as the result of this study. It is discerning to note that less than 80% of the Oregon sample had distributed AIDS-related information on campus, and less than 70% had established AIDS guidelines. Counseling services had been

adjusted in less than 60% of the schools and only slightly over one-third had provided any staff training to deal with the AIDS situation. Considering the warnings of both educational and medical experts, these numbers do not indicate that AIDS-related issues have actually been given the focus they demand.

It is paramount that every college and university institute administrative policies to contend with the threat of AIDS on campus. These policies should address several issues.

1. Guidelines for dealing with cases of AIDS and ARC should be concise. They should include issues of civil rights and discrimination, as well as institutional policy.

2. Consistent and appropriate AIDS-related education should be required for all students through academic health courses. AIDS-related information should also be integrated into other classroom curriculums.

3. Faculty, health service staff, and counselors should also be targeted for AIDS-related education. This could be accomplished by way of required staff in-services conducted by well-informed personnel who are knowledgeable of both institutional policies and in AIDS-related subject matter. This mandatory education directed toward the aforementioned staff would provide consistent and accurate information that would benefit students and administration.

By being prepared for AIDS on campus, hasty policy-making could be avoided when an AIDS-related problem arises. Foresight in planning for a potential AIDS-related situation could well prevent a climate of panic or helplessness. Concrete policies are the only way to make certain that administrative policies are carried-out consistently and without deviation.

The AIDS situation requires strong leadership to develop and implement institutional policies and education that focuses on behaviors. The current representation of educational services by the Oregon sample is certainly not adequate to effectively make the necessary behavior changes that will prevent an AIDS epidemic on these campuses.

Future Research

Research such as the Philadelphia study and this study are a valuable means of tracking AIDS-related campus activities and priorities. They also show the deficiencies and the progress in current programs and services. This research is also intended to provide impetus for further AIDS-related campus issues.

Further research should also be designed to examine the effectiveness of current AIDS-related programs and services. It should also study and report increases and decreases in these areas. If information and education are the only ways to prevent potential disaster on

campuses as indicated repeatedly in the current literature, it is imperative that campus programs and services be continually evaluated for effectiveness and improvement possibilities.

Conclusion

Chapter Five discussed objectives of this study. It was found that there was a trend for the larger institutions to have more AIDS-related programs, policies, and services in place than the smaller schools. However, this discrepancy was not seen in ideal conceptualized programs or preferred target groups for AIDS-related information.

Even though the respondents' conceptualizations of effective AIDS-related programs, policies, and services, and what had actually taken place on the sampled campuses showed a significant relationship, considering the medical and educational community's forecasts, these colleges and universities did not indicate the kind of major focus on AIDS-related issues one might expect.

It would appear that the Oregon sample, (though generally indicating an increase of AIDS-related campus activities over the Philadelphia sample), has demonstrated a lack of focus on the problems related to AIDS on campus. Considering the continual increase of media and expert attention given to the issue of AIDS, it would be expected that colleges and universities would have also placed a major emphasis on AIDS-related issues. The increase of

AIDS-related campus activities reported by the Oregon sample compared to the Philadelphia sample is certainly not profound, given the year's time difference between the two studies.

AIDS on campus is an issue that cannot be ignored. Both the medical and educational communities are urging heightened focus on risk behaviors which are not uncommon to the general college and university population. These behaviors must be modified to avoid devastation. Education is the only way colleges and universities can effectively protect their students, staff, and faculty.

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APPENDICES

APPENDIX A

SAMPLE POPULATION

Blue Mountain Community College
2410 N.W. Carden Avenue
P.O. Box 100
Pendleton, Oregon 97801-0100

Central Oregon Community College
2600 N.W. College Way
Bend, Oregon 97701-5998

Chemeketa Community College
4000 Lancaster Dr. N.E.
P.O. Box 14007
Salem 97309-5009

Clackamas Community College
19600 S. Molalla Avenue
Oregon City, Oregon 97045

Clatsop Community College
16th and Jerome Streets
Astoria, Oregon 97103

Lane Community College
4000 E. 30th Avenue
Eugene, Oregon 97405

Linn-Benton Community College
6500 S.W. Pacific Blvd.
Albany, Oregon 97321-3774

Mt. Hood Community College
26000 S.E. Stark Street
Gresham, Oregon 97030

Portland Community College
12000 S.W. 49th Avenue
Portland, Oregon 97219

Rogue Community College
3345 Redwood Highway
Grants Pass, Oregon 97526

Southwest Oregon Community College
Coos Bay, Oregon 97420

Tillamook Bay Community College
Service District
6385 Tillamook Avenue
Bay City, Oregon 97107

Treasure Valley Community College
650 College Blvd.

Ontario, Oregon 97914

Treaty Oak Community College
Service District
300 E. 4th Street
The Dalles, Oregon 97508

Umpqua Community College
P.O. Box 967
Roseburg, Oregon 97470

Oregon State Univeristy
Corvallis, Oregon 97331-2118

Easter Oregon State College
La Grande, Oregon 97850

Portland State University
P.O. Box 751
Portland, Oregon 97207

Western Oregon State College
Monmouth, Oregon 97361-1394

Southern Oregon State College
1250 Siskiyou Blvd.
Ashland, Oregon, 97520

Oregon Institute of Technology
Klamath Falls, Oregon 97601-8801

University of Oregon
Eugene, Oregon 97403

Columbia Christian College
9101 E. Burnside
Portland, Oregon 97216-1515

Northwest Christian College
828 11th Avenue
Eugene, Oregon 97401-9983

Western Baptist College
500 Dear Park Dr. S.E.
Salem, Oregon 97301-9392

Concordia College
2811 N.E. Holman Street
Portland, Oregon 97211-6099

George Fox College
414 N. Meridian Street
Newberg, Oregon 97132

Oregon Graduate Center
19600 N.W. von Neumann Drive
Beaverton, Oregon 97006-1999

Lewis and Clark College
0615 S.W. Palatine Hill Rd.
Portland, Oregon 97219

Pacific University
2043 College Way
Forest Grove, Oregon 97116

Linfield College
McMinnville, Oregon 97128-6894

Reed College
3203 S.E. Woodstock Blvd.
Portland, Oregon 97202

Willamette University
900 State St
Salem, Oregon 97301-9989

Marylhurst College
P.O. Box 261
Marylhurst, College 97036-0261

University of Portland
5000 N. Willamette Blvd.
Portland, Oregon 97203-5798

Warner Pacific College
2219 S.E. 68th Avenue
Portland, Oregon 97215-4099

APPENDIX B

COVER LETTER AND SUPPORT LETTER

Department of Health



Corvallis, Oregon 97331-6406

(503) 754-2686

Dear Health Director:

Attached is a letter from Barbara Williams asking for your assistance. Specifically, Barbara is gathering data from Oregon colleges and universities regarding AIDS programming for a graduate thesis.

Your participation, although voluntary, will be most appreciated. You will receive a summary of the results which may be of value to you in your work.

The anonymity of your institution is absolutely guaranteed.

Sincerely,

Redacted for privacy

Margaret M. Smith, Ed.D.
Associate Professor

MMS/cl

October 25, 1987

Dear Health Care Professional,

Enclosed you will find a three-page questionnaire regarding AIDS education on campus and related issues. I am distributing this questionnaire to all community colleges, four-year colleges, and universities in Oregon, (specialty schools such as business, medical, art etc. are excluded), in an effort to replicate a Pennsylvania study conducted by Barbara Ann Caruso, R.N., M.Ed., and John R. Haig, Ph.D. Their study was published in the July issue of Journal of American College Health. The results of this current study will be reported in my Master of Science thesis.

All respondents are assured anonymity. A return envelope is included, which will be opened by a second-party.

For purposes of replication of the previous research, it is requested that only a physician or a R.N. fill-out the questionnaire. Please respond by November 20, 1987.

Thank you for your cooperation in this study.

Sincerely,

Redacted for privacy

) Barbara Williams
Oregon State University
Department of Health
Waldo Hall
Corvallis, Or. 97331

APPENDIX C
QUESTIONNAIRE

AIDS CAMPUS SURVEY

This anonymous and confidential questionnaire was designed to determine how Oregon academic institutions would cope with the impact of AIDS on campus if they were given the resources and authority to mount fully effective programs.

For each of the following please identify the priority level (low, medium, or high) that you feel should be attached to these items.

I. Information Resources

- 1) Identify the priority level that you feel should be attached to your health service providing AIDS-related information to the following groups.

	Low	Med	High
current students	---	---	---
parents of current students	---	---	---
faculty, staff, administration	---	---	---
trustees & alumni	---	---	---
local community & media	---	---	---

- 2) Identify the priority level that you feel should be attached to the following modes of distributing AIDS-related information, (to any or all of the above people).

	Low	Med	High
written pamphlets	---	---	---
seminars/workshops on AIDS	---	---	---
improve library holdings	---	---	---
guidelines for dealing with suspected or actual AIDS cases, (e.g. rights of students/employees to attend classes, or work, live in dorms, eat in the lunchroom, etc.)	---	---	---
referrals to national/local agencies specializing in AIDS information	---	---	---

II. Human Resources & Medical Services

- 3) What priority should be attached to providing the following kinds of resources/services?

	Low	Med	High
make screening & testing for AIDS available to students and staff	---	---	---
provide group health insurance for long term treatment of AIDS	---	---	---
have referrals to qualified medical centers	---	---	---
offer counseling specifically geared toward persons at risk with respect to AIDS, (especially gay population)	---	---	---

III. Current Programs (questions about activities at your institution)
Please use Section V at the end of the questionnaire to make any additional comments that clarify your answers here.

- 4) Has your institution established any guidelines for dealing with cases of AIDS? yes ___ no ___

- 5) Has any sort of committee or task force been established for dealing with cases of AIDS? yes___ no___
- 6) Has your institution made any of the following changes in response to AIDS?
 allocated time for training staff to provide services for AIDS victims? yes___ no___
 if so, how many people? _____
 how were they trained? _____

 purchased, published, and/or distributed information brochures? yes___ no___
 if so, approximately how many distributed? _____
 allocated a portion of the budget for hiring new personnel? yes___ no___
 if so, how many people? _____
- 7) Is there a Gay Caucus of any sort on campus? yes___ no___
- 8) Do you have an interest in joining an area AIDS Coalition that is designed to share information about resources in the above categories? yes___ no___
- 9) Have you received a copy of these publications?
 "AIDS ON CAMPUS", (American Council on Education) yes___ no___
 "General Statement on Institutional Response to AIDS", (American College Health Association) yes___ no___
 If "yes" to either of the above, have you discussed them in a staff meeting? yes___ no___
- 10) Have you made adjustments to your counseling services in response to the AIDS problem? yes___ no___
- 11) Do you know of any student requests for changing dorms or roommates due to concerns over AIDS? yes___ no___
- 12) How many cases of AIDS or ARC do you estimate have been identified on campus to date? yes___ no___

IV. Demographic Information (please check appropriate box)

- 13) Type of Institution
 2 year college (Assoc. pgms.) _____
 4 year college (Bachlr. pgms.) _____
 col./univ. (w/ post-Bachlr. pgms) _____
 private _____
 public _____
- 14) Proportion of students that are male____, female____
- 15) Approximate student enrollment, (full-time)
 < 1,000___ 1,000-3,000___ 3,000-5,000___ > 5,000___

- V. Comments Please use the back of this page to expand your answers to any of the above questions, and also to make other comments and suggestions related to this survey.
 Thank you for your thoughtfulness.

Please insert your completed questionnaire in the envelope provided, all replies will be opened by a second-party to insure anonymity.
 QUESTIONNAIRE DEVELOPED BY B.A. CARUSO, R.N., M.Ed, and J.R. Haig, Ph.D.