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Title: COMPONENTS OF AN AIDS TRAINING PROGRAM

Abstract Approved: John O. Schuenn

Many studies have demonstrated training can be effective in increasing an individual's knowledge about AIDS. However, few studies have examined the effects of different methods on reducing an individual's fear and the perceived consequences of working with someone who is HIV positive or has AIDS. Retail organizations should train their employees about AIDS since these employees come into contact with numerous customers and employees, all with the potential of being infected with the AIDS or HIV virus. This study compared three training interventions to examine their effects on employees' knowledge of AIDS, fear of AIDS, and perceived consequences of working with an HIV positive or AIDS infected co-worker. All employees viewed a video, produced by the retail organization, regarding Hepatitis and HIV. Next, employees were randomly assigned to three treatment groups. Treatment group one viewed a video in addition to the pretest. Group two also viewed the second video and had a discussion on their fears and concerns about AIDS. Group three served as the control group and received no additional training. A repeated measures design

identified no significant differences across treatment condition, though trends were in the predicted direction. Finally, significant differences were found across time.

COMPONENTS OF AN AIDS TRAINING PROGRAM

A Thesis Proposal

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by

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I dedicate this thesis to all of you exceptional individuals. After I graduate, I hope all of our paths will cross again.

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CHAPTER 1

INTRODUCTION

In recent years, organizations have taken more interest in their employees. Employees are no longer perceived as helpers who are only there for several hours to work. Instead, employees are considered to be a vital component of the organization. As a result, organizations are protecting their human assets in order to ensure a more smoothly run operation.

One way organizations protect and keep their employees motivated is through education and training (Riggio, 1990). Course offerings include the opportunity to earn high school diplomas, to learn new skills for promotions and career advancements, and to keep abreast of pertinent issues. Training topics may range from the routine orientation of day-to-day operations to more specific topics such as sexual harassment, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) training.

It is advantageous to an organization for its management and employees to know general information about AIDS (Vest, O'Brien, & Vest, 1991). AIDS training may prove to be invaluable if first aid is required for an injured employee or customer. Also, training is valuable to help dispel the stereotypes and myths associated with the disease, especially the ways AIDS can and cannot be transmitted in the workplace. A case of an AIDS infected

co-worker may lower morale and productivity, spark violence, and cause panic if people are under-educated about the disease. Until AIDS is no longer a concern, organizations with the foresight to protect their employees should offer AIDS training to both educate their employees and keep the workplace safe. Organizations providing AIDS training programs include colleges (Pryor, Reeder, & McManus, 1991), social work agencies (Pitts, Jackson, & Wilson, 1990), gay and lesbian organizations (Thomas & Hodges, 1991) churches (Sheridan, Humfleet, Phair, & Lyons, 1990), and businesses (Breuer, 1992).

The Need For AIDS Training

Many people realize the importance of AIDS training for health care personnel since they are in direct contact with many patients, but what about retail employees? In a given day, retail employees come in contact with numerous customers and with other employees. Any of these customers or employees could potentially be infected with HIV. Two important reasons why the organization should train employees about HIV and AIDS are morale and productivity of the workers. Morale and productivity may decline if an employee becomes HIV positive and the other employees do not understand the disease. In the past, some employees have refused to work near an HIV infected co-worker (Chapman, 1986).

Numerous articles have been written about AIDS in the workplace. However, these articles generally provide advice for managers on what organizations should do to deal with employees who either have AIDS or are HIV positive. Few articles evaluate the effectiveness of different AIDS training programs.

Though most people have heard of AIDS, many people are still unclear about the specific ways HIV can be transmitted. A recent study reported many African-American men and women believed they were not at risk because AIDS only affected gays and whites. The researchers recommended more education so African-Americans could see themselves as a population at risk for infection (Johnson, Gant, Hinkle, Gilbert, Willis, & Hoopwood, 1992). Thomas and Hodges (1991) reported misconceptions of HIV transmission among Black and Hispanic homosexual and bisexual men. These misconceptions included the transmission of HIV through everyday contact at work, contact with perspiration or tears of another person, and drinking from the same glass as an infected person. An assessment of public health students' level of knowledge about AIDS was studied to determine the need for curriculum changes in school programs. Most students answered questions incorrectly regarding HIV transmission and AIDS in intravenous (IV) drug users, women, prostitutes, and children (Richwald, Sekler, Kitimbo, & Friedland, 1989). In 1990, a random telephone survey

identified individuals who believed that they could be infected with HIV by insects and by donating blood and that people infected with HIV could not look or feel well ("HIV/AIDS Knowledge," 1991).

The examples of misconceptions described above are not unique to the sample groups. The many misconceptions about AIDS and the need for understanding the misconceptions indicate to educators that training is needed. Therefore, knowledge of misconceptions regarding HIV transmission is important to decide what information needs to be included in AIDS training programs.

Evaluating AIDS Training Programs

In 1982, Levi Strauss & Company, Inc. developed an AIDS training program available during lunchtime sessions (Feuer, 1987). The program was well received and employees wanted more information; however, no mention of data supporting the effectiveness of the program was presented. In the same vein, The Prudential Insurance Company, Inc. has been providing employee education seminars on AIDS every six months. Only anecdotal evidence about employees' reactions to working with HIV positive employees was reported (Breuer, 1992). Cohen and Cohen (1991) reported that concerns of phobic responses to AIDS prompted a first-year medical student to design and implement a training program for other medical students. The overall goal was to educate a generation of physicians who would be well adjusted to the

AIDS epidemic. However, no data was reported to support the program's effectiveness.

Many reported or described AIDS training programs lack control methods allowing determination of which training components were most effective. An AIDS training program consisting of a video presentation, lecture, and question-and-answer period was presented to 18 businesses in the Louisville metropolitan area (Bell et al., 1990). The one hour training session included a brief history of the AIDS epidemic, ways of transmitting the disease, precautions when applying first aid, high-risk groups, signs and symptoms, and where to go to receive additional information. An increase in the mean scores from the pre and posttests of 80% to 90% was found in participants regarding confidential testing, 67% to 88% regarding the ability of handling an AIDS-related situation at work, 60% to 95% regarding the perceived ability of transmitting knowledge of transmission (Bell et al., 1990).

Johnson, Campbell, Toewe, and Bell (1990) surveyed first-year and second-year medical students about AIDS and the impact of a six-hour workshop on AIDS consisting of lectures and films covering a wide range of information on AIDS. Scores increased for students enrolled in the workshop compared to the scores of a group who received no training.

In another study (Gann, Anderson, & Regan, 1991), second-year medical students' beliefs were evaluated before and after a two-day symposium. Part of the symposium informed the students about the scope and dynamics of the epidemic and provided a discussion of ethics. The remainder was devoted to describing present and future tools experts are using to change the epidemic's course. Results indicated the training program can have an impact on certain key beliefs. However, personal risk and willingness to become involved with HIV patients are likely to be more difficult to change than beliefs concerning policy issues related to control of the epidemic. Gann et al. concluded training that deals with knowledge deficits is likely to be less effective than training combining factual information with material addressing emotional and ethical concerns.

The fear of contagion has produced negative feelings about people with AIDS. The AIDS Health Education Program of the University of Louisville's Department of Psychiatry and Behavioral Sciences investigated this by surveying all medical school faculty and students regarding their attitudes about AIDS. Both faculty and students were fearful of infection, felt uncomfortable working with people with AIDS, had negative attitudes towards people with AIDS, and were confused and uncomfortable with legal and ethical issues associated with AIDS. The findings suggest several curriculum design changes. Fears need to be addressed and

class lectures need to include information about actual risks involved in patient care activities (Feldmann, Bell, Stephenson, & Purifoy, 1990).

Pryor et al. (1991) conducted a study to dispel employees' fears of working with an HIV infected co-worker through an educational film; special interest was paid to whether the film would differently affect participants whose attitudes differed on homosexuality. Participants were randomly assigned to an experimental group who watched the intervention videotape and a control group who viewed a similar videotape of equal length on the subject of robotics. The film provided factual information about HIV transmission with an emphasis where workplace transmission is unlikely. Results indicated the participants who held anti-homosexual attitudes tended to hold extreme negative attitudes towards people with AIDS compared to the control group, even when a person contracted AIDS through non-homosexual transmission. For this group, the training had little effect on their attitudes. Participants who were more comfortable with homosexuals showed increased positive attitudes about interacting with people with AIDS.

Franzini, Sideman, Dexter, & Elder (1990) conducted a study to determine if behavioral interventions would increase subjects' knowledge about AIDS and safe sex behaviors. Seventy-nine San Diego State University students participated in three one-hour training sessions. These

sessions included live modeling of assertive interactions, role-playing, behavior shaping, corrective feedback, verbal reinforcement, assertiveness training, and an AIDS educational lecture. Subjects were trained to discuss sex in an assertive and straight forward manner as measured by the role-play scenarios. Results indicated the experimental group's scores increased in assertive behavior compared to a control group which received no treatment. The authors concluded AIDS education must extend beyond lectures and paper and pencil measures of knowledge. Role-plays which introduce, request, and insist on sexual practices which reduce the risks of HIV infection are appropriate next steps, since actual behavior change is the target.

Summary

The literature indicates many situations where AIDS training programs have been successful. Levi Strauss & Company and The Prudential Insurance Company were among the first organizations to provide AIDS training to their employees. Another program trained 18 companies about the disease's history, symptoms, and transmission. The employees' self-confidence, self-assessment, and knowledge regarding AIDS was increased. Several studies have reported significant increases in knowledge about AIDS as a function of training, clarifying the misconceptions regarding the transmission of HIV. Also some studies reported changes in fears and safe-sex behavior as a function of training.

What type of training should an organization provide to its employees about AIDS in the workplace? Popular training methods include lectures, videotapes, role playing, and discussions. The purpose of this study was to determine what components should be included in an AIDS training program to both increase knowledge and reduce employees' fears of AIDS in the retail setting. Before and after several interventions, employees' levels of knowledge and fear associated with AIDS were measured to determine the effect of the training program.

This study compared three training methods. Treatment group one viewed two knowledge-based videos. Group two viewed the same videos and discussed their fear and concerns about AIDS. Group three served as the control group and only viewed a mandatory knowledge-based video.

The hypotheses for the study are as follows:

1) Hypothesis 1: Subjects in treatment group two would show the largest gains in knowledge scores and the lowest fear and consequences scores.
2) Hypothesis 2: Subjects in treatment group one would not show large gains in knowledge scores and the fear and the consequences scores would not be as low as in group two.
3) Hypothesis 3: Subjects in treatment group three would show the smallest gains in knowledge and fear scores and consequences scores would be the highest.

CHAPTER 2

METHOD

Subjects

Forty-five employees (8 male and 37 female) of a rural retail discount store in the Mid-West served as subjects. Employees of this store and of similar stores are in the low to middle economic class range with little or no education past high school. Employee ages ranged from 18 to 76 years.

Design

A repeated measures design was used for this experiment. Employees' performance scores on the pretest, posttest1 and posttest2 questionnaires were compared to determine the influence of the first and second intervention. The three conditions included information, information and discussion, and a control group. Three dependent measures were the Knowledge of AIDS Scale (Thomas, Gilliam, & Iwrey 1989; Vest et al., 1991), Fear of AIDS Scale (O'Brien, 1989), and the Consequences of Employing An AIDS Victim Scale (Vest et al., 1990).

Procedures

During a weekly store meeting, employees were given a consent form (Appendix A) to read and sign. Then, the pretest (Appendix B) was distributed to the employees to complete during the same meeting. Within the next week, employees viewed the training videotape "Bloodborne Pathogens Exposure Control: General Awareness Associate

Training" (Appendix C) in small groups of five to eight people. Immediately after viewing the videotape, the employees completed posttest1 (Appendix B). Next, employees were randomly assigned to one of three treatment groups with 15 employees per group. Immediately after the completion of the second intervention, the employees completed posttest2 (Appendix B). The third group, the control group, completed the posttest2 approximately the same time as the other two groups.

Treatment Conditions

Treatment Group One

Group one viewed a second videotape (outlined in Appendix D) which provided factual information not addressed in the first intervention. This videotape differed from the first in two ways. First, it was narrated by a nurse well versed on the subject of HIV and AIDS. The first videotape, produced by the retail organization, was narrated by organizational executives. Second, it provided more specific information on topics briefly addressed in the first videotape, and it presented new information. The videotape discussed modes of transmission, non-transmission, issues of safety, working with an HIV infected co-worker, and safety with accidents.

Treatment Group Two

Group two viewed the same videotape as group one, and then participated in a discussion. The discussion (Appendix

E) focused on the fears of working with people with AIDS.

Treatment Group Three

The remaining employees received no additional training.

Dependent Measures

All subjects completed a questionnaire which included demographic information about the employees and three scales. The scales were a) Knowledge of AIDS Scale (Thomas, Gilliam, & Iwrey, 1989; Vest et al. 1991), b) Fear of AIDS Scale (O'Brien, 1989), and c) Consequences of Employing an AIDS Victim Scale (Vest et al., 1990). The demographic information was only collected on the pretest.

Knowledge of AIDS Scale

The 25-item Knowledge of AIDS Scale (Appendix B) used in the study is a combination of two previously published scales. Items one through ten were taken from a true or false scale used by Vest et al. (1991). Items included on the scale are based on documents published by the United States Department of Health and Human Services and the Centers for Disease Control. The remaining items, 11 to 25, consist of true or false items developed by Thomas, Gilliam, & Iwrey (1989). These two scales combined form the Knowledge of AIDS Scale used in this study. Repetitive items were omitted resulting in a 25 item scale. The scale was scored by assigning one point for each correct answer, yielding a possible score ranging from 0 to 25.

Fear of AIDS Scale

The Fear of AIDS Scale (Appendix B) was developed by O'Brien (1989), with Cronbach's alpha reliability level of .92. The five-item scale was developed to assess work-related fear of AIDS. Scores on the scale range from 5 (low fear) to 25 (high fear).

Consequences of Employing an AIDS Victim Scale

The Consequences of Employing an AIDS Victim (Appendix B) Scale is an 11-item scale with Cronbach's alpha reliability level of .90. Items one through four measure beliefs about loss of revenue. Items 5 through 11 assess beliefs about how disruptive it would be to employ HIV infected people. Overall scores for the scale range from 11 (few perceived adverse consequences) to 55 (many perceived adverse consequences (Vest et al., 1990).

Both the Fear of AIDS Scale and the Consequences of Employing AIDS an Victims Scale are scored using a Likert scale. The employees will read and rate each statement on a five-point scale (one = strongly disagree; five = strongly agree).

Data Analysis

This study utilized a repeated measures design. The MANOVA statistical design determined whether there were significant differences between the means of more than two groups across multiple subject measures.

CHAPTER THREE

RESULTS

The three dependent measures utilized in this study were the Knowledge of AIDS Scale, Fear of AIDS Scale, and the Consequences of Employing an AIDS Victim Scale. The independent variables are the three treatment conditions.

Demographic Variables

The repeated measures design with the MANOVA statistical design showed no significant difference among the groups with regard to demographic variables. This indicates the three treatment groups were equal in respect to gender, age, race, educational level, and marital status.

The Knowledge Measure

The means for treatment groups one and three increased from the pretest to the posttest1, and slightly declined after the posttest2. The scores for treatment group two increase continually across the measurement conditions. The analysis revealed a significance over time ($F(2,45) = 14.66$, $p<.05$) but did not find significance from the treatment groups ($F(2,45) = .42$, $p>.05$). The Knowledge means are presented in Table 1 and depicted in Figure 1.

The Fear Measure

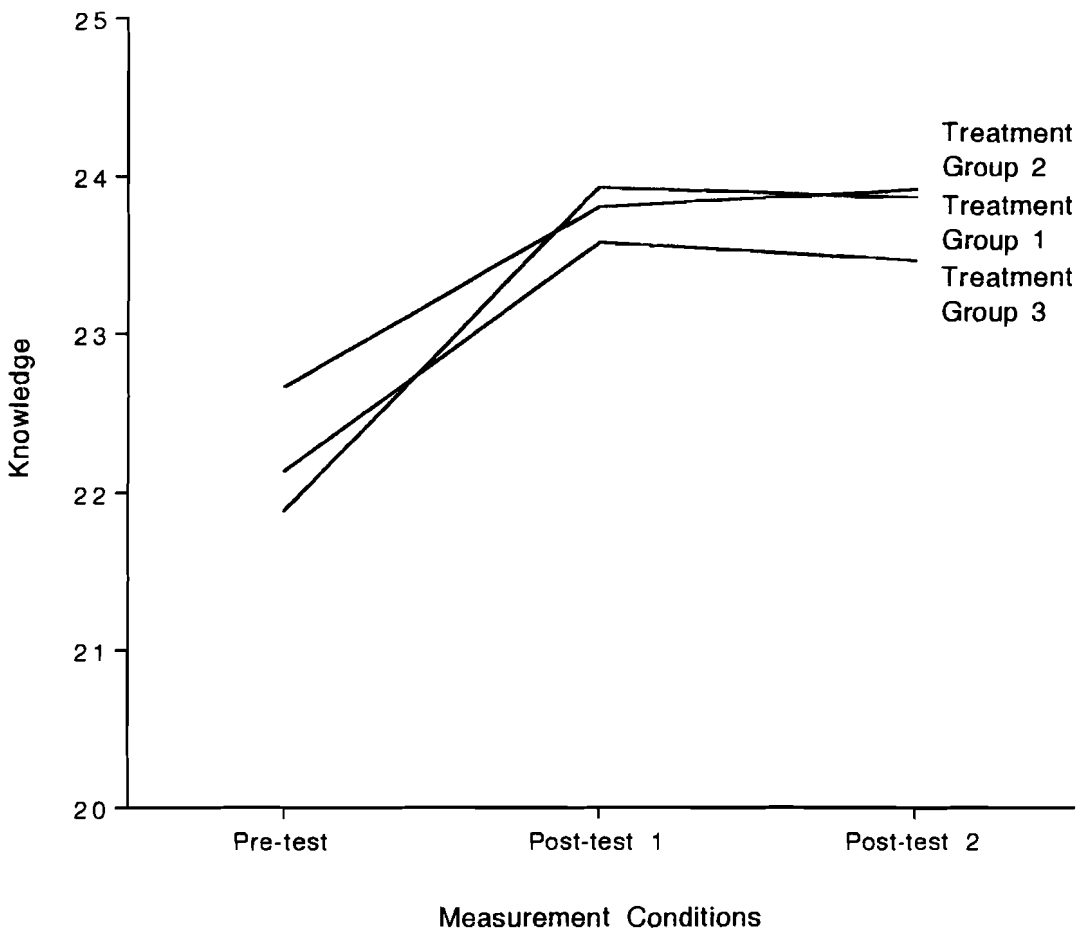
The means for treatment groups one and three declined from pretest to posttest1, and then increased on posttest2. The scores for treatment group two, however, continued to decline.

Table 1

KNOWLEDGE SCALE

	Means	STANDARD DEVIATIONS	GROUP SIZE
Pretest			
Condition 1	21.867	3.067	15
Condition 2	22.667	2.410	15
Condition 3	22.133	3.357	15
POSTTEST1			
Condition 1	23.933	1.387	15
Condition 2	23.800	2.007	15
Condition 3	23.600	1.639	15
POSTTEST2			
Condition 1	23.867	1.060	15
Condition 2	23.933	1.100	15
Condition 3	23.467	1.642	15

Figure 1: Means for the Treatment Groups on the Knowledge Scale



Significance over time was reported ($F(2,45) = 15.23$, $p<.05$); however, no significance was found by treatment group ($F(4,45) = 1.20$, $p>.05$). The Fear scores are presented in Table 2 and depicted in Figure 2.

The Consequences Measure

Scores declined from the pretest to posttest1, and then increased after posttest2 for treatment groups one and three. Again, the scores for treatment group two continued to decline across the measurement conditions. Again, significance was reported by time ($F(2,45) = 15.05$, $p<.05$), and no significance by treatment group ($F(4,45) = 1.08$, $p>.05$). The Consequences scores are presented in Table 3 and depicted in Figure 3.

Table 2

FEAR SCALE

	MEANS	STANDARD DEVIATIONS	GROUP SIZE
PRETEST			
Condition 1	14.200	7.664	15
Condition 2	15.533	6.610	15
Condition 3	13.667	7.316	15
POSTTEST1			
Condition 1	10.267	4.935	15
Condition 2	11.200	3.858	15
Condition 3	9.000	3.836	15
POSTTEST2			
Condition 1	13.200	5.570	15
Condition 2	10.667	7.584	15
Condition 3	10.467	5.397	15

Figure 2: Means for the Treatment Groups on the Fear Scale

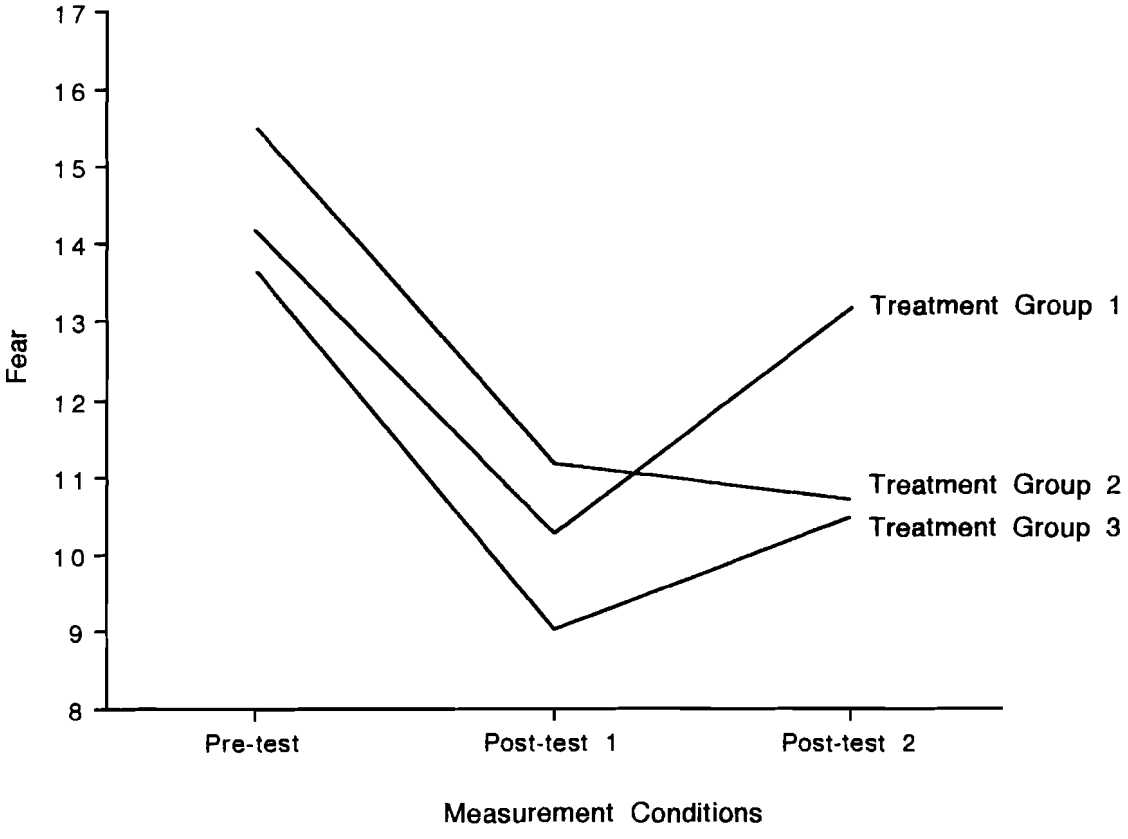
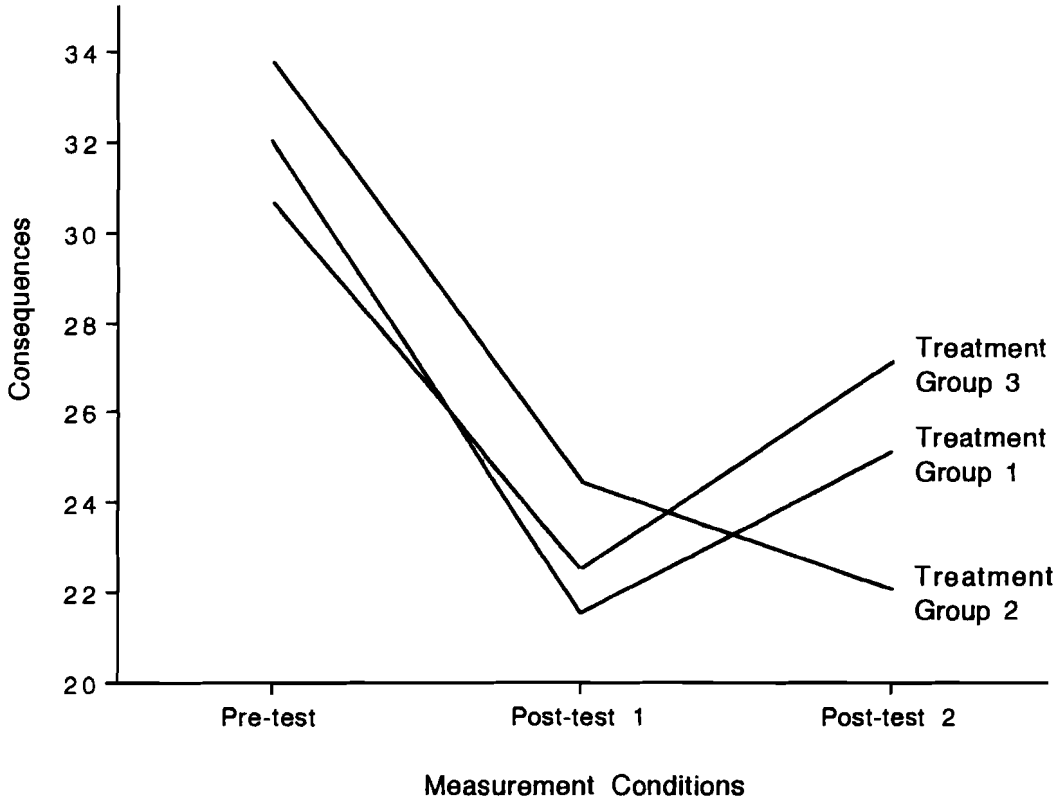


Table 3

CONSEQUENCES SCALE

	MEANS	STANDARD DEVIATIONS	GROUP SIZE
PRETEST			
Condition 1	32.067	15.764	15
Condition 2	33.800	14.551	15
Condition 3	30.667	11.555	15
POSTTEST1			
Condition 1	21.533	9.531	15
Condition 2	24.400	7.189	15
Condition 3	22.533	8.417	15
POSTTEST2			
Condition 1	25.133	11.753	15
Condition 2	22.133	14.530	15
Condition 3	27.067	11.228	15

Figure 3: Means for the Treatment Groups on the Consequences Scale



CHAPTER 4

DISCUSSION

The Knowledge Measure

Due to a ceiling effect across all groups on the pretest measure, knowledge scores were unlikely to increase significantly with further training. Scores improved slightly for all groups after the initial intervention, but no change occurred after the second intervention. It is interesting to note both groups one and three posted slight declines, where as group two maintained gains. Overall, however, subjects were reasonably knowledgeable about AIDS before beginning training.

The Fear Measure

As hypothesized, treatment group two resulted in the greatest reduction of fear. Neither group one nor the control group had an opportunity to discuss their concerns about information provided in the videotape or concerns about AIDS in general. As a consequence, fear levels did not maintain and, in the case of group one, returned to pretest levels. The difference between groups one and two demonstrates additional information is not enough to maintain reduced fear levels.

The Consequence Measure

Again, as hypothesized, the methods employed resulted in the greatest reduction on the consequence measure. The increased score in the control group suggests reduced

concerns without further intervention may not be maintained for long periods. The increased score for group one suggests additional information, by itself, is not enough to maintain reduced concerns. Rather, an intervention consisting of factual information and, perhaps more importantly, an opportunity to discuss concerns is critical to reducing peoples fears and concerns about working with and interacting with HIV positive individuals.

It was hypothesized that 1) treatment group two would have the highest knowledge scores and the lowest fear and consequences scores; 2) knowledge scores would not be as high and the fear and consequences scores would not be as low for group one when compared to group two; and 3) treatment group three would have the lowest knowledge and the highest fear and consequences' scores. The hypothesis was not supported as treatment group two did not yield statistically significant scores, although trends were in the predicted direction. Also significance was not found by treatment groups since there were only 15 employees within each treatment group; therefore, statistical power was low.

Implications

Theoretical

This study identifies, to psychologists and trainers, the components of factual information and discussion combined together yield better results in HIV and AIDS training programs. Factual information presented alone

improved the scores but did not maintain them. Therefore, changes in attitudes and beliefs, in general, probably would not be maintained without the opportunity for a discussion regarding fears and concerns.

Practical

Since there is yet no cure or vaccine for HIV and AIDS, all types of organizations need to consider training for future safety and health reasons. Retail organizations willing to train employees regarding this deadly disease need to understand factual information presented by itself is not effective. As this study indicates, improvements in the scores were made by factual information; however, scores were not maintained without the added component of a discussion.

Research

The results of this study are important as an addition is made to both the literature of AIDS training programs and to the realm of Industrial/Organizational Psychology. Additional research on the effect of different training components will allow trainers to prepare more effective training programs.

Future research should use larger sized treatment groups in order to establish the statistical power needed for the appropriate analysis. In addition, research should focus specifically on the various training components, particularly the discussion component, to determine the

effective component(s) in retail organizations. It may have been helpful, for example, to have included a measure after every component (i.e. measure fear and concern both prior to and after discussion in group two) to isolate the effectiveness of the different components.

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APPENDIX A

Participant Consent Letter

Please read this consent form carefully.

You are invited to participate in a study to determine what components need to be included in an AIDS training program to reduce employees' fears of AIDS in the workplace.

Your privacy will be protected. Your name will not be associated with this study, only your time card number to match separate questionnaires after the study is complete. No-one will have access to your individual results except the experimenter. **Not even management or Home Office.**

Your participation in this study is completely voluntary. Should you wish to terminate your participation, you are welcome to do so at any point in the study. Termination of participation will have no bearing on your employment with Wal-Mart.

If you have any questions or comments about this study, feel free to ask the experimenter:

Mike Russell, 1610 Center #24, , Emporia, KS 66801,
(316) 341-5363 days, (316) 343-9082 evenings.

Thank you for your participation.

I, _____, have read the above information
(please print name)
and have decided to participate. I understand my participation is voluntary and I may withdraw at any time without prejudice after signing this form should I choose to discontinue participation in the study.

_____ _____
Subject and/or authorized Representative Date

THIS STUDY HAS BEEN REVIEWED BY THE EMPORIA STATE UNIVERSITY COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS.

APPENDIX B

Questionnaire

INSTRUCTIONS: PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS. DO NOT WRITE YOU NAME ON ANY OF THESE FORMS.

Time Card Number _____
Male or Female _____
Age ____
Race: (check one)
____ Black ____ Indian
____ White ____ Other (if other, please list)
Education: (check one)
____ Less than high school diploma
____ High school diploma
____ Vocational education (Vo-Tech)
____ Some college
____ College graduate
____ Post graduate
Marital status: (check one)
____ Single ____ Married ____ Divorced

PLEASE CIRCLE T OR F (TRUE OR FALSE) FOR THE FOLLOWING 25 STATEMENTS.

1. T or F AIDS is a highly contagious disease.
2. T or F Most people who contract AIDS die from the disease.
3. T or F AIDS can be contacted when an AIDS victim sneezes or coughs on others.
4. T or F AIDS can be contracted through nonsexual touching such as shaking hands.
5. T or F Persons who share tools or equipment with AIDS victims are likely to contract the disease.
6. T or F AIDS cannot be contracted through face-to-face conversation with an AIDS victim.
7. T or F AIDS can be transmitted when people eat or drink after one another.
8. T of F AIDS can be transmitted only through blood.
9. T or F There is a vaccine to prevent AIDS.
10. T or F AIDS can be contracted from toilet seats.
11. T or F Your body can't fight off infections caused by AIDS.
12. T or F Stress causes AIDS.
13. T or F Kiss someone with AIDS, and you will get it.
14. T or F Touch someone with AIDS, and you will get it.
15. T or F Anyone can get AIDS.
16. T or F You get AIDS from what you eat.
17. T or F AIDS is spread by using someone's personal belongings, like a comb.
18. T or F AIDS is not at all serious, it is like having a cold.
19. T or F You can get AIDS by being around someone with AIDS.

Time Card Number _____

20. T or F You can get AIDS from having sex with someone who has AIDS.
21. T or F Most people who get AIDS usually die from the disease.
22. T or F Using a condom during sex can lower the risk of getting AIDS.
23. T or F Receiving a blood transfusion with infected blood can give you AIDS.
24. T or F AIDS is a life-threatening disease.
25. T or F People with AIDS usually have other diseases as a result of AIDS.

Rate these items on a scale of 1-5 to indicate the extent to which you agree or disagree with each statement. (1 = strongly disagree; 5 = strongly agree).

_____ 26. It may be dangerous for me to work around someone with AIDS.
_____ 27. Working with AIDS victims places co-workers in a life-threatening situation.
_____ 28. There is a reason to fear employees who have AIDS.
_____ 29. AIDS victims pose a threat to their co-workers.
_____ 30. There is a reason to single out employees who have AIDS.

I believe that allowing AIDS victims to work in our facility will...

_____ 31. Result in lost sales.
_____ 32. Cause us to lose customers.
_____ 33. Hurt the company's image.
_____ 34. Undermine our ability to provide services to clients.
_____ 35. Cause employees to refuse job assignments.
_____ 36. Undermine company morale.
_____ 37. Result in acts of violence.
_____ 38. Increase the number of grievances filed.
_____ 39. Disrupt the flow of work.
_____ 40. Cause employees to quit.
_____ 41. Diminish the ability of other employees to concentrate on their work.

APPENDIX C

"Bloodborne Pathogens Exposure Control General Awareness Associate Training" Intervention 1 Video

I. Introduction

II. Bloodborne diseases
- A. HBV - Hepatitis B
  1. Definition and Description
  2. Symptoms
- B. HIV
  1. Definition and description
  2. Modes of transmission
  3. Symptoms

III. Who has HIV and HBV?
- A. Anyone can get them.

IV. Universal Precautions
- A. Treat all blood or body fluids as potentially infectious.
- B. Who can be infected?
  1. AIDS and hepatitis B are threats to your health whether you think about it or not.
  2. The better you understand the risks, the easier it is to protect yourself and your fellow employees.
  3. AIDS and hepatitis B are not spread through the air like cold or flu germs. You won't get either disease from working alongside someone who is infected.

V. Workplace Transmission
- A. Blood and certain other body fluids.
- B. Means of transmission
  1. Cutting yourself with an object contaminated with blood or body fluids.
  2. Getting infected blood or body fluids on your skin, especially if you have sores, nicks, or cuts.
  3. Getting contaminated blood or body fluids in the mucous membranes of your eyes, nose, or mouth.

VI. Emergency Assistance
- A. Emergency assistance should only be performed by outside professionals.
- B. Observe the following if a personal choice is made to render emergency assistance.
  1. Don't take unnecessary risks.
  2. Do whatever you must to save a life but **DO NOT** touch blood or body fluids.
  3. Treat all blood and body fluids as if they are infectious.
  4. When providing first-aid protect yourself first, treat the victim second.

5. Use protective equipment (gloves, goggles, etc.)
6. When performing CPR, always use a protective mask equipped with a one-way valve.

VI. The clean-up

A. A hazardous situation will exist until:

1. The entire area is cleaned of blood and body fluids.
2. Contaminated cleaning equipment has been disinfected or disposed of safely.
3. Clean up contaminated broken glass with tongs, forceps, or a brush and a dust pan. **WEAR GLOVES!**
4. Be alert for sharp items, which may puncture the skin, when emptying trash containers.

VII. Safe Housekeeping

A. Whenever blood or body fluids need to be cleaned:

1. Wear gloves, maybe two pairs for protection. Avoid tearing your gloves on equipment.
2. Restrict access to the area.
3. Do not leave the area unattended until the area has been cleaned and disinfected.
4. Use disposable towels to soak up most of the blood.
5. Put all blood soaked towels and waste in a sealed biohazard bag. Dispose of it as regulated waste.
6. Clean with an appropriate disinfecting solution. Ten parts water to one part bleach will do it. Bleach will kill both HBV and HIV. After cleaning, disinfect mops and other cleaning equipment. Otherwise, you may spread viruses to other areas of the facility.

VIII. Other exposure hazards

A. You may deal with blood and body fluids in accidents and in general cleaning. You may contact blood and body fluids in:

1. Vomit
2. Urine

B. You may come in contact with blood and

body fluids when cleaning:

1. Toilets
2. Sinks
3. Trash Containers

IX. Common sense rules

A. Wash your hands and remove any protective clothing before:

1. Eating
2. Drinking
3. Smoking
4. Applying cosmetics or lip balm
5. Handling contact lenses
6. Keep your hands away from you face, especially your nose, mouth and eyes while cleaning.

B. Hand washing

1. Hand washing is one of the best defenses against spreading infection, including HBV and HIV. Always wash your hands with non-abrasive soap and water at the end of your shift and after removing work gloves.

C. **REPORT ANY EXPOSURES TO YOUR MANAGER, ALL REPORTS WILL BE TREATED IN THE STRICTEST OF CONFIDENCE.**

1. Post exposure steps:
   a. Flush area with warm water, and then wash with soap and water.
   b. If you have an open wound, squeeze gently to make it bleed, then wash with soap and water.
   c. Notify your supervisor so the post exposure process can be initiated.

X. Summary

A. Protecting yourself from bloodborne diseases requires knowing the facts, practicing good hygiene and taking a few sensible precautions. These are measures which are under your control. The protective measures are important, so take them seriously.

APPENDIX D

AIDS in the Workplace Video

Intervention 2 Video

I. Basics
   A. Description of HIV and AIDS
   B. Symptoms of HIV and AIDS
   C. Modes of transmission
      1. Blood to blood
      2. Exchange of body fluids
      3. Vaginal secretions
      4. others?
   D. Modes of non-transmission
      1. Casual contact
         a. Hand shake
         b. Hugging
         c. Kissing (non-tongue kiss)
         d. Others?

II. Working with an infected co-worker
   A. Safety for all employees
      1. Using tools or equipment after infected co-workers used them.
      2. Using the same bathroom (stress non transmission unless there is a mess).
      3. Using the same break/lunch room.
      4. Conversing with an infected co-worker at a reasonable close distance.
      5. Sharing office or work station.

III. Safety with accidents
   A. Cuts
      1. Take care of cuts immediately.
      2. Do not continue to work after you have been cut. Get cut cleaned and bandaged immediately.
      3. Also clean work station immediately to avoid the spread of possible viruses.

APPENDIX E

Second Intervention:

Group Two

Discussion Format

THESE FOUR SCENARIOS ARE TO BE READ TO TREATMENT GROUP TWO. THE SCENARIOS ARE DESIGNED TO STIMULATE DISCUSSION THAT CAN BE LEAD BY THE NURSE, WHO WILL BE PRESENT.

1. Two employees are taking a break and are in the employee breakroom. In walks another employee, who everyone knows is infected with the HIV virus. Are these two employees in danger of infection at this point? Why?

2. This same HIV infected employee comes to your area to train under you. Would you refuse the task? Would you treat him or her differently? Would you act differently?

3. A customer is injured on the sales floor. The customer is bleeding and there is blood on the floor. How could you possibly become infected if you helped? Would anyone refuse to help? Why?

4. There is a shift change, and you have to use the same equipment as the HIV worker. Would this be a problem? Why?

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FROM: Emporia State University Graduate School

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