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The Development of Aids Education (K-12) in the United States Through 1989

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THE DEVELOPMENT OF AIDS EDUCATION (K-12) IN THE UNITED STATES THROUGH 1989

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An overview of the nature of HIV/AIDS, its routes of transmission, incidence (particularly in the adolescent population), associated diseases, diagnosis and treatment options are discussed. Control of the epidemic depends on education and other public health strategies to change the high risk behaviors associated with the most common means of acquiring the virus. This dissertation examines the chronology and nature of federal responses to the HIV/AIDS epidemic in its early stages and examines the major components of five landmark reports (Surgeon General's Report, 1986; Institute of Medicine and National Academy of Sciences Report, 1986; Secretary of Education's Report, 1987; Presidential AIDS Commission Report, 1988; and the Centers for Disease Control, 1988) as well as the guidelines offered by the various reports to implement efficacious programs of education in schools (K - 12) to control known risk taking behaviors which place American youth at risk of

contracting HIV and contributing to a second generation of those that live with HIV/AIDS.

Subsequent to the five reports, twenty-eight states and the District of Columbia mandated forms of HIV/AIDS education; these mandates were examined with respect to origin and policy, implementation (including curriculum, materials, instruction, selection and inservicing of personnel, target population, parent and community involvement), funding and evaluation. Additionally, five states (New York, Rhode Island, Florida, Iowa, and Washington) were selected on the basis of demographics, incidence, geographic location, and comprehensiveness of policy for further analysis. Innovative aspects of each state's program as well as a comparison of notable elements were included.

Recommendations to enhance the effect of HIV/AIDS education include an altered and enhanced media role, targeting and providing non-traditional educational programs for high risk adolescents not in academic institutions, internalization of the knowledge received by out of school reinforcement of the HIV/AIDS prevention message by significant others, evaluation of the impact of HIV/AIDS education programs over a longer period of time need and the inclusion of comprehensive health education curriculum.

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Special acknowledgement must be made to Judy Zajac, the master high school English teacher, who clarified both my writing style and my thoughts on today's high school student.

Finally, I dedicate this dissertation to Kim, a very special lady, who I believe is saying, "it's about time!"

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"An ounce of prevention is worth a pound of cure."

Ben Franklin (1706-1790)

"Forewarned, forearmed; to be prepared is half the victory."

Miguel de Cervantes Saaverda (1547-1616) in Don Quixote, Pt. II, ch. 17

CHAPTER 1

THE AIDS CRISIS: AN OVERVIEW OF THE AIDS EPIDEMIC

Background of HIV/AIDS in the United States

Only ten years ago the acquired immune deficiency syndrome (AIDS) was unknown. During the first decade (1981-1991) of the epidemic, over 65,000 people of the more than 115,000 persons diagnosed with AIDS in the United States, have died from this disease. Many more have become infected with the human immunodeficiency virus (HIV), the virus that causes AIDS, the disease. Although considerable progress has been made in learning about the virus--its natural course, its causes, routes of transmission, tests to diagnose and monitor its course, medications to treat as well as retard the spread of HIV infection, and research into the development of a vaccine--the morbidity and mortality from HIV infection will continue throughout the 1990's.

The first recognized cases of what is now known as the acquired immune deficiency syndrome (AIDS) occurred in the spring of 1981. The Centers for Disease Control (CDC) in Atlanta, Georgia received reports of five cases of an unusual pneumonia in previously healthy homosexual males living in Los Angeles, California. None of these patients

responded to antibiotics that would treat the usual types of pneumonias. All were found to have pneumocystic pneumonia a very rare type of pneumonia which, prior to this report, occurred only in individuals who had had transplants and were receiving immunosuppressive drugs or chemotherapy.[1] One month later a previously rare skin cancer that usually occurred primarily in older men of Mediterranean origin, Kaposi's sarcoma, was reported among young homosexual men in New York City.[2]

These two reports were the first glimpses of what was to become a major health problem--a disease defined by severely damaged immunologic defenses against a wide range of parasitic, fungal, bacterial, and viral infections (opportunistic infections), as well as several malignancies. (See illustrations in Tables 1-3).

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[1]Centers for Disease Control (CDC), "Pneumocystis Pneumonia-Los Angeles," Morbidity and Mortality Weekly Report (MMWR) 30, (1981a): 250-252.

[2]CDC, "Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men - New York City and California," MMWR 30, (1981b): 305-308.

Table 1.-- CDC Case Definition of AIDS

"AIDS is a disabling or life threatening illness caused by human immunodeficiency virus (HIV) characterized by HIV encephalopathy, HIV wasting syndrome or certain diseases due to immunodeficiency in a person with laboratory evidence for HIV infection, or without certain other causes of immunodeficiency.[3]

Table 2.-- Infections Indicative of AIDS

Clinical Presentation	Causative Organism
Pneumonia (PCP)	Pneumocystis carinii
Enterocolitis	Cryptosporidium
Mucosal and skin lesions	Herpes simplex
Esophagitis	Candida albicans
	Herpes simplex
	Cytomegalovirus
Other pneumonias, meningitis and encephalitis (brain infections)	Toxoplasma gondi
	Aspergillus
	Cryptococcus neoformans
	Candida albicans
	Cytomegalovirus
	Nocardia
	Strongyloides
	Atypical Mycobacterium
Progressive multifocal leukoencephalopathy (brain infection)	Papovarus (J-C virus)

[3]Council of State and Territorial Epidemiologists and CDC, Center for Infectious Diseases, AIDS Program, "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," MMWR 36 supp. 1 (August 14, 1987): 3S-15S.

Table 3.-- Cancers Associated With AIDS

Kaposi's sarcoma	Cancer of the oropharynx (mouth)
Non-Hodgkin's lymphomas	Hepatocellular (liver)
Hodgkin's disease	Chronic lymphocytic leukemia
Burkitt's lymphoma	Lung cancer (adenosquamous type)

Scope of the Problem

Health departments have reported over 115,000 cases of AIDS and over 65,000 AIDS related deaths to the Centers for Disease Control (CDC). AIDS is a major cause of morbidity and mortality in children and young adults in the United States, being the tenth leading cause of death among those between fifteen and twenty-four in 1984; the seventh leading cause of death for this age group in 1986; and the sixth leading cause of death for this age group in 1987.[4] For adults, AIDS ranked fifteenth among leading causes of death in 1988,[5] and seventh among estimated years of potential life lost before age sixty-five in 1987.[6] Further, the first 50,000 cases of AIDS were reported to CDC between the years 1981 to 1987, but the second 50,000 were

[4]B.W. Kilbourne, J.W. Buehler, and M.F. Rogers, "AIDS as Cause of Death in Children, Adolescents, and Young Adults," American Journal of Public Health 80 (1990): 499-500.

[5]U.S. Department of Health and Human Services (DHSS), Public Health Service, "Annual Summary of Births, Marriages, Divorces and Deaths: United States, 1988," DHSS Publication no. (PHS) 89-1120 (Monthly vital statistics report) 37, no. 13 (1989): 1.

[6]CDC, "Years of Potential Life Lost Before Age 65 - United States, 1987," MMWR (1989), 38: 27-9.

reported between December 1987, and December 1989.

Incredible strides in understanding AIDS at the most basic scientific levels have been made since the disease was first described. Much has been learned about the epidemiology of the disease, its routes of transmission, its natural history, and the complex variety of illnesses caused by the virus now known as the human immunodeficiency virus (HIV) discovered in 1983. Newly explored avenues of clinical research are producing more hopeful methods of treating HIV infection and AIDS: antiviral drugs and immune system modulators to halt progression of the infection and to correct AIDS related immune deficiencies are being developed and tested as more is learned about the life cycle of the human immunodeficiency virus (HIV)--these achievements are grounds for hope, but no vaccine against HIV exists, nor is a cure on the horizon.

The cost of medical care and social services has been high, and medical practitioners and public health officials have expressed concerns about the availability of personnel and health care facilities to meet future needs. In addition, many asymptomatic individuals are infected with the virus (HIV) and do not yet have the diagnosis of AIDS, the disease. Those individuals with diagnosed AIDS are in the minority, representing the "tip of the iceberg," as compared to the estimated numbers of individuals infected with the virus, knowingly or not. The only known way to

escape contracting this fatal disease for which there is no cure, is preventing its transmission. The sole weapon that may work, according to former Surgeon General C. Everett Koop is, "... education, education, and more education," about the specific ways of avoiding exposure to the virus.[7]

More than 90 percent of AIDS cases have been attributed to transmission of the virus through either high-risk sexual behavior or intravenous drug abuse. Figure 1 illustrates the most common modes of transmission while Table 4 depicts both the exposure category and distribution of AIDS cases by year of diagnosis. The remaining 10 percent of AIDS cases have been related to blood or blood product transfusion, for example, transfusion recipients, hemophiliacs; health care workers with occupational exposures; and mother-infant transmission (the virus is transmitted from mother to child during pregnancy, at the time of delivery, or shortly after birth). (Appendix A represents statistics from 1991).

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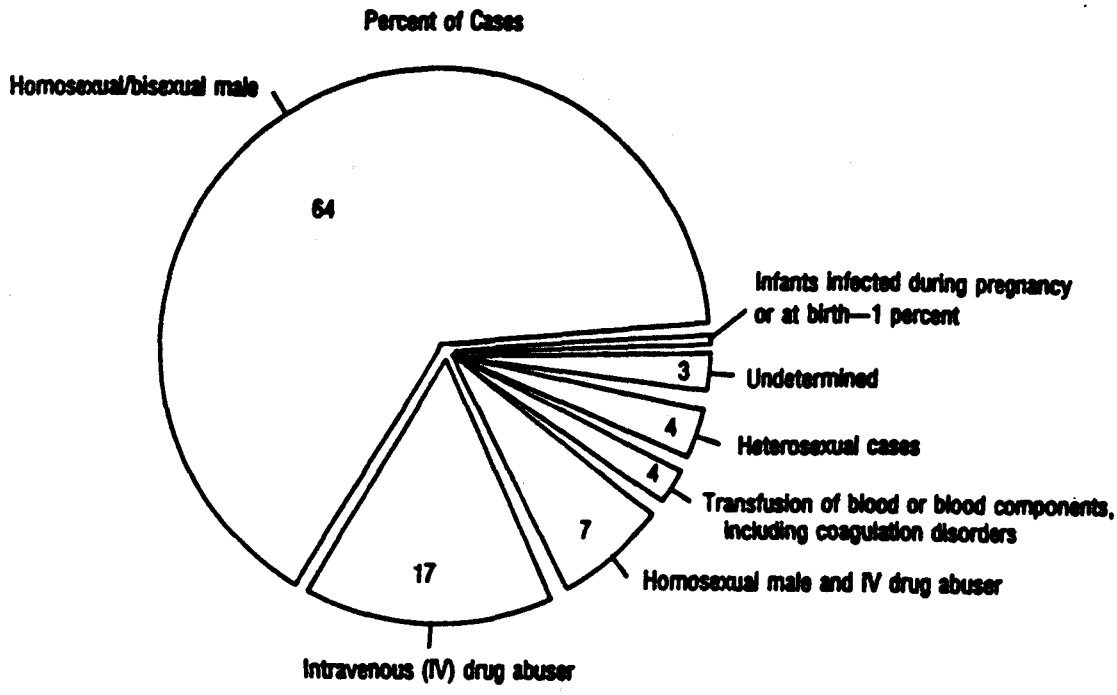
[7]C. Everett Koop, "Teaching Children About AIDS," Issues in Science and Technology 4 (Fall 1987): 67-71.

Figure 1.-- Mode of Transmission for Persons With AIDS (PWA)



Source: "AIDS Weekly Surveillance Report," Centers for Disease Control, December 21, 1987.

Table 4.-- Distribution of Reported AIDS Cases (percentage) by Year of Diagnosis and Exposure Category

Distribution of Reported AIDS Cases (percentage) by Year of Diagnosis and Exposure Category

Year of Diagnosis	Adults									Pediatric					N
	Male														
	Homosexual	IVDU[a]	Homosexual +IVDU	Hemophilic	Hemosexual	Pattern II[b]	Transfusion	Other[c]	Hemophilic	Risky Mother[d]	Transfusion	Other[c]	Total	
1981	64.9	11.0	7.1	0.5	0.5	6.0	0.5	4.5	0.0	4.5	0.0	0.5	100	302
1982	60.7	16.9	9.4	0.6	1.1	5.1	0.8	2.9	0.2	1.7	0.4	0.3	100	1,076
1983	61.4	17.8	9.4	0.5	1.0	3.5	1.5	2.3	0.1	2.0	0.3	0.0	100	2,933
1984	64.3	16.7	8.7	0.9	1.5	2.2	1.7	2.1	0.1	1.5	0.3	0.0	100	5,926
1985	64.1	17.5	7.5	1.0	2.0	1.6	2.5	1.8	0.1	1.5	0.4	0.0	100	11,038
1986	62.9	18.2	7.8	0.9	2.5	1.4	2.7	2.1	0.1	1.3	0.2	0.0	100	17,777
1987	60.5	20.1	6.8	1.0	3.2	1.2	2.9	2.7	0.1	1.4	0.2	0.0	100	25,987
1988	56.9	22.8	6.3	1.0	4.1	1.1	2.5	3.7	0.1	1.3	0.1	0.1	100	29,761
1989[e]	55.3	23.2	5.8	0.7	5.0	1.2	1.9	5.3	0.1	1.2	0.1	0.1	100	22,901
Total	59.5	20.6	6.9	0.9	3.4	1.4	2.4	3.3	0.1	1.4	0.2	0.1	100	117,701

[a]IVDU: intravenous drug user. [b]The cases assigned to this category involve individuals from those countries in central, eastern, and southern Africa and some Caribbean countries in which the majority of AIDS cases have been ascribed to heterosexual transmission, the male-to-female case ratio is approximately 1:1, perinatal transmission is more common than in other areas, and intravenous drug use and homosexual transmission occur at a very low level. [c]This category includes cases currently under investigation for which no history of exposure has yet been reported and cases for which no exposure mode could ever be determined. [d]Mother with, or at risk for, HIV infection. [e]The 1989 figures include only those cases reported through December 31, 1989. All data shown in this table are subject to delays in reporting. Therefore, counts of cases diagnosed in a particular year may underraise the number that will ultimately be reported. This type of underestimate is particularly likely for cases diagnosed in 1988 and 1989.

Source: Computed from CDC's AIDS Public Information Data Set for AIDS cases reported through December 31, 1989, from, C.F. Turner, H.G. Miller, and L.E. Moses editors, AIDS: The Second Decade, (Washington, D.C., National Academy Press, 1990), 44.

HIV/AIDS in Adolescents

Only 1 percent of reported AIDS cases have occurred among adolescents, though 21 percent of reported cases have occurred among persons aged twenty to twenty-nine, one-fifth of persons diagnosed with AIDS.[10] However, Mark Nadel, Associate Director of National and Public Health Issues, wrote in a report to the Chairman of the Senate Committee on Governmental Affairs, Senator John Glenn, that AIDS cases among individuals in their twenties had increased by 41 percent during 1989, an increase similar to the overall increase in AIDS cases.[11] Because of the long incubation period between HIV infection and the onset of diagnosable symptoms, some of the persons aged twenty to twenty-nine with AIDS probably were infected as adolescents. As of December 31, 1989, approximately twenty-four thousand cases of AIDS had been reported among teenagers and young adults between the ages of thirteen and twenty-nine. Table 5 shows the distribution of reported AIDS cases by age at diagnosis, using the broad age categories into which CDC has coded the data released to the public.

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[10]Centers for Disease Control, AIDS Weekly Surveillance Report. Atlanta, Ga., Centers for Disease Control, April 11, 1987, 3.

[11]United States General Accounting Office, "AIDS Education: Public School Programs Require More Student Information and Teacher Training," (GAO/HRD90-103), (Washington, D.C., May 1, 1990): 8.

Table 5.-- Distribution of AIDS Cases Reported Through December 31, 1989 by Age at Diagnosis

Diagnosis (years)	No. of Cases	Percentage
< 1	785	0.7
1-12	1,210	1.0
13-19	461	0.4
20-24	5,090	4.3
25-29	18,966	16.1
30-39	54,334	46.1
40-49	24,951	21.2
50 +	11,984	10.2
Total	117,781	100.0 #

Percentages may not sum to 100.0 because of rounding

SOURCE: Special tabulations provided by the Statistics and Data Processing Branch of the AIDS Program, Centers for Disease Control. In AIDS: The Second Decade, p. 152.

Adolescents at Risk

Over the long term, the best way to stop the spread of HIV infection will be to reduce the development of behaviors that lead to transmission of the virus. AIDS education should begin before young people start engaging in risky sexual practices or taking drugs.

Early adolescence is a critical period in children's lives. They are leaving many of the securities associated with childhood and are beginning to shape a new identity for themselves even as they experience dramatic changes physically, socially, psychologically, and cognitively. They find themselves in a period of uncertainty which could

have lasting effects on them emotionally and, in the case of AIDS, physically. Adolescence is characterized by impulsiveness, a desire for immediate gratification, and a tendency to question authority. The latter is especially true when advice from authorities disagrees with the adolescent's own limited personal experiences. Other adolescent characteristics, such as the search for an identity and self-esteem and subsequent need for peer approval, makes resistence to peer pressure difficult. A lack of social experience, combined with the dynamics of new sexual relationships, make it hard for some adolescents to defend abstinence from sexual or drug related activities both identified as high risk activities for HIV transmission.[12]

Not all teens are at risk for HIV infection. Some, by virtue of their low level of risky behavior or because of the absence of the virus among potential partners, will remain uninfected. Thus, the vast majority of very young teenagers, as well as older adolescents, who have not yet begun sexual intercourse and do not inject drugs, have little to worry about. While a small number of children received blood transfusions or blood products, infected by contaminated blood prior to the implementation of mandatory screening in 1985, these individuals, now older and possibly

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[12]J. Santrock, Adolescence: An Introduction, (Dubuque, Iowa: William C. Brown), 1981.

involved in risky behaviors, need counselling regarding their own HIV status and the potential risk they pose to others.

A section in Issue Brief distributed by the National School Boards of Education Association sums up the reason why schools cannot avoid the problem of AIDS: "AIDS will be the number one killer of the young, exceeding the number of deaths resulting from automobile accidents. That is why our public schools must be very much involved in dealing with the AIDS problem."[13]

Adolescent High Risk Activities

Several factors further illustrate the need for intervention strategies. Statistics regarding sexual activity showed a dramatic increase occurs during the teenage years. A U.S. Department of Health and Human Services 1982 study revealed that by age fifteen, 16 percent of boys and 5 percent of girls in the United States have had heterosexual intercourse at least once. By age seventeen, these rates had almost tripled for boys and increased five times for girls. (See Figure 2). Between 1971 and 1982, the proportion of sexually active adolescents increased from

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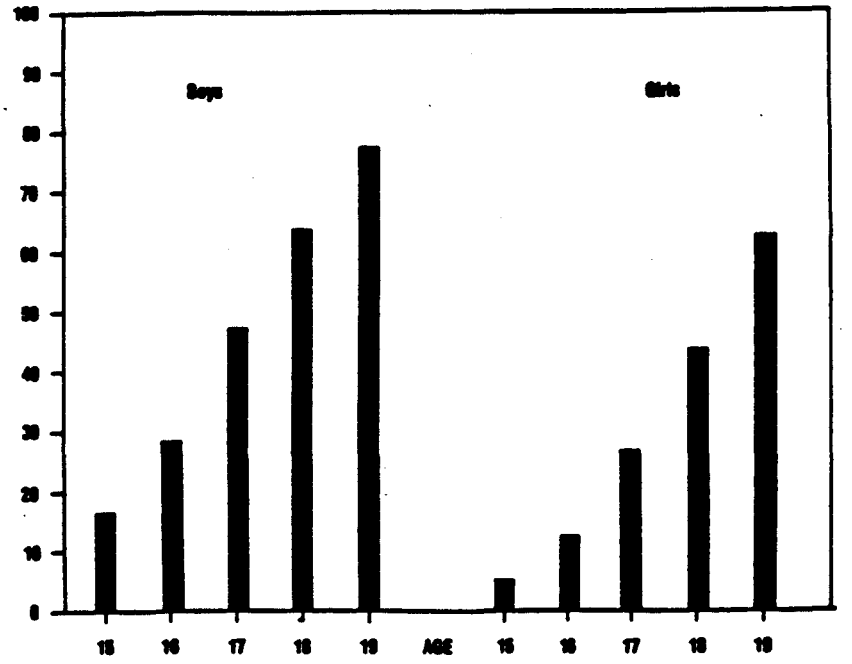
[13]National State Boards Education Association, "AIDS and the Impact on Schools," Issue Briefs (1987): 1.

28 percent to 42 percent.[14] A nationwide study of high school students disclosed that one-half of the boys and one-third of the girls sampled had had intercourse.[15]

Figure 2.-- Percentage of Boys and Girls 15 to 19 Years Olds Who Have Had Heterosexual Intercourse



Source: Tabulations from the 1982 National Longitudinal Survey of Youth by the Center for Human Resource Research, (Ohio State University, 1983), In, Risking the Future, (Washington, D.C.: National Academy Press, 1987).

[14]Office of Office of Population Affairs: National Survey of Young Women (1971, 1978, and 1979), and National Survey of Family Growth. (Washington, D.C.: U.S. Department of Health and Human Services, 1982).

[15]Zelnick, M, J.F. Kantner, "Sexual Activity, Contraceptive Use, and Pregnancy Among Metropolitan-Area Teenagers: 1971-1979," Family Planning Perspective 12 (no. 5, 1980): 230-237.

Adolescents between the ages of fifteen and nineteen years of age have the highest overall rates for sexually transmitted diseases when reported rates are adjusted for frequency of sexual activity (see Figure 3).[16] Of adolescents who use contraception, only 21 percent use condoms,[17] and further, one in ten teenage girls becomes pregnant each year.[18] In addition, research indicates about one-fourth of male adolescents have experienced orgasm through homosexual contact.[19]

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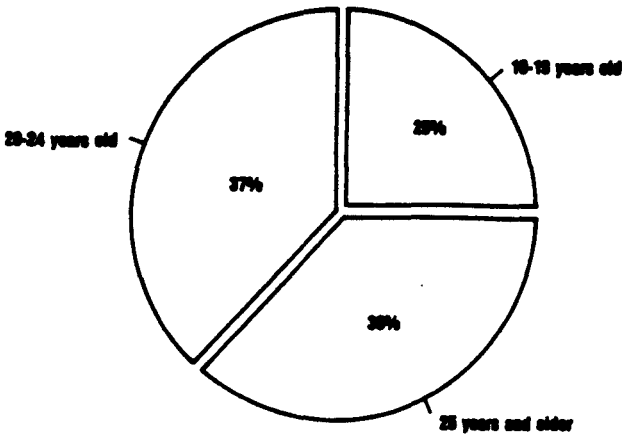
[16]P.J. Weisner, W.C. Parra, "Sexually Transmitted Diseases: Meeting the 1990 Objectives - A Challenge for the 1980's." Public Health Reports 97 (no. 5 1982): 409-416.

[17]W.F. Pratt, W.D. Mosher, C.A. Bachrach, M.C. Horn, "Understanding U.S. Fertility: Findings from the National Survey of Family Growth, Cycle III." Population Bulletin 39 (no. 5, 1984): 1-42.

[18]Alan Guttmacher Institute: United States and Cross-National Trends in Teenage Sexuality and Fertility Behavior. (New York: Alan Guttmacher Institute, unpublished paper at National State Boards of Education Offices, Virginia).

[19]G. Remafedi, "Homosexual Youth: A Challenge to Contemporary Society." Journal of American Medical Association (JAMA) 258 (no. 2, 1987): 222-225.

Figure 3.-- Distribution of Persons With Syphilis or Gonorrhea By Age



Source: Centers for Disease Control, Sexually Transmitted Disease Cases Reported, 1985.

In reviewing research related to adolescent drug use, one study reported that about 29 percent of high school seniors have had experience with an illicit drug within the past month; just over 1 percent of these individuals used heroin.[20] A conservative estimate by one group of researchers suggests that over 200,000 teens have used IV drugs (See Table 6 for first time drug usage).[21]

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[20]L.D. Johnston, J.G. Bachman, P.M. O'Malley, Drug Use Among American High School Students, College Students and Other Young Adults: National Trends Through 1985. Rockville, Md., National Institute on Drug Abuse, 1986.

[21]R.J. DiClemente, J. Zorn, L. Temoshok, "Adolescents and AIDS: A Survey of Knowledge, Attitudes and Beliefs About AIDS in San Francisco," American Journal of Public Health 76 (no. 12, 1986): 1443-1445.

Table 6.-- Percentage of Students in the High School Class of 1987 Reporting Initiation of Use of Selected Drugs, by Grade of First Use.

Drug	6th	7th-8th	9th	10th	11th	12th	Never Used the Drug
Marijuana	2.9%	10.0%	12.3%	12.3%	8.2%	4.4%	49.8%
Inhalants	2.5	3.3	3.6	2.7	3.4	1.4	83.0
Hallucinogens	0.3	0.9	1.9	2.5	3.3	1.5	89.7
Cocaine	0.2	0.6	2.2	3.7	5.4	3.0	84.8
Heroin	0.1	0.1	0.3	0.4	0.2	0.1	98.8
Opiates other than heroin	0.6	1.0	2.0	2.0	2.5	1.0	90.8
Stimulants	0.6	3.8	5.7	5.4	3.8	2.4	78.4
Sedatives	0.4	1.5	2.5	1.9	1.5	0.8	91.3
Tranquilizers	0.4	1.6	2.6	2.6	2.4	1.4	89.1
Alcohol	8.8	22.6	34.5	19.3	11.5	5.5	7.8
Getting drunk	3.3	13.8	20.3	17.8	11.9	5.7	27.1
Cigarettes	21.0	19.4	10.9	7.2	5.7	2.9	32.8
Cigarettes (daily use)	1.6	5.2	5.3	4.4	3.3	1.6	78.7

NOTE: The entries in this table show percent reporting that their *first* use occurred in particular grades. The sample size for all percentages is approximately 6,000 persons.

Source: L.D. Johnston, P.M. O'Malley, and J.G. Bachman, Illicit Drug Use, Smoking and Drinking by America's High School Students, College Students, and Young Adults 1975-1987, (Rockville, Md.: National Institute on Drug Use, 1988.

Review of Adolescent AIDS Knowledge Studies

Recent surveys of AIDS related knowledge and behavior among adolescents indicate that teens are still misinformed or confused about HIV infection. One of the first studies (Price, et. al., 1985) involved a convenience sample of males and females between the ages of sixteen to nineteen years of age from four local high schools in Ohio (N = 250). The questionnaire consisted of twenty-nine true/false statements related to HIV/AIDS knowledge, sources of information regarding HIV/AIDS and one question asking if

they were personally worried about contracting HIV/AIDS. Demographic data were also requested which included variables of whether they had ever taken a sex education course and/or a health education course. Only three of the questions were correctly answered by at least 75 percent of the students. These three questions consisted of statements that had to do with being born with HIV/AIDS, dying from HIV/AIDS and the likelihood of homosexuals contracting the virus; less than 50 percent of the students were aware of who was at more risk of getting AIDS, what would happen to people who developed the disease, and what means were used to detect the virus or and modes of transmissibility. Seventy-three percent of the students responded that they were not worried about getting AIDS; however, 100 percent of the females (as compared with 58 percent of the males) stated they were personally worried about contracting HIV/AIDS. Most of the students indicated they had received their information from the mass media, and less than one-third claimed they had received information on AIDS from schools or medical personnel. Significantly, this study was conducted in a suburban community located in a state with a relatively low incidence of AIDS.[22]

The next two studies, conducted a year later were

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[22]J. Price, S. Desmond, & G. Kukolla, "High School Students' Perceptions and Misperceptions of AIDS," Journal of School Health 55 (1985): 107-109.

administered in two areas with a high incidence of AIDS. In July 1985, the Gallup Organization conducted a telephone survey of one hundred teenagers in New York City and 230 other teens nationwide: the service reported that teenagers are somewhat less likely than adults to mention sexual contact, blood transmission, and drug paraphernalia as means of AIDS transmission.[23] The other, a 1985 San Francisco study by DiClemente et.al. (N = 1,326) suggested that, although 92 percent of students correctly indicated that sexual intercourse was one mode of contracting HIV/AIDS, only 60 percent knew that using a condom during sexual intercourse could decrease the risk of getting the disease. Eighty-one percent of the adolescents knew that sharing IV drug needles and receiving infected blood were other modes of transmission, but more than one-third believed that HIV/AIDS could be spread by shaking hands. Almost 90 percent of respondents agreed that HIV/AIDS instruction should be included in the school curriculum.[24]

In Massachusetts (1986), a larger random sample survey of 860 adolescents between the ages of sixteen and nineteen, found that many adolescents, including those in the highest

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[23]Public Awareness of AIDS, (Princeton, N.J., The Gallup Organization, Inc, July 1985).

[24]D. DiClemente, J. Zorn, L. Temoshok, "Adolescents and AIDS: A Survey of Knowledge, Attitudes and Beliefs About AIDS in San Francisco," American Journal of Public Health 76 (1986): 1443-1445.

risk subgroups of sexually active (70 percent) or psychoactive drug users (13 percent), did not know what sexual and drug precautions were needed to prevent transmission of the virus. Only 15 percent of those surveyed reported changing their sexual behavior because of concern of contracting HIV/AIDS, and only 20 percent of those who changed their behavior used effective methods. Of those who used drugs other than alcohol and marijuana, only 8 percent did not know that HIV/AIDS could be transmitted by injecting drugs.[25]

The CDC sponsors an annual national survey of high school students' knowledge, attitudes and beliefs about HIV/AIDS to gain information for planning educational programs and for monitoring changes over time. The survey administered during the fall of 1987 (given concurrently in some cases with local surveys) found that virtually all of those that responded (between 52 and 100 percent), had heard of AIDS and the majority knew about the routes of transmission.[26] A follow up study selected data from state, territorial, and local departments of education from thirty states, ten cities and two territories during February to May, 1989. This data dealt with HIV-related knowledge and

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[25]L. Strunin, & R. Hingson, "Acquired Immunodeficiency Syndrome and Adolescents: Knowledge, Beliefs, Attitudes, and Behaviors." Pediatrics 79 (no. 5, 1987): 825-828.

[26]Centers for Disease Control (CDC), "HIV - Related Beliefs, Knowledge and Behaviors Among High School Students," MMWR 37 (1988): 717-721.

behaviors among high school students (N=1,175,227) with school response rates ranging from 27 percent to 100 percent. From 33 percent to 86 percent (median: 62 percent) of students from all sites reported having been taught about AIDS or HIV infection in schools; the range of students who discussed AIDS or HIV infection with their parents or other adults in their families varied from 53 percent to 69 percent (median: 56 percent). Better results in knowledge were obtained (98 percent with a median of 88 percent) from the student data knowing that HIV infection could be acquired by sharing needles and syringes used to inject drugs and having sexual intercourse without using a condom.[27]

Helgerson's study of two local districts in an area with a low rate of AIDS found similar results. Information was gathered from junior high and senior high school students (N = 657) in two Connecticut school districts regarding student knowledge about the AIDS virus. The findings revealed that, in spite of some factual knowledge about AIDS, much misinformation existed with respect to methods of viral transmission, high risk behaviors for acquiring the virus, and methods to avoid acquisition of the virus. In addition, the students were also polled as to where they had learned of AIDS; most identified television

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[27]CDC, "HIV-Related Knowledge and Behaviors Among High School Students - Selected U.S. Sites, 1989," MMWR 39 (1989): 385-97.

and radio (57 percent) as the source compared with parents (6 percent) or teachers (4 percent) as the source of information. Over half of the respondents answered that they wanted to learn more about AIDS in school.[28]

The 1987-88 National Adolescent Student Health Survey including eighth and tenth grade students from selected classrooms randomly chosen from a national probability sample of 217 schools in twenty states (N = 11,000) indicated that approximately 90 percent of the teens knew that the AIDS virus could be transmitted by sexual intercourse or by sharing needles. These teens reported knowing that condoms provided an effective way to avoid AIDS, and believed condoms should be used. The respondents also believed sexual intercourse was acceptable for teens as long as it occurred with a steady partner.

While the teens correctly identified the two most common means of HIV virus transmission, many respondents also incorrectly indicated that the virus could be transmitted by saliva and donating blood. In addition, they also believed that the risk of HIV/AIDS could be reduced by washing after sex and making sure their partner looked healthy. Perhaps most telling was that one teenager in every five believed that persons infected with the AIDS virus could spread the virus only if they were obviously

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[28]S. Helgerson, "Acquired Immunodeficiency Syndrome and Secondary School Students: Their Knowledge is Limited and They Want to Learn More," Pediatrics 81 (no. 3, 1988): 350-355.

sick with AIDS.[29] This significant doubt in the risk posed by asymptomatic but HIV-infected individuals and the misperception of protection afforded by washing are cause for concern.

Lastly, a survey to explore general knowledge and attitudes about HIV/AIDS among elementary school children was conducted in a public school system in Vermont. The sample included fifty-five children in grades one to three and ninety-two children in grades four to six. Students had received no formal instruction about HIV/AIDS prior to participating in the survey which consisted of an open ended semi-structured interview for the younger children and a written questionnaire for the older children. The results indicated that awareness of and accurate information about HIV/AIDS increased steadily though the early school years. For example, 62 percent of first graders indicated that they had heard of HIV/AIDS, but only 15 percent could provide even minimally accurate information about the disease. From third grade on, over 90 percent of children had heard of HIV/AIDS, with the majority capable of providing additional accurate information. Although the majority of fourth through sixth graders responded correctly to the survey questions, certain misconceptions were evident, such as that

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[29]L. Johnston, J. Bachman, and P. O'Malley, "Results of the 1988 National High School Senior Survey," (press release),(Ann Arbor, Mich., University of Michigan, Feb. 28, 1989): 1.

doctors could make you better, and that HIV/AIDS could be contracted by donating blood. These intermediate students identified many concerns during the interview/survey process such as whether or not their parents could die of AIDS. Many children had misconceptions about modes of transmission such as spread via drinking fountains or touching people. Others thought if someone was acting strange, he might have AIDS, and not be drunk. The researchers also asked each child to draw a picture of a virus and a person with AIDS. Most children associated AIDS with chicken pox, the virus with which they were most familiar and drew both regular people and images of death. Like the older students, television, which continues to play a significant role in providing information about AIDS to both children and adults, was the primary source of information about HIV/AIDS for many children.[30]

The results of this study indicated that children are aware of AIDS at a very young age and have many fears, fantasies, and misconceptions about the disease. These misconceptions discussed in the findings from studies of teenagers are therefore inculcated at an early age. This study strongly supported the need for developmentally appropriate HIV/AIDS education at all grade levels.

Schools, with the ability to reach 95 percent of the

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[30]D. Fassler, K. McQueen, P. Duncan, P. & L. Copeland, "Children's Perceptions of AIDS," Journal of American Academy Child Adolescent Psychiatry 29 (no. 3, 1990): 459-462.

nation's youth, or 25 percent of the American population, can contribute both to the current and future health of the American public, and they represent the optimal setting for conducting HIV/AIDS education and prevention programs, for both school-aged children and through them, their parents.[31]

For something as important as the well being of the nation's youth, required HIV/AIDS health education will play a critical role in assuring that youth receive accurate information and develop skills to protect themselves and their partners from this deadly virus. While the tradition of education in this country has traditionally been the responsibility of each individual state and their communities, the federal role--getting factual, scientifically accurate information into the hands of local teachers--is also important, as the youth of America must be educated about HIV/AIDS thereby preventing the transmission of the human immunodeficiency virus via avoidable, high-risk behaviors.

To this end, states began to mandate HIV/AIDS education in the public schools in 1987, and by the end of 1989, twenty-eight states and the District of Columbia had such mandates. Although most states and large school districts had some kind of AIDS education, not all were comprehensive, taught early enough, or repeated at different grade levels.

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[31]D.W. Haffner, "AIDS and Adolescents: The Time for Prevention is NOW," (Washington, D.C.:, Center for Population Options, November 1987).

Statement of the Problem/Research Question

HIV/AIDS prevention education has been strongly recommended by the highest U.S. government officials to take place in all schools in order to educate all students to protect them from this fatal disease. Because patterns of health behavior and risk taking are often established during the teenage years, intervention efforts will be most effective if the programs reach teens before they begin practicing the behaviors that put them at risk.

This research will examine the policies of those states which have mandated HIV/AIDS education to ascertain how they have implemented the various recommendations and guidelines suggested by assorted governmental offices such as the Surgeon General's office, the Department of Education, the Centers for Disease Control, and the Presidents Commission on AIDS. This information will be collected from those policies in effect through 1989.

Specific questions to be addressed in reviewing policies.

1. Which states mandate HIV/AIDS prevention education?
2. How has each state confronted the mandate?
3. What is the grade level at which instruction about HIV/AIDS will begin and how often will it be taught, and at what recurrent grade levels?
4. What is the context in which HIV/AIDS prevention is taught?
5. Are concepts such as human sexuality, abstinence, contraception, homosexuality, safer sex, drug education, self-esteem and decision making skills presented?
6. What special HIV/AIDS education training are teachers given?
7. What curricula, instructional material or guidelines are provided and by whom?
8. What learning outcomes are given?
9. How are the programs evaluated?
10. What involvement do parents have?
11. If an advisory committee exists, what is it scope?
12. How much, if any, state funding is allotted for HIV/AIDS education programs in the schools?
13. What is the percentage of HIV/AIDS cases per state?

The problem of HIV/AIDS has been identified with an emphasis on the needs of children and adolescents. Selected federal and national reports and recommendations will be examined in the following chapter as a basis for the subsequent laws enacted mandating HIV/AIDS education in the schools in various states.

CHAPTER 2

FEDERAL RECOMMENDATIONS

Introduction

This chapter will be an analysis of selected initial federal and national organizations guidelines and recommendations related to HIV/AIDS prevention education in the school setting through 1988. Discussed, in order of public release, the reports will be examined specifically with respect to how they relate to HIV/AIDS education in the schools and how they served as a foundation to the individual state mandates that followed in many instances. In addition, early local initiatives and their integration with federal suggestions for school-based HIV/AIDS education will be examined.

Recommendations and guidelines issued in reports from various federal government agencies regarding, among many issues, the topic of HIV/AIDS education in the schools, preceded many state mandates. The United States does not address the subject of education specifically as do nations that have central systems of education. Under the reserved powers clause of the Tenth Amendment, control over education is reserved to each state. In turn, most states have delegated responsibilities for providing education to local

units of government.[1] However, the federal government through the Department of Education and other agencies does recommend policies to the states. In some cases, such as racial desegregation and school prayer, the decisions of federal courts have been binding upon the states. Federal legislation, as in the case of PL 94-142, sets standards and processes for the education of handicapped persons. However, regarding HIV/AIDS education, federal guidelines and recommendations are only advisory to the states and local school districts.

The earliest and most prominent reports regarding HIV/AIDS education in the schools came from the U.S. Surgeon General, C. Everett Koop; the Secretary of Education, William Bennett; the National Academy of Science and Institute of Medicine; the Presidential Commission on AIDS, chaired by Admiral James Watkins; and the recommendations from the Centers for Disease Control. Each of these reports will be analyzed with respect to the main points relevant to the topic of AIDS education in the schools. Although there have been other position statements and reports issued by health and education associations that have addressed concerns and made recommendations on HIV/AIDS education in the schools, for purposes of this study, they will not be

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[1]G. Gutek, Education in the United States: A Historical Perspective, (New Jersey: Prentice-Hall, 1986), 30.

examined due to volume of duplicative statements based on these early reports.

Federal Reports

The pandemic nature of the AIDS problem, especially statistics predicting the rise of AIDS in both the heterosexual population and adolescent population, caused both governmental agencies and private health groups to urge education about AIDS. The summer of 1985, the public saw Rock Hudson go to Paris for AIDS treatment. Calls for massive public education were made, with only some television networks broadcasting public health warnings by 1987. One year later, in 1988, every household received a brochure distributed by the Government of the United States, entitled, Understanding AIDS. In the preface, Surgeon General Koop wrote that, "Stopping AIDS is up to you, your family and your loved ones." He added that the President had called the AIDS virus "Public Enemy Number One."[2]

Whether education would be an effective method of reducing high risk sexual behaviors was quite another issue. "A NBC/Wall Street Journal poll found that AIDS had no effect on 92 percent of those polled even though they knew what behaviors spread the disease and this was found particularly true on college campuses, where sex tends to be

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[2]U.S. Department of Health & Human Services, Centers of Disease Control, "Understanding AIDS," (1988): 1.

impulsive."[3] Another NBC poll found that 91 percent of the American public supported HIV/AIDS education in the schools.[4]

Public health expert, Dr. Alan Yankauer, warned in a 1986 editorial: "Nevertheless, one cannot help but be skeptical about the magnitude of any long-term impact of such educational efforts in the light of past experience with sexually transmitted diseases."[5] One learns from history that education without effort to impress the absolute reality of the impact of this disease upon both individuals and society may be ineffective. With the increasing numbers of women and their newborn who are HIV positive, one is seeing a change in the face of persons with AIDS--no longer just a disease of homosexuals and intravenous drug abusers in big cities on each coast. HIV/AIDS is in every state, every social group, every economic group; and it affects all ages and races. It has commonly been heard that, within the second decade of AIDS, there will be few persons who will be able to say they don't know someone with AIDS. That is the reality of this disease.

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[3]Smilgis, M., "The Big Chill: Fear of AIDS," Time (February 16, 1987): 52.

[4]National Broadcasting Corp.,Inc. NBC News poll results, New York (January 16, 1987).

[5]A. Yankour, "The persistence of public health problems," American Journal of Public Health 76 (no. 5, 1986): 495.

The following section addresses the aforementioned reports as well as several significant private sector reports, in the order that they were brought to the public's attention.

Surgeon General's Report

The report from the Surgeon General of the U.S. Public Health Service to the people of the United States on Acquired Immune Deficiency Syndrome, October 22, 1986, was prepared by C. Everett Koop at the request of the White House.[6] His professional experience was that of former professor of pediatrics and pediatric surgery. In addition to being the surgeon general of the U.S. Public Health Service (PHS), Koop was the deputy assistant secretary for health of the U.S. Department of Health and Human Services (DHHS) functioning in this capacity from 1981 until his retirement in October, 1989.

After five years of silence by governmental figures, including the President of the United States, Surgeon General Koop's report on AIDS was the first to emerge from the federal administration regarding the battle against AIDS, although reluctantly. His recommendations in this report contradicted the long-established administration view that explicit sex education belonged in the home. U.S. News

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[6]C.E. Koop, Surgeon General's Report on Acquired Immune Deficiency Syndrome, (Washington, D.C.: U.S. Public Health Service Public Affairs Office, 1986).

and World Report quoted that, "Koop's outspokenness is being applauded--this recent report went straight to the point in explicit language and was a breakthrough for a federal document."[7] Koop was the first top-ranking health official who had a mandate from the President to publicly discuss AIDS, and he spoke out with remarkable candor. Surgeon General Koop released his thirty-six page report on AIDS to the public, press, and media without providing an advanced copy to the White House. He gathered his information by interviewing scientists, health officials, and gay community leaders. His report called sexual education and AIDS instruction in the schools a matter of "life or death."

Koop's report included the latest scientific evidence about the virus and its etiology, and provided explicit diagrams showing how the virus was transmitted sexually and by drug use. He calmed some unfounded fears about "casual contact" transmission of HIV and rejected quarantines or compulsory blood testing. The most controversial aspect about the report was his strong proposal for fighting the disease by teaching young children about AIDS and its transmission in the schools and at home. More specifically, he stated that education concerning AIDS must start at the "lowest grade possible" as part of any health and hygiene program including a continuing sex-education program.

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[7]K. McAuliffe, "AIDS: At The Dawn of Fear." U.S. News and World Report (January 12, 1987): 62.

He added in a subsequent interview that "There is no doubt that we need sex education in schools and that it must include information on heterosexual and homosexual relations," stating that the threat of AIDS should be sufficient to permit a sex education curriculum with a "heavy emphasis on prevention of AIDS and other sexually transmitted diseases."[8]

Koop noted that while adults are reluctant to discuss sexual practices and homosexuality with children, adults need to be warned that only "frank, open discussions" with teenagers and even younger children will teach them how to protect their health. He urged abstinence for teenagers and said that the only safe sex was in "mutually faithful monogamous relationships" and recommended the use of a condom.

Koop urged that these lessons be reinforced at home, with open conversations between parents and children on sexuality and drug use, stating that "We warn our children early about the dangerous consequences of playing with matches or crossing the street before checking for traffic, . . . we have no less a responsibility to guide them in avoiding behaviors that may expose them to AIDS." He added in a subsequent interview that the threat of AIDS could provide an opportunity for parents to instill in their

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[8]Koop, 31.

children their own moral and ethical standards."[9]

Koop's report surprised many because his candid recommendations contradicted the long established administration view that explicit sex education belonged only in the home. Education Secretary William Bennett, an opponent of a national sex-education policy, endorsed many of Koop's conclusions in his own report one month later. Bennett said he was not opposed to community-based sex education in the schools, but added that, "There ought to be a place where kids can get the right scientific information, provided it is buttressed with the right moral teaching." He regarded parental involvement as crucial, stating, "Parents must know what is being said and must be informed."[10]

Koop's outspoken views earned praise as well as concern from the educators who would have to implement his recommendations. When one talks about HIV/AIDS, one needs to talk about sex, death, drugs and alternative lifestyles. Even seven and eight-year-old children have heard of AIDS on the television. Most Americans favor some form of sex education in school and forty states either support or

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[9]B. Kantrowitz, K. Springen, and M. Hager, "The Grim ABC's of AIDS." Newsweek (November 3, 1986): 66-67.

[10]Ibid.

require sex education according to the Alan Guttmacher Institute.[11]

With AIDS, the lack of accurate information can be fatal. A significant number of teenagers are sexually active; consequently, prevention of teenage pregnancy is the recent focus in sex education efforts. Koop's report urged all teenagers to avoid sex and drugs; and, more specifically, that teenage boys be told to avoid anal intercourse with other males because it, too, could lead to HIV infection and AIDS. Short of abstinence, condoms are the best known protection against the disease; the report also stressed avoidance of IV drug use and needle-sharing.[12]

When asked in an interview if he would want his grandchildren to be told how to use a condom, Koop responded, "I don't fear my grandchildren being told that, because their parents have trained them in morality, in taking responsibility for their sexual behavior. But, since no one can guarantee abstinence and monogamy, you have to let people know the alternative."[13]

Koop concluded by professing the ideal instruction in human development, including sexuality, would involve a

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[11]A. Guttmacher Institute, Risk and Responsibility: Teaching Sex Education in America's Schools Today, (New York: Alan Guttmacher Institute, 1989).

[12]Koop, 18.

[13]N. Needham, "Gruff, Tough and No Bluff." NEA Today 7 (no. 7, February 1989): 10-11.

partnership of parents, schools, clergy, and civic groups. If one of the partners is weak, the others can take up the slack. He added that parents should not be frightened by what their children are taught in school: rather, they should use the occasion to teach their own values.

National Academy of Sciences and Institute of Medicine Report

On October 30, 1986, a week after Koop's initial recommendations, the National Academy of Sciences and the Institute of Medicine issued an update of a previous report, "Confronting AIDS." In this follow-up report, the Academy blamed the absence of strong federal leadership for the dimensions of the AIDS problem. The Institute of Medicine, established in 1970, is an arm of the National Academy of Science, established in 1863 by Congress as a private, nonprofit, self-governing corporation to further science and technology and to advise the federal government upon request within its field of competence.

This National Academy devoted its annual meeting in 1985 to AIDS,[14] and followed up this meeting with its report, a 390-page document, which recommended a massive media, educational, and public health campaign to curb the spread of HIV infection by changing high-risk behavior. The

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[14]Institute of Medicine and National Academy of Sciences, Mobilizing against AIDS: The Unfinished story of a virus, (Mass., Harvard University Press, 1986).

Academy report further recommended a long term, comprehensive research program in the biomedical and social sciences to prevent or treat HIV infection and its complications. Implementation would require considerable funding to prevent a catastrophic HIV/AIDS epidemic in the U.S. since a vaccine or a cure for AIDS was not imminent.

Committee members, representing some of the nation's top ranked universities, called for "plain talk" or straight forward language, to combat the sexually transmitted disease, AIDS. Adolescents were specifically targeted for education as it is largely teens who are experimenting with unprotected sex and drugs--two high risk behaviors most closely tied to the spread of the HIV/AIDS virus. The report continued to say that, ". . . if an educational campaign is to change behavior that spreads HIV, its message must be as direct as possible." Echoing Koop's report, the Academy affirmed that sex education in the schools was a "life or death matter." The report urged that educators "be prepared to teach that intercourse without a condom was very risky," and to "use whatever vernacular necessary for that message to be understood."

In addition to those sexual practices that could spread the AIDS virus, educators should also point out which practices are safe. The Academy report stressed that this information should get maximum exposure, especially within the African-American and Hispanic communities where AIDS

infections are disproportionately high. The committee recommended the removal of legal and administrative barriers to the use of paid television for these educational purposes. The report concluded by stating that a large-scale "media, educational, and public health campaign" was the only avenue to prevent the spread of the disease, and this could not be achieved without a big increase in federal spending.[15]

Dr. David Baltimore, the Nobel Prize winning biologist from the Massachusetts Institute of Technology who co-chaired the study with Dr. Sheldon Wolff of Tufts University School of Medicine, said, "We are quite honestly frightened about the prospects here and feel that the problem requires Presidential leadership."[16] They urged President Reagan to establish a national commission on AIDS to coordinate efforts to combat the disease and also to take a leadership role in making control of AIDS a major national goal (This commission was subsequently established in May, 1987.)

World Health Organization

Two weeks following the preceding reports, in mid-November, the World Health Organization admitted that it was late in responding to the seriousness of the AIDS problem

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[15]Ibid.

[16]A. Lewis, "A Dangerous Silence," Phi Delta Kappan (January 1987): 348-9.

and announced that it was launching a major education and research campaign focused on AIDS.[17]

President Reagan

On February 11, 1987, President Reagan, in his Domestic Policy Council Memorandum, established the following principles to guide Federal assistance regarding AIDS education:

1. Despite intensive research efforts, prevention is the only effective AIDS control strategy at present. Thus, there should be an aggressive Federal effort in AIDS education.

2. The scope and content of the school portion of this AIDS education effort should be locally determined and should be consistent with parental values.

3. The Federal role should focus on developing and conveying accurate health information on AIDS to educators and others, not mandating a specific school curriculum on this subject, and trusting the American people to use this information in a manner appropriate to their community's needs.

4. Any health information developed by the federal government that will be used for education should encourage responsible sexual behavior--based on fidelity, commitment, and maturity, placing sexuality within the context of marriage.

5. Any health information provided by the Federal Government that might be used in schools should teach that children should not engage in sex, and should be used with the consent and involvement of parents.[18]

Six years into the epidemic, the Reagan administration

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[17]World Health Organization, Report on AIDS (Geneva, World Health Organization, November, 1986).

[18]Reagan, R., Domestic Policy Council Memorandum, (Feb. 11, 1987), in Bennett, W., AIDS and the Education of Our Children, U.S. Department of Education): 1988): i.

finally approved an aggressive HIV/AIDS education effort after months of internal dispute and the issuance of the highly praised Surgeon General's report; however, that education effort was to emphasize sexuality within the context of marriage and teach children to avoid sex. These guidelines were to become, for most subsequent reports, doctrine.

During early April 1987, while HIV/AIDS became the number one health concern (superceding cancer and health care costs), President Reagan, responded with his infamous lines, "It's not how you do it--it's: Don't do it;" "Just say no, abstain from sex before marriage and be monogamous thereafter;" and, "Say no to drugs."[19]

One month later in May 1987, President Reagan said, "No one knows to what extent the virus has infected our entire society, it is time we knew exactly what we are facing."[20] With that statement he announced the formation of a national commission to render advice on ways of dealing with the spread of AIDS. This commission was asked to review research, assess the long term impact on the health care system, and recommend ways to protect those who do not have the disease. It would have advisory power only and would not be separate from already existing cabinet offices.

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[19]M. Kramer, "Facing Life in the AIDies," U.S. News and World Report (June 15, 1987): 13.

[20]Ibid.

Money for research on HIV/AIDS at this time, came from the Congress, not the executive branch. Later Secretary of Education William Bennett issued his report, and at this time was heard to comment to a group of educational textbook writers (when asked about AIDS education) that he expected curriculum materials on AIDS to become a "growth industry."[21]

Secretary of Education

William J. Bennett, Secretary of Education for the U.S. Department of Education, issued a guide for parents and teachers entitled "AIDS and the Education of Our Children," in October 1987.[22] This twenty-eight page handbook provided information about the disease AIDS and placed the discussion of how best to teach school children about AIDS and HIV transmission within a solid moral framework.

The handbook was divided into three sections. The first of these reviewed what was currently known about AIDS; the second presented a framework for AIDS education; and the third listed additional sources of information about the disease. Bennett's report did not conceal the fact that male homosexual intercourse was the most common means by which AIDS was transmitted, with intravenous drug use being

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[21]Ibid.

[22]Bennett, W. J., AIDS and the Education of Our Children: A Guide for Parents and Teachers, (U.S. Department of Education, Consumer Information Center, Dept. ED, Pueblo, Colo.) October 1987.

the second most common means.

Bennett wrote that the cities with over half of the reported AIDS cases included New York, San Francisco, Los Angeles, Houston, Miami, and Washington, D.C.; and he emphasized that America's young people were especially at risk. He demonstrated this point with statistical information not unlike the statistics presented earlier. His report, like others, warned that there was no cure or vaccine for AIDS, stating that with the multiple strains of the virus the development of an effective vaccine was probably all but impossible. "While AIDS is always fatal," Secretary Bennett underscored in his introduction, "...the key fact young people (as well as adults) need to know is this: there is much they can do to avoid contracting AIDS. Most cases of AIDS result from behavior that can be avoided."[23]

The second part of Bennett's handbook discusses four principles of HIV/AIDS education to guide parents, schools and community. The first of these is that "Children should be helped to develop clear standards of right and wrong." Specific means to accomplish this would be to "Teach restraint as a virtue, present sex education within a moral context, speak up for the institution of the family, and set clear and specific rules regarding behavior." The second principle is "To set a good example." The actions suggested

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[23]Ibid., iv.

to do this are to "Demonstrate moral standards through personal example and follow the principles of good health, demonstrate responsibility for others in personal relationships." The third principle is to "Help children resist social pressures to engage in dangerous activities." Means of implementation are to "Help students identify negative pressures, be attentive to children's behavior inside and outside of school, encourage students to provide a good example to their peers, and be able to discuss drugs knowledgeably." The last principle is to instruct children about AIDS. This last principle can be enhanced by "Providing the facts about AIDS, talking to children about their fears, teaching about sex in a way that emphasizes the reasons for abstinence, restraint, and responsibility, getting the community involved in AIDS education, teaching drug prevention to children and finding appropriate opportunities to discuss AIDS."[24]

In this section Bennett presents a rather extensive discussion on "Condoms and AIDS" in which he notes that "Condoms can reduce, but by no means eliminate the risk of contracting AIDS." He adds that any discussion of condoms must not undermine the importance of restraint and responsibility in the minds of young people; although condoms have been around for a long time, teen pregnancy has increased. He points out that this paradox results because

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[24]Ibid., 9-17 passim.

condoms fail (especially when used in homosexual activity) and, even though teens know about condoms, they fail to use them. This section concludes with a cautionary note to the reader that promotion of the use of condoms may suggest to teenagers that adults expect them to engage in sexual intercourse, and that this issue must be kept in mind in any discussion.[25]

The handbook also contains a discussion of laws concerning students and school personnel who have HIV/AIDS and lists guidelines for selecting appropriate materials to teach about the sensitive subjects associated with AIDS. The booklet concludes with a list of resources about AIDS, such as books, pamphlets, and hot line numbers.

Presidential AIDS Commission

Not until June 24, 1988, did the chairman of the President's AIDS commission issue its national policy recommendations. This Commission was originally established June 25, 1987, with members appointed by White House domestic policy advisor Gary Bauer, a protege of Education Secretary William Bennett. The Commission was asked to advise the President and Secretary of Health and Human Service and other relevant cabinet heads on the public health dangers, including the medical, legal, ethical, social and economic impact from the spread of the human

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[25]Ibid., 16.

immunodeficiency virus (HIV) and its resulting illnesses. The Commission was also asked to recommend measures that Federal, State, and local officials could take to protect the public from contracting HIV, assist in finding a cure for AIDS, and care for those who already had the disease.

The original eleven Commission members were led by chairpersons, Dr. Eugene Mayberry and Woodrow Myers. Because of internal turmoil and lack of administrative support, the two chairpersons resigned. President Reagan then appointed Admiral James D. Watkins, the former Chief of Naval Operations and member of the Joint Chiefs of Staff, as the chairperson. Some critics felt that the original commission was stacked heavily with conservative idealogues who had little background knowledge about AIDS. To temper this attitude, Watkins insisted on two key elements for his Commission: 1) credible testimony in public hearings as the basis for recommendations (rather than any preconceived ideologies of Commissioners); and 2) the regular appearance of HIV-infected persons to put more abstract issues into human perspective. As was described by one of its members:

> "The Commission was made up of thirteen individuals. By non-mutually exclusive categories, we were eight men, five women, one Black, one gay, five physicians, two nurses, two academics, one minister, one legislator, one publisher, five business executives, one government official, one sailor; geographically, seven from New York/Washington, three from the Midwest,

two from the West Coast, and one Southerner."[26]

Their final report made 579 specific recommendations based on testimony from over six hundred of the most knowledgeable witnesses in over forty hearings. By insisting that witnesses present their testimony in understandable language, the report became a useful document in which an individual could find guidance. The final report was consistent with valid public health principles and recognized the role of local decision-making in translating ideas to action essential to long term success. Thus, the report can be used as an understandable and useful resource document for policy makers at the local level.

Two subsequent motions as a result of the report of this Commission were included in a recent HIV Act.[27] These motions resulted in the creation of a new Commission and the use of a formula to determine the distribution of funds to state programs. Additionally, the report confirmed the concept that the state is the basis of the public health system and recommendations for state legislative improvements were made, many of which, such as funding, testing and education. were consequently enacted.

One of the biggest problems identified by the

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[26]Gebbie, K. M., "The President's Commission on AIDS: What Did It Do?" American Journal of Public Health 79 (no. 7, July 1989): 868.

[27]U.S. Public Health Laws 100-607, signed November 4, 1988.

Commission's report was the failure to offer each child the knowledge basis for healthy adult life. As stated in the executive summary, "Knowledge is a critical weapon against HIV--knowledge about the virus and how it is transmitted, knowledge of how to maintain one's health, and knowledge of one's own infection status. It is critical that knowledge lead to responsibility toward oneself and others. It is the responsibility of all Americans to become educated about HIV."[28]

Chapter Seven of the Commission's Report is entirely devoted to the subject of education. The introduction to this chapter is emphatic in stating that HIV-related education take place in as many locations as possible, including the home, church, community agencies and the schools, both within and outside of society's mainstream. Nevertheless, a great deal of sometimes "acrimonious debate" over the content of HIV education has occurred. The Commission was concerned that, "In the promotion of the personal, moral, and political values of those from both ends of the political spectrum, the consistent distribution of clear, factual information about HIV transmission has suffered." Consequently, HIV/AIDS education prevention programs, for example, "Should discourage promiscuous sexual activity and recognize the benefits of abstinence and

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[28]The Presidential Commission, The Report of Human Immunodeficiency Virus Epidemic, (Washington, D.C.: Government Printing Office, June 1988): XVII.

monogamy, yet be explicit in nature so that there is no confusion about how to avoid acquiring or transmitting the virus."[29] The Report's introduction asserts that it is possible to develop educational materials and programs that convey this message without promoting high risk behaviors other reports infer will occur. The Report stresses that HIV/AIDS education programs must emphasize personal responsibility for one's actions and the subsequent consequences. The Commission recommends that state departments of health should assume the responsibility for coordinating HIV-AIDS related education initiatives, including the development of both one and five year plans to define the state's response (by January 1, 1989, and January 1, 1993).

Section One of the the Commission's chapter on Education addresses the topic of general public education. This section includes information that every citizen should know, such as, basic facts about HIV infection and AIDS, and the obligation to be caring and non-discriminatory; further, it lists resources for more information. The role of the media is discussed in terms of its opportunity to enhance the public's knowledge and attitudes about HIV, by providing constant, accurate information about the epidemic and support for community educational activities. Also included in this first section are the important functions

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[29]Ibid., 83.

of the National AIDS hot line which provides educational information in a professional, confidential, direct manner to anyone that calls; and the National AIDS Clearinghouse, a resource for public health officials and health care providers. Both of these services are resources operated by the Centers for Disease Control (CDC). Noteworthy is the recommendation that information related to curricula and instruction produced by school districts or state departments of health be cataloged and made available.

Section two of the chapter on education discusses the importance of targeting distinct populations and recognizing their unique educational needs. The Commission, quite aware that, while the AIDS epidemic affects all segments of society, behavior, and not membership in a particular group or population, was the factor that placed a person at greater risk for HIV infection. Nevertheless, assessment of the educational needs of a community must occur at the local level in order to meet the community's specialized needs. These recommendations focused on the needs of minority populations, hard to reach populations, runaway and homeless youth, and those with learning or physical impairments.

Section three of the chapter of education responds to the lack of HIV/AIDS education in the schools. Divided into two subject areas, the first talks of the immediate need for HIV/AIDS education, and the second, of the need for long term comprehensive health education. Immediate need for

HIV/AIDS education in the schools exists for elementary and secondary students. The content of this education should include both current and accurate information about the AIDS epidemic at an age appropriate level. Current and accurate information is essential so that students can make informed decisions about their behavior and avoid actions that put them at risk for HIV infection. The report emphasizes that "School based education should highlight the benefits of character development, abstinence, and monogamy."[30]

Decisions about appropriate content and methods of instruction should be determined at the local level because HIV/AIDS involves one's most personal behaviors; accordingly, many educators may find incorporating a standard HIV/AIDS curricula into all classroom programs difficult. For example, some communities, the report explains, still do not believe that the HIV/AIDS epidemic is something that will ever affect them and, therefore, do not see a need to provide HIV-related education to their students; consequently, funding for additional educational material and teacher preparation is insufficient.

The Commission report recommended that state boards of education mandate age appropriate HIV/AIDS education curricula for all students. Information about the epidemic and model curricula are to be developed with assistance from the state's department of health. School staff delivering

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[30]Ibid., 88.

HIV/AIDS education should receive extensive inservice education before beginning instruction, and no one should be forced to teach the content if not comfortable with the subject.

The report also recommended the establishment of local advisory committees to monitor and evaluate the HIV school-based education. Further, funds need to be increased in order to design and implement HIV/AIDS education curricula, to publish newsletters, and to convoke conferences in order to disseminate current information and model programs. They recommended that the CDC increase funds to colleges and universities for the creation and/or expansion of HIV/AIDS prevention and education programs on campus.

Another major point that the Commission emphasized was that an age-appropriate, comprehensive health education curriculum that encompassed grades K-12 be introduced in each state. To provide HIV/AIDS education is a significant step--yet it is only a temporary measure to correct a larger problem. The expert witnesses who testified before the Commission clearly demonstrated that "The problems that are afflicting youth today, such as sexually transmitted diseases including HIV infection, drug abuse, school-aged pregnancy, and decisions to drop out or run away, are all inseparably intertwined." They add, "That the HIV epidemic provides a unique impetus to address these problems in total rather than continue the piecemeal, fractured, and largely

ineffective approach that is being undertaken today."[31]

Many illnesses are related to lifestyle or long term patterns of behavior which include, smoking, drinking, eating too many calories or too much fat, and being inactive. Other behavior relevant to health and illness are responses to the mental and physical stresses of events in life. What is done early in life lays the foundation for the rest of one's life, and if health oriented, can be the basis for a healthy and cost effective life span.

The Commission report discusses adolescent changes that occur both physically and socially, and states that the ages ten to fifteen are highly formative for health relevant behavior patterns such as cigarette smoking, alcohol use, drug use, eating disorders, and exercise habits, and sexual activity.

Because of the highly formative nature of the pre-teen and adolescent years as well as societal changes (such as a breakdown in family support), the Commission believed that comprehensive health education, taught through a life science curriculum, would offer ". . . a distinct opportunity to stimulate early interest in science and to learn how to deal more effectively with matters of deep human concern."[32] To this end, they recommended that the President direct the Secretary of Health and Human Services

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[31]Ibid., 89.

[32]Ibid., 90.

and the Secretary of Education to co-chair a task force on comprehensive, school-based health programs for all students in grades K-12 to be fully implemented by the year 2000.

The Centers for Disease Control (CDC)

In 1986, the Centers for Disease Control (CDC) was designated the lead agency within the Public Health Service (PHS) for AIDS information, education, and risk reduction activities, currently the agency's only preventative intervention. The AIDS prevention program includes surveillance and epidemiological studies as well as information and education programs directed toward the general public, school and college-aged youth, persons at increased risk for infection, and health care workers. These four components of the prevention program conform to the major elements of the U.S. Public Health Service's "Information Education Plan to Prevent and Control the Spread of AIDS in the United States."[33]

Prior to this designation, the CDC had already addressed the needs of children infected with AIDS in its Guidelines for Education and Foster Care of Children with HIV issued on Aug. 30, 1985.[34] These guidelines were used

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[33]Centers for Disease Control, Information and Education Plan to Prevent and Control AIDS in the United States, Washington, D.C., Public Health Service, March 1987).

[34]Centers for Disease Control, "Education and Foster Care of Children Infected With Human T-Lymphotrophic Virus Type III/Lymphadenopathy-Associated Virus," MMWR 34 (1985): 517-521.

to establish policies for schools for HIV infected students.

In addition to several national meetings convened by the CDC concerning HIV/AIDS, the CDC recognized the magnitude of HIV/AIDS as the nations major health problem and that the education of the public needed to be seen as a long-term undertaking. CDC's answer to this was a major campaign called, "America Responds to AIDS," which began in July 1987. The initial campaign included the following: designation of October 1987, by President Reagan as "AIDS Awareness and Prevention Month;" the distribution of many public service announcements and advertisements for the media; mobilization of public and private organizations in AIDS prevention efforts; and a brochure to be distributed to every household as ordered by a Congressional mandate.

This brochure, proposed by the CDC, was sent under the name of Surgeon General Koop early in the summer of 1988 via the Public Health Service to every household (one hundred seven million copies in English and four million in Spanish) in the country. Entitled, "Understanding AIDS,"[35] the brochure contained detailed information telling Americans how to protect themselves and their families against HIV infection and AIDS. Public acceptance of the Surgeon General's brochure was extremely positive with almost all who received it, glad to get it, and feeling that it was a

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[35]Koop, C.E, "Understanding AIDS" (DHSS Publication No. HHS-88-8404, Rockville, Md., Public Health Service, 1988).

good use of their tax dollar; very few were offended by it. Whether its purpose to "increase knowledge and influence attitudes and beliefs," was achieved will be determined by future studies.[36]

To extend the impact of the AIDS school health educational effort, in September 1987, cooperative agreements were signed with fifteen national, private sector organizations with the capacity, constituency, and experience to help schools in communities across the nation provide effective AIDS education, as well as assisting state and local health departments. Five of these cooperative agreements were awarded to national organizations that addressed the specific educational needs and interests of black and Hispanic youth. Seven awards were made to organizations that would increase the number of schools and agencies serving out of school youths that provide effective education about AIDS. Two awards were made to organizations to help State departments of education provide effective education about AIDS, and one award was made to an organization representing college health services to help colleges and universities provide effective education about AIDS. (See Appendix B for cooperative agreements list).

In addition, cooperative agreements were established with fifteen state and twelve local education agencies that

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[36]B. Gerbert, B. and B. Maguire, "Public Acceptance of the Surgeon General's Brochure on AIDS." Public Health Reports 104 (no. 2, March-April 1989): 130-133.

serve jurisdictions with the highest cumulative incidence of AIDS to provide intensive, locally determined education for school-aged populations. The following fiscal year, 1988, CDC extended this assistance to all state departments of education.

Meanwhile, with respect to AIDS education in the schools, the CDC published Guidelines for Effective School Health Education To Prevent the Spread of AIDS[37], a fourteen page supplement to the CDC's Morbidity and Mortality Weekly Report on January 29, 1988. The Guidelines were developed in consultation with representatives from fifteen national organizations, and incorporated the principles for AIDS education based on the President's Domestic Policy Council Memorandum by recommending that the scope and content of school health education about AIDS be locally determined and consistent with parental and community values.

A summary of the Guidelines based on testimony presented to the U.S. House of Representatives Committee on Education and Labor, February 3, 1988, offered nine recommendations:

1) Parents, teachers, students, and appropriate community representatives should be involved in the developing, implementing, and assessing AIDS education policies and programs.

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[37]Centers for Disease Control, "Guidelines For Effective School Health Education to Prevent the Spread of AIDS," MMWR 37 (Suppl. No S-2, Atlanta, Ga: Centers for Disease Control, 1988): 1-14.

2) AIDS education should be developed as an important part of a more comprehensive school health education program.

3) Education about AIDS should be taught by regular classroom teachers in elementary grades and by qualified health education teachers or other similarly trained personnel in secondary grades.

4) AIDS education programs should help students acquire essential knowledge to prevent HIV infection at each appropriate grade.

5) AIDS education programs should describe the benefits of abstinence for young people and of mutually monogamous relationships within the context of marriage for adults.

6) Education about AIDS should be designed to help teenage students avoid specific behavior that increases the risk of becoming infected with HIV.

7) Training about AIDS and AIDS education should be provided for school administrators, teachers, nurses, and counselors, especially those who teach about AIDS.

8) Sufficient program development time, classroom time, and educational materials should be provided for education about AIDS.

9) The processes and outcomes of AIDS education should be monitored and assessed periodically.[38]

Specifically, the Guidelines recommended that students receive essential information about AIDS at certain grade level ranges (early elementary school, late elementary/middle school, junior high/senior high school), with the exact grades determined locally in accord with community and parental values. (Appendix C - Full copy of Guidelines)

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[38]D. Tolsmas, "Activities of the Centers for Disease Control in AIDS Education," Journal of School Health, 58, (no. 4, April 1988): 135.

Again, the AIDS epidemic was well into its fifth year before governmental agencies responded in providing direction for educating the American public and more specifically America's youth. The Surgeon General began the initiative with a curriculum plan that was explicit in language and direct in approach to teaching all children about AIDS. Both President Reagan and Secretary of Education William Bennett responded with similar statements regarding AIDS education for children (though in a less explicit but more moralistic manner) that did not include a specific curriculum plan. Concurrently, the Centers for Disease Control were assisting communities that faced high-risk populations, including some large urban school districts, by providing specific curricula to guide teachers with their lesson plans. Furthermore, the National Academy of Science and Institute of Medicine Report, chastised the response of the federal government and urged the implementation of AIDS content for school aged children.

Other organizational reports have emerged in response to the AIDS epidemic. The 1986 report from the National School Boards of Education (NSBE)[39] had as its primary objectives to provide school board members with medical facts known about AIDS, information about the legal implications of AIDS in the school setting, and an overview

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[39]S. Hooper, S. and G. Gregory, AIDS and the Public Schools, (Alexandria, Va: National School Boards Association, 1986).

of possible school board policy responses to AIDS. The report examined the dilemmas of developing a curriculum for HIV/AIDS education throughout the country. Some local boards of education and even some state boards of education demonstrated resistance to introducing any sensitive subject, many far less sensitive than AIDS; for example, some school districts had yet to adopt comprehensive sex education.

Dr. Meyer, Indiana State Health Commissioner, stated in the NSBE report that, "We have tried for twenty years to encourage state legislators, and of course local school boards, to adopt a comprehensive K-12 health and education program that would encompass sex education for what we euphemistically call "Family Life."[40] The NSBE report suggested that HIV/AIDS education become part of classes other than sex or health education, classes such as general science, biology, psychology, civics, or current events. HIV/AIDS education should also include drug abuse prevention classes or workshops since in addition to being transmitted sexually, HIV can be transmitted by certain activities associated with drug abuse.

At the Local Level

While the national reports were being written, one might question what was occurring at the local level. Since

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[40]Ibid., 51.

no national comprehensive plan or document to assist schools in the development of their own HIV/AIDS education and prevention programs existed prior to the 1988 CDC Guidelines, many school districts in the country began developing their own policies and procedures about HIV/AIDS education.

The first program in the country specifically established to promote HIV/AIDS prevention for young people was created in San Francisco in 1984. Marcia Quackenbush was hired by the University of California at San Francisco AIDS Health Project to help coordinate an AIDS prevention program for teenagers living in an area populated with many HIV infected persons. She has since that time been instrumental in the development of prevention education material for teenagers and children.[41],[42]

In December 1986, the U.S. Conference of Mayors conducted a survey of forty of the seventy-three largest school districts and twenty-five state school agencies to assess the degree to which AIDS policies and education were already developed or implemented in the nation's schools.[43]

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[41]M. Quackenbush, M. Nelson, & K. Clark, eds., The AIDS Challenge: Prevention Education for Young People, (Santa Cruz, Ca: Network Publications, 1988).

[42]M. Quackenbush, & S. Villarreal, Does AIDS Hurt? Educating Young Children About AIDS, (Santa Cruz, Ca: Network Publications, 1988).

[43]U.S. Conference of Mayors, "Local School Districts Active in AIDS Education," AIDS Information Exchange 4 (January 1987): 1-10.

of the seventy-three local school districts, 54 percent were already providing some form of AIDS education to public school students. A small number of local school districts, especially those located in the metropolitan areas with the highest number of AIDS cases (New York, San Francisco, Los Angeles, Miami, and Houston), had initiated AIDS education programs early in the epidemic. Programs in these cities included such components as curriculum guides, educational materials for students, and staff and teacher training, The information these programs provided to students was detailed typically including the definition of AIDS, its causes and symptoms, routes of transmission, treatment, prevention (including safer sex information), and civil rights issues associated with the disease. Of the districts that offered HIV/AIDS education, 63 percent provided it in the seventh grade, 60 percent provided it in the ninth grade, and 90 percent provided it in tenth grade. Ninety-eight percent provided medical facts about HIV/AIDS, 78 percent mentioned abstinence as a means of avoiding infection, and 70 percent addressed the issues of avoiding high-risk sexual activities, selecting sexual partners, and using condoms. Most of the remaining districts responded that they were in the process of planning programs.[44]

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[44]United States Conference of Mayors,"Local School Districts Active in AIDS Education," AIDS Information Exchange 4 (1987): 1-10.

Conclusion

School is nearly a universal experience of all American children. This implies that teachers have the ability to reach 95 percent of the nation's youth or 45.5 million students in an optimal setting for conducting HIV/AIDS education and prevention programs, the one major intervention currently known that has the potential of limiting the consequences of HIV infection.[45]

A June 1987, survey conducted by the National Association of State Boards of Education revealed only five states had mandated HIV/AIDS education, although one year later twenty-three states and the District of Columbia required HIV/AIDS instruction. By the end of 1989, twenty-eight states and the District of Columbia had mandated HIV/AIDS education. The results of the data obtained from these jurisdictions will be analyzed considering the major federal recommendations regarding HIV/AIDS education in the schools with respect to the research questions posed in the previous chapter.

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[45]D.Haffner, AIDS and Adolescents: The Time for Prevention is NOW, (Washington, D.C., Center for Population Options, November 1987).

CHAPTER 3

STATE SURVEY ANALYSIS

Introduction

All children and adolescents are entitled to a health education that includes strategies to prevent contracting a terminal disease. Education about HIV/AIDS is different from education about other sexually transmitted diseases in that most sexually transmitted diseases are curable and none (which are not curable) are lethal.

At present, the only way to stop the spread of HIV infection will be to reduce behaviors that lead to transmission of the virus. HIV/AIDS education should begin in the schools, a near universal experience for America's youth, before they begin engaging in those behaviors.

Focusing questions were used to ascertain compliance with the federal recommendations described in the various reports analyzed. The primary question is, which states have mandated the implementation of an HIV/AIDS curriculum? Subsequently, other information related to policy implementation was collected. The information necessary to respond to the questions was acquired from the actual state policies on HIV/AIDS education, from kindergarten to grade twelve (K-12), from each state department of education

through the 1989-90 school year. In addition, a discussion of the activities of those states not mandating but implementing HIV/AIDS education is included.

States that Mandate HIV/AIDS Education

The first state to mandate HIV/AIDS education in the United States was Rhode Island in February, 1987. This action was followed by Virginia, Oklahoma, Nevada, Alabama, North Carolina, and Pennsylvania, all having legislated their state policies during the 1986-1987 school year. The next school year, 1987-1988, revealed a substantial increase in states (Delaware, Illinois, New York, Michigan, New Mexico, Georgia, Kentucky, Maryland, Washington, Oregon, South Dakota, Georgia, Kansas, Minnesota, Vermont, Connecticut, Florida, Iowa, Utah, and the District of Columbia) mandating HIV/AIDS education. The following school year, 1988-1989, brought the total number to twenty-eight states and D.C., West Virginia and Indiana having passed HIV/AIDS education legislation (see Table 7).

Considering the urgent necessity for HIV/AIDS education, several states responded to the call for state laws at a relatively rapid pace. However, some policies were found to be more comprehensive than others. For example, some specified K-12 HIV/AIDS instruction while other policies omitted specific grade levels in which the students would receive instruction. Yet, as Michigan and Minnesota, with fairly thorough policies, require that

districts offer HIV/AIDS education, but do not make such education a graduation requirement for students. This anomaly is addressed in the following discussion of actions taken by the twenty-nine states that legislated HIV/AIDS education in the schools.

Table 7.-- States mandating HIV/AIDS education, source of mandate and date passed.

STATE	SOURCE OF LEGISLATION	DATE PASSED
Alabama	Board of Education	June 1987
Connecticut	House Bill	June 1988
D. of C.	Board of Education	September 1987
Delaware	Board of Education	September 1987
Florida	House Bill	July 1988
Georgia	Senate Bill	May 1988
Illinois	Senate Bill	September 1987
Indiana	Board of Education	February 1989
Iowa	Senate Bill	July 1988
Kansas	Board of Education	May 1988
Kentucky	House Bill	March 1988
Maryland	Board of Education	March 1988
Michigan	Senate Bill	October 1987
Minnesota	Legislature	May 1988
Nevada	Assembly Bill	April 1987
New Mexico	Board of Education	October 1987
New York	Board of Regents	September 1987
N. Carolina	House Bill	July 1987
Oklahoma	House Bill	April 1987
Oregon	Administrative Rules	April 1988
Pennsylvania	Board of Education	July 1987
Rhode Island	Senate Bill	February 1987
South Dakota	Board of Education	April 1988
Tennessee	Board of Education	January 1988
Utah	Administrative Code	July 1988
Vermont	House Bill	June 1988
Virginia	House Bill	March 1987
Washington	Omnibus Bill	March 1988
W. Virginia	Board of Education	September 1988

Context of HIV/AIDS Education

A closer analysis of the policies of the twenty-nine jurisdictions mandating HIV/AIDS education policies follows. Of interest are the variety of options by which the local districts may accomplish their mandate some having more than one context within which to teach the content. Most often states added an HIV/AIDS education component to an existing program, such as their comprehensive health education program.

Comprehensive School Health Education (CHE), is defined as, "Health education in a school setting that is planned and carried out with the purpose of maintaining, reinforcing, or enhancing the health, health-related skills, and health attitudes and practices of children and youth that are conducive to their good health."[1] Comprehensive health education (CHE) is a requirement in many states for students from grades K-12. Comprehensive health education generally includes the following topic areas or curriculum strands: community health, consumer health, environmental health, family life, growth and development, nutritional health, personal health, prevention and control of disease and disorders, safety and accident prevention, and substance use and abuse. HIV/AIDS education is often presented during

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[1]National Professional School Health Education Organization, "Comprehensive School Health Education," Journal of School Health 54 (August 1984): 312-315.

more than one strand of the CHE curriculum, a fitting placement for the information and actions in the Centers for Disease Control (CDC) Guidelines, and the Presidential Commission on the HIV Epidemic.

To elaborate, the CDC's Guidelines for Effective School Health Education to Prevent the Spread of AIDS, stated that

> "Education about AIDS may be most appropriate and effective when carried out within a more comprehensive school health education program that establishes a foundation for understanding the relationships between personal behavior and health. It may also have greater impact when students already have had opportunities to develop decision-making and communicative skills, resistance to persuasion, and a sense of self-efficacy and self-esteem."[2]

In addition, the need for comprehensive school health education was repeated six months later by the report of the President's Commission on the HIV/AIDS Epidemic. That document concluded its chapter on HIV/AIDS education by recommending:

> "The President of the United States should direct the Secretary of Health and Human Services and the Secretary of Education to co-chair a task force on comprehensive school based health programs. And, that all schools, both public and private, should have comprehensive health education programs for grades K-12 fully implemented by the year 2000."[3]

Another context found for including HIV/AIDS education, was Family Life Education (FLE). This course or unit of instruction is commonly found at the secondary level.

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[2]CDC, Guidelines (1988): 3.

[3]Presidential Commission, HIV Epidemic (1988): 91.

Generally, family life education programs attempt to provide students with knowledge about individuals as sexual beings, as well as addressing such issues as family roles and responsibilities, parenting skills, human development and interpersonal relations.[4] Sexuality education (SE) may often be included as an important component of the more broadly defined FLE program or be a distinct educational program. The other contexts where HIV/AIDS education may occur in the school curriculum include basic health classes, or learning modules such as sexually transmitted diseases or human growth and development.

Of the twenty-nine jurisdictions that have mandated HIV/AIDS education, the following have done so through existing comprehensive health education requirements: Alabama, District of Columbia, Delaware, Florida, Georgia, Illinois, Indiana, New Mexico, New York, North Carolina, and Vermont.

Additionally, several states provide more than one context for HIV/AIDS education. The content areas and states are as follow:

Communicable and or sexually transmitted disease requirement--District of Columbia, Michigan, Washington, Kansas and Utah;

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[4]S. Koblinsky and J. Weeks, "Family Life Education in California Ninth and Tenth Grades," Journal of School Health 54 (May 1984): 181.

Basic Health Education Requirement--Oregon, Pennsylvania, and West Virginia;

Family life Course--Iowa, Kentucky, Rhode Island, and Virginia;

Human growth and development--Iowa, Nevada, and Rhode Island;

Sexuality education--Georgia and Kansas;

Parenting skills--Kentucky; and

Life management--Florida.

The mandates in six states (Connecticut, Maryland, Minnesota, Oklahoma, South Dakota, and Tennessee) identify no context or give the local district the freedom to choose the area in which to teach HIV/AIDS content.

Lastly, four other states (Indiana, North Carolina, Vermont, and West Virginia) have mandated that the HIV/AIDS educational material be integrated throughout the curriculum in such courses as social studies, science, home economics, and health education.

After analysis, one might question: Have all the states with a comprehensive health education requirement mandated HIV/AIDS education? Inquiry into this domain was pursued by contacting the National Association of State Boards of Education, the agency which collects and maintains data of this type. Information was shared from results of a national phone survey completed to determine what the health

requirements were in each of the states and D.C.[5] Of the twenty-eight states and the District of Columbia where HIV/AIDS education was mandated, twenty states required comprehensive health education (CHE). Of the remaining nine states in the study, four states recommended CHE, two states required basic health education, and three of the states had no state health requirement at all. Of the thirty-eight states currently either requiring or recommending CHE, many incorporated HIV/AIDS content into their existing programs. Table 8 illustrates the educational context of HIV/AIDS education in the twenty-nine study jurisdictions.

Table 8. -- States Mandating HIV/AIDS Education and Their Health Education Requirements.

STATE	CHE Req.	CHE Rec.	Other Req.	None
Alabama	yes			
Connecticut			elective	
D.of C.	yes			
Delaware	yes			
Florida	yes			
Georgia	yes			
Illinois	yes			
Indiana	yes			
Iowa	yes			
Kansas		yes		
Kentucky			family life	
Maryland				none
Michigan		yes		
Minnesota	yes			
Nevada		yes		

[5]M. Schumacher, interview by author, National Association State Boards of Education, Alexandria, Va., July 1989.

Table 8. -- con't.

STATE	CHE Req.	CHE Rec.	Other Req.	None
New Mexico	yes			
New York	yes			
N. Carolina	yes			
Oklahoma				none
Oregon	yes			
Pennsylvania	yes			
Rhode Island	yes			
South Dakota				none
Tennessee	yes			
Utah	yes			
Vermont	yes			
Virginia	yes			
Washington		yes		
W. Virginia	yes			

Grade Levels

Identification of the specific states that have mandated HIV/AIDS education and the context in which the material is presented has been discussed. Next, the questions of grade levels HIV/AIDS content is presented, the frequency of instruction and how required learning outcomes are accomplished is discussed. As Surgeon General Koop stated, "Education about AIDS should start at an early age, so that children can grow up knowing the behaviors to avoid to protect themselves from exposure to the AIDS virus."[6]

[6]Koop, Surgeon General's Report, 5.

Of the twenty-eight states and the District of Columbia (D.C.) with HIV/AIDS education policy requirements, all but four (Indiana, Minnesota, Nevada, Tennessee) indicate a specific grade level or range of grade levels. Seventeen states (Connecticut, Delaware, Iowa, Kansas, Kentucky, Maryland, Michigan, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, and Washington) and the District of Columbia require that initial HIV/AIDS education occur in the "early grades" (Grades K-5). Six states (Alabama, Georgia, Illinois, North Carolina, Oklahoma, and West Virginia) require it in the middle grades (6-8). Only Florida requires it in either grade nine or ten.

Although Kentucky is the only state with a policy to formally address the specific amount of instructional time to be devoted to HIV/AIDS education, the policies of Oregon, South Dakota, and Washington require that HIV/AIDS prevention content be taught annually. Other states vary in their requirements between once in every three years in elementary to once in secondary school. Table 9 represents the grade levels at which HIV/AIDS content is to be presented as well as the states' requirements related to learning outcomes.

Table 9. -- Grade level HIV/AIDS education required and learning outcome requirements

STATE	GRADE LEVEL(S)	LEARNING OUTCOMES REQ.	REC.	NONE
Alabama	5-12	x		
Connecticut	K-12			x
D.C.	4-12	x		
Delaware	3-12	x		
Florida	9 or 10	x		
Georgia	6-12	x		
Illinois	6-12	x		
Indiana	ns	x		
Iowa	1-12	x		
Kansas	E S		x	
Kentucky	K-12		x	
Maryland	3-12		x	
Michigan	3-12		x	
Minnesota	ns		x	
Nevada	ns		x	
New Mexico	E M S	x		
New York	E M S		x	
N. Carolina	7-12	x		
Oklahoma	7-12			x
Oregon	E M S	x		
Pennsylvania	E M S	x		
Rhode Island	E M S	x		
South Dakota	K-12			x
Tennessee	ns	x		
Utah	3-12	x		
Vermont	E S		x	
Virginia	5-12	x		
Washington	5-12		x	
W. Virginia	6-12	x		

Abbreviations: ns=not specified; E=elementary; M=middle; S=secondary

Content of HIV/AIDS education

As a preface to this section, the following is a brief summary of federal documents' recommendations on HIV/AIDS content issues. The Guidelines for Effective School Health

Education To Prevent the Spread of AIDS, from the CDC's Department of Health and Human Services, maintains that schools should assure that students receive at least the essential information about AIDS in each of three grade level ranges (Refer to Appendix C with specific age related content). This essential information should be given in accord with both community and parental values (in other words, this content is determined locally). Koop urged that instruction encourage and value abstinence and mutually faithful, monogamous relationships; however, instruction regarding the use of condoms should be included. Bennett added that there was much young people could do to escape contracting AIDS, such as avoiding such known high risk behaviors including IV drug use and sexual activity even with the use of condoms. The National Academy of Science report strongly urged the necessity of teaching, in whatever way that the message could be understood, that intercourse without condoms was a matter of life and death.

Essentially, each of the twenty-eight states (except Connecticut) and D.C., described in their individual policies that basic information about HIV/AIDS be presented at an age appropriate level, in congruence with community values. Such information should include general information about the nature of the disease, the routes of virus transmission, risk factors and behaviors associated with HIV contraction and general means of prevention.

In addition to the basic content to be presented, a review of the policies revealed some other interesting recommendations. Eighteen of the states required that abstinence from sexual intercourse until marriage be taught and seven of these states also required that students be taught the importance of monogamy within marriage. Illinois went one step further: besides its HIV/AIDS education law, Illinois legislated an additional law which requires that teachers teach abstinence from sexual intercourse and fidelity in marriage.

Fifteen of the states require that interpersonal - social skills be addressed formally in teaching the HIV/AIDS content at the various levels. Some of the skills listed are the processes of decision making, conflict resolution, goal setting, means of dealing with peer pressure, stress management, and self esteem building.

Thirteen of the states require that instructional content related to the avoidance of substance abuse, specifically intravenous drug use (IVDU) be presented as a major risk factor. Three states in particular, North Carolina, Oklahoma, and Oregon stress the relationship of needle sharing in the content related to IVDU and HIV transmission.

Seven states refer to use of condoms in their policies. Two states, Georgia and Kentucky, insist that condoms or any birth control device are not to distributed or sold anywhere

near the school nor should such devices or distribution of such devices be associated with any school clinic. Oklahoma and Washington curricula discuss the unreliability of condoms and Vermont's instructional materials delineate the consequences of not using a condom. At the other end of the spectrum are North Carolina and Oregon which require condom instruction. In addition, Oregon is also the only state whose policy requires instruction in techniques of "safe sex."

Lastly, there is specific content unique to individual states. As far as content on alternative life styles, the Oklahoma policy is the only state that mandates that homosexuality be discussed in its instruction. Alabama policy, on the other hand, states that content related to homosexuality is to be avoided at all costs unless deemed "absolutely necessary." Finally, Tennessee is the lone state that deals with the concept of "universal precautions" for handling blood and body fluids in its HIV/AIDS education policy. Table 10 illustrates how the life style content areas are incorporated into the state policies.

Table 10. -- HIV/AIDS Education Life Style Content Areas in State Policies

STATE	A	M	SKILLS	IVDU	CONDOMS	HS
Alabama	x	x	x	x		x
Connecticut	x			x		
D. of C.*						
Delaware	x					
Florida	x	x	x	x		
Georgia	x		x		x	
Illinois	x	x		x		
Indiana	x	x				
Iowa	x		x	x		
Kansas			x			
Kentucky	x		x	x	x	
Maryland			x			
Michigan*						
Minnesota			x			
Nevada*						
New Mexico	x		x	x		
New York	x			x		
N. Carolina	x		x	x	x	
Oklahoma				x	x	x
Oregon	x	x	x	x	x	
Pennsylvania	x					
Rhode Island	x					
South Dakota*						
Tennessee*						
Utah	x	x				
Vermont	x	x				
Virginia			x			
Washington	x	x	x	x	x	
W. Virginia	x		x			

Abbreviations: A = Abstinence; M = Monogamy; Skills = self-esteem, decision making, refusal skills, coping with peer pressure; IVDU = intravenous drug use; HS = homosexuality, * = not specifically addressed in policy.

Parental and Community Support

Parents are the primary educators of children about morals and values, personal relationships, sexuality and self-esteem. Moreover, what the child sees in practice in the home is what he or she learns to generalize to the rest of the world. School based education in these areas is reinforced if children relate such education to the values they learn at home. Parents need to be involved in both the development and evaluation of lessons on these topics. They should be encouraged to preview any health and HIV/AIDS teaching materials used to instruct their children. In a multi-cultural society, community input and parental involvement are important components to consider when teaching content such as drug use and abuse and human sexuality in this age of AIDS.

Parental advisory groups should be involved in the health education being presented to their children. However, three basic premises underlie the concept of advisory groups: First, involving representative lay people, including parents, in the planning phase speeds the process of educational change among individuals. Second, when lay people are involved in decisions the results are "better" than ones made solely by professionals. Third, individual involvement in planning provides a beneficial

learning experience.[7]

The specific scope and content of HIV/AIDS education in schools should be locally determined and should be consistent with parental and community values. The CDC Guidelines state, "That school systems should obtain broad community participation to ensure that school health education policies and programs to prevent the spread of AIDS are locally determined and are consistent with community values."[8] Each community advisory group should have representatives from the school board, faculty, parents, students, school health services, local medical societies, the local health department, minority groups, religious organizations, business leaders, and any other pertinent organization. By having an advisory council and community involvement, various opinions and perspectives can be heard, problems resolved, and a commitment for implementing and maintaining HIV/AIDS education programs at a local standard can be achieved. In addition, the President's Domestic Council Memorandum agreed that the scope and content of the school responsibility of HIV/AIDS education effort be locally determined and should be consistent with parental values.[9]

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[7]S. Dorman and D. Foulk, "Characteristics of School Health Education Advisory Councils," Journal of School Health 57 (October 1987): 337.

[8]CDC, Guidelines (1988): 2.

[9]R. Reagan, Domestic policy memorandum, Feb. 11, 1987.

The policies were reviewed to ascertain documentation of parental involvement and local community support in developing and implementing school based HIV/AIDS education programs.

First, the policies were analyzed for evidence of parental involvement with HIV/AIDS education classes. The role of parents took a variety of forms in HIV/AIDS education. Maryland offered an annual parent awareness program; in West Virginia, parents were encouraged to attend staff development sessions; Pennsylvania required that instructional materials be made available to all parents; and Washington required that parents attend meetings about the HIV/AIDS education program before they have the option of exempting their children from such education. Twenty-one states (Alabama, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Maryland, Michigan, Nevada, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia) and the District of Columbia, made specific provisions for student exemption for all or parts of the HIV/AIDS instruction. Most states requested a note from the parent stating the reason for the exemption, i.e. religious or moral, before the child would be excused. Two states, New York and Tennessee, added, that in order for the student to be excused, the parents needed to agree to teach the required HIV/AIDS content that the school would have taught.

Three other states, Kentucky, Nevada, and Utah required written parental permission prior to the class on HIV/AIDS, so that parents are aware of what and when their child would be learning about HIV/AIDS in class.

Seven states (Connecticut, Delaware, Indiana, Minnesota, North Carolina, New Mexico, and South Dakota) did not mention this exemption clause in their HIV/AIDS policy. According to a NASBE staff researcher though, there is usually a policy that exists in other education policies that give parents the right to exempt their child if any education conflicts with parental moral and or religious beliefs.

Second, nearly every state policy requiring HIV/AIDS education provides a role for the local community in developing and implementing an HIV/AIDS school based education program. This responsibility is usually accomplished by requiring districts to form local advisory boards to ensure that HIV/AIDS education programs are consistent with local values. Fourteen of the twenty-nine jurisdictions have provisions for local advisory boards. Some boards are involved in actually creating the local plan while others serve as advisors to their school boards. Ten other states' policies address the role of parents in various capacities, primarily through HIV/AIDS informative AIDS awareness programs.

Teacher Training

The Presidential Commission recommended that all teachers and school personnel have training in the area of HIV/AIDS education. To achieve this need, the CDC has assisted states and school districts via state departments of health by providing financial and medical advisory assistance to school districts for HIV/AIDS education. Most of the states hold regional training workshops that train district teams to coordinate the training of HIV/AIDS education teachers and district staff. These programs vary in the length of the program or staff inservice and also in the frequency of informational offerings; some of the policy statements specify that instructor inservices will be held annually and others are non-specified.

Three states stand out in their approach to instructing teachers and staff about HIV/AIDS. Oregon's annual Seaside Health Promotion Conference is nationally respected for its innovative approach to improving and redesigning school health programs. The State Education and Health Agencies host the annual event and invite a limited number of districts to send teams to participate in the conference. These teams learn about comprehensive health education and wellness in the broadest sense. Vermont also hosts an annual conference known as the Mountainside Wellness Conference in which the state health education center and state education sponsor HIV/AIDS training. Nevada has a

Prevention Plus Summer Institute, an annual conference of health promotion for educators and administrators. Co-sponsored by the State Education Agency and the Nevada Rural Alliance, the Institute includes ample information about HIV/AIDS education. There is no expense for participants and graduate credit is available.[10]

A few states are working with institutions and boards of higher education to incorporate HIV/AIDS information into certification standards for health educators. Kansas is in the process of developing teacher certification requirements for teaching human sexuality. Its State Education Agency will work with teacher education institutions and make recommendations that will go before the State Professional Standards Board and the State Board of Education for final approval. Only instructors who teach an entire class on human sexuality must be specifically certified. Those who teach human sexuality as part of a larger subject will not need certification but will be encouraged to receive training. Besides Kansas, other states enacting certification requirements for health educators are Kentucky, Rhode Island, and Utah.

Each of the twenty-nine jurisdictions has either developed grade specific models for districts, special guides for teachers, state models, or supplements for

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[10]NASBE, personal correspondence with M. Schumacher, August 1989.

existing health curricula instructional units. While some of the materials are locally produced based on CDC guidelines for content, all need approval by either the local district or the state board. Only Nevada and Pennsylvania specify in their state mandate that instructional materials should be developed by each local district according to the needs and values of their geographic area, population and risk factors. Several of the state education agencies work with their HIV/AIDS education advisory boards to review and recommend HIV/AIDS education curricula.

During the examination of curricular materials, it was interesting to discover some of the ways that different states have handled the dissemination of HIV/AIDS information to the teachers. For example, Oklahoma and Virginia are among the states that have provided HIV/AIDS information and training through state wide teleconferences. Florida keeps educators up to date via an electronic mail network, and Minnesota distributes an AIDS education newsletter.

Evaluation Activities - Student

The Centers for Disease Control (CDC) have assisted the states in conducting two kinds of HIV/AIDS education surveys. The first survey, developed at the state level, measures the availability of HIV/AIDS education at the local level. The information collected from the schools or

districts reports the numbers of teachers trained and the numbers of students taught. Overall, forty-three states (including twenty-five of the twenty-eight states mandating HIV/AIDS education) and the District of Columbia have conducted this type of survey during the 1989 school year, The four states for which no available survey data were collected for the CDC records are Illinois, Minnesota, South Dakota, and Virginia.

The second survey, also developed by state and local educators, measures HIV knowledge, beliefs, and IV drug behaviors. Thirty-seven states and the District of Columbia used all or some of this survey. Seven states (Connecticut, Florida, Indiana, Minnesota, Rhode Island, Vermont, and Virginia) of the twenty-nine jurisdictions mandating HIV/AIDS education chose not to participate in this survey. The reasons why the survey was not conducted varied from the nature of the personal questions (particularly those related to sexual behavior), to the time and cost factors which some argued could be better spent in "doing the education." In some instances, time parameters ("too early" as program had just begun) prohibited participation in the survey.

On the other hand, thirteen states (Delaware, Illinois, Iowa, Maryland, Michigan, New Mexico, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Tennessee) and the District of Columbia of the twenty-nine jurisdictions used all of the survey questions.

The remaining nine states (Alabama, Georgia, Kansas, Kentucky, Nevada, South Dakota, Utah, Washington, and West Virginia) used only the HIV/AIDS related knowledge and beliefs and IV drug behavior (not the sexual behaviors) portions of the survey (See Table 11).

Evaluation Activities - Curriculum

According to both state policy mandates and data from NASBE telephone interview data, a broad range of evaluation activities occurred in the twenty-nine states mandating HIV/AIDS education.[11] Eight of the states that require HIV/AIDS education (Alabama, Connecticut, Delaware, Illinois, New York, Oregon, Pennsylvania, and Rhode Island) reported that its outcomes would be evaluated as part of the general periodic system of evaluating all curriculum areas, including site visits. This review takes place in three to five year cycles often as part of the accreditation process and does not always include the depth necessary to provide details about HIV/AIDS education programs.

Ten states (Iowa, Kansas, Kentucky, Maryland, Nevada, Oregon, Rhode Island, South Dakota, Tennessee, and West Virginia) require districts to submit either education plans, curricula, or compliance reports. Four other states (North Carolina, Pennsylvania, Rhode Island, and Utah) have

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[11]NASBE, "HIV/AIDS Education Survey: Profiles of State Policy Actions," part 5, Evaluation Activities (Virginia, National Association of State Boards of Education, 1989): 17.

various state-wide tests administered on a regular basis in which questions related to HIV/AIDS information is included in either the health or science segment.

Three state education agencies are working with universities to evaluate their HIV/AIDS education programs. Michigan State University is assisting in evaluating the states Model Comprehensive Health Education Program which includes HIV/AIDS education; the University of North Carolina is conducting a study of local AIDS Advisory Councils in the state; and the University of Vermont is providing on-site evaluation of programs to secondary schools in the state.

Kentucky is developing indicators of improvement in a tangible way, for example, the reduction of sexually transmitted diseases, to be reached by school year 1994-1995 (See Table 11).

Table 11. -- State Activities Related to HIV/AIDS Evaluation

STATE	SURVEY/AVAIL. DATA		REVIEW PROCESS
Alabama	part	+	general rev.
Connecticut	no	no	general rev.
D. of C.	all	+	ns
Delaware	all	+	general rev.
Florida	no	+	ns
Georgia	part	+	ns
Illinois	all	no	general rev.
Indiana	no	+	ns
Iowa	all	+	compliance
Kansas	part	+	compliance
Kentucky	part	+	compliance
Maryland	all	+	compliance
Michigan **	no	no	ns
Minnesota	no	no	ns
Nevada	part	+	compliance
New Mexico	all	+	ns
New York	all	+	general rev.
N. Carolina **	all	+	tests
Oklahoma	all	+	ns
Oregon	all	+	genl.+ compl.
Pennsylvania	all	+	general + tests
Rhode Island	no	no	compliance
South Dakota	part	no	compliance
Tennessee	all	+	compliance
Utah	part	+	compliance
Vermont **	no	+	ns
Virginia	no	no	ns
Washington	part	+	ns
W. Virginia	part	+	compliance

Abbreviations: Survey Data - All = the full survey used; Part = full survey without sexual behavior questions; Review Process - general = general, periodic or cyclic review; compliance = compliance reports, education reports; Tests = state test pool questions incorporated into science and or health sections; NS = there was no curricular evaluation specified; ** = University associated research studies related to evaluation.

Funding

The Center for Disease Control currently funds every state at an average of $250,000, not enough to cover all of the costs involved in establishing effective HIV/AIDS education programs in every state. This insufficiency is particularly crucial for states which have cities with an especially high incidence of HIV.

The five states that did receive money in the 1988-1989 school year, according to each state's policies, were Florida ($553,000), Kansas ($1.5 million), Minnesota ($900,000), New York (amount undisclosed), and Washington ($314,000). Some states had appropriated money for HIV/AIDS staff positions, but hiring did not occur due to staff freezes.

Six state education agencies (New Mexico, North Carolina, Oregon, Rhode Island, Tennessee, Vermont) and the District of Columbia reported the use of funds from their general health education budgets in order to provide resources to HIV/AIDS education within a larger program, according to NASBE staff researcher.[12] Some state health agencies received support and resources in the form of staff time, costs of joint conferences, and educational material.

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[12]NASBE, personal correspondence with M. Schumacher, July 1989.

States Lacking HIV/AIDS Education Mandates

As of January 1990, twenty-eight states and the District of Columbia mandated that students be required to receive HIV/AIDS education content in some formalized manner. Of the remaining twenty-two states which have not mandated HIV/AIDS educational requirements, most have addressed the subject in some context and have made some specific suggestions and/or recommendations.

Eight states (Arizona, California, Massachusetts, Mississippi, Montana, Nebraska, South Carolina, and Wyoming) have recommended that local districts provide information related to HIV/AIDS to students, faculty, staff, parents, and school board members. Some, like California, included alternate health education programs such as Family Life Education, which encompasses sex education; some, like Arizona, specifically state that sex education shall not, by law, be taught until a student is in high school and then with many constraints on the content.

States not specifically mandating a special policy for HIV/AIDS education in the schools have recommended that districts include this information in already existing health requirements wherever appropriate. This type of recommendation usually translates into teaching the material either in the communicable disease unit or the venereal (or sexually transmitted) disease unit already established in the existing curriculum. Five states (Arkansas, Idaho,

Louisiana, Maine and Missouri) have existing Comprehensive Health Education in place in which this practice occurs. Two other states, Colorado and Wisconsin, include the HIV/AIDS information unit in the prescribed Health Education course, while New Jersey teaches information about HIV/AIDS within the sexuality unit of the Family Life Education course. Three states, New Hampshire, Ohio, and Texas, teach information about HIV/AIDS as a subset of a required unit on venereal diseases. North Dakota is in the process of developing a sex and drug education program, a pilot for a future comprehensive health education program. The state of Hawaii, a one school district state, mandated HIV/AIDS education for all school children during 1987 only. Nevertheless, HIV/AIDS education continues to be incorporated into Hawaii's curriculum at all levels, though it currently is not a legally binding mandate. Alaska recommends that the department of education and or health provide educational materials on HIV/AIDS from the Red Cross to districts upon request.

The emergent nature of the AIDS crisis has required that students immediately be educated on the methods of protecting themselves from contracting the human immunodeficiency virus (HIV) which progresses to AIDS, the disease. At the national level, both governmental and scientific reports have been issued urging state governments, their education and health departments, to

provide the direction for their local needs. Thus, this analysis of state actions, to ascertain the individual state responses was performed. Although some states lack HIV/AIDS educational policies, this is not to say that they are not actively involved in HIV/AIDS education in their local districts. All students must receive effective HIV/AIDS education statewide, which can only be accomplished with a strong state policy. A map of the United States with reported AIDS cases and the states that have developed state policies mandating HIV/AIDS education is included in Appendix D.

The next chapter shall discuss how five representative states implemented the federal guidelines into their own state policies for HIV/AIDS education.

CHAPTER 4

IMPLEMENTATION OF HIV/AIDS EDUCATION POLICIES

Introduction

Few descriptions in the literature document precisely how schools are actually implementing their established state guidelines. Information concerning the actual process is found either in local newspapers or journal articles pertaining to a particular school district's innovative program (for example, a rap group or theatre company performing a play related to HIV infection prevention) or if controversial issues arise for example (the distribution of condoms within a school setting). Little documentation is found concerning the actual implementation, process, or outcome evaluations of the HIV/AIDS education programs in the schools which makes drawing conclusions about the adequacy or effectiveness of the HIV/AIDS prevention programs difficult.

Comparisons of studies suggest that some adolescent AIDS prevention programs are assigned insufficient classroom time and are not viewed as part of an ongoing educational activity but rather as "one shot deal" where a film on AIDS is shown for example. Also, younger teens report that intercourse and drug use may be initiated before they

receive information about the hazards associated with their behaviors, including HIV infection, and the means to protect themselves. Issues such as these were substantiated in the report to the Chairman of the Committee on Governmental Affairs[1], regarding AIDS education in the public schools. Two-thirds of public school districts provided formalized HIV education for students usually in the middle grades (seven through ten) during the 1988-1989 academic year. Sixty-six percent of the districts reported that "at some point" between grades seven and twelve students received HIV/AIDS information and, lastly, that only five percent of those districts reported the provision of HIV/AIDS education at every grade level.

Much of the literature regarding AIDS education in school-aged children revolves around the areas of theoretical approaches[2] or research studies in which surveys are conducted to ascertain the attitudes, behaviors, and knowledge (pre-test/post-test) of the students before and

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[1]M. V. Nadel, Chairman, AIDS Education: Public School Programs Require More Student Information and Teacher Training, General Accounting Office, GAO/HRD-90-103 (Washington, D.C., Government Printing Office), May 1, 1990.

[2]D. D. Allensworth and C.W. Symons, "A Theoretical Approach to School-Based HIV Prevention," Journal of School Health 59 (February 1989): 59-65.

after a class on AIDS.[3] Further, some articles focus on youth in particular geographic areas[4] or minority adolescents1[5] whose behaviors associated with HIV infection are known to be high. Insofar as what HIV/AIDS prevention education content is covered in these studies, other than to reference the particular class, the time allotted, the outline of basic topics, and teaching methodology employed, most reports cite that the information presented is usually in accordance with the CDC Guidelines.[6] Other reported data include the age of the students, pre-test and post-test

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[3]Selected knowledge, attitudes and belief studies. J. Brooks-Gunn, C. Boyer, and K. Hein, "Preventing HIV Infection and AIDS in Children and Adolescents: Behavioral Research and Interventions Strategies," American Psychologist 43 (1988): 958-64; J. Price, S. Desmond, and G. Kukula, "High School Students' Perceptions and Misperceptions of AIDS," Journal of School Health 55 (1985): 107-109; G. Ramafedi, "Preventing the Sexual Transmission of AIDS During Adolescence," Journal of School Health 9 (1988): 139-143; Centers for Disease Control (CDC), "HIV-Related Beliefs, Knowledge, and Behaviors Among High School Students, MMWR 37 (1988): 717-721.

[4]Selected geographic studies. R. E. Fullilove, M. T. Fullilove, B. P. Bowser and S. A. Gross, "Risk of Sexually Transmitted Disease Among Black Adolescent Crack Users in Oakland and San Francisco California," Journal of the American Medical Association 263 (1990): 851-855; R. J. DiClemente and R. DuNah, "A Comparative Analysis of Risk Behaviors Among a School-Based and Juvenile Detention Facility Sample of Adolescents in San Francisco," Abstract Presented at the Fifth International Conference on AIDS, Montreal, June 4-9, 1990.

[5]R. J. DiClemente, C. B. Boyer, and E. S. Morales, "Minorities and AIDS: Knowledge, Attitudes and Misconceptions Among Black and Latino Adolescents," American Journal of Public Health 78 (1988): 55-57.

[6]Centers for Disease Control (CDC), "Guidelines For Effective School Health Education to Prevent the Spread of AIDS," MMWR 37 Suppl. S-2 (1988): 1-14.

results, and the credentials of the teacher of the class (usually the principal investigator of the study), are included.

Aside from the formal policies of states legislating HIV/AIDS education, comparatively few specific references are reported in educational literature regarding the actual implementation or the evaluation of HIV/AIDS prevention education programs occurring in the public schools. Anecdotal local school reports predominate the literature.

The following section will include a short review of the role the federal, state and local governments play in reference to HIV/AIDS education.

The Role of Government in Education

The United States is a federal nation with large areas of governance being reserved to the states, their counties, local communities, and school districts. Unlike countries such as France or England, the federal government in the United States has a limited role in education. The governance of public schools in almost every jurisdiction is separated from general government and other political units. Each state has a system of state control over educational standards. Furthermore, school codes in most states are separate from other statutes; school board elections frequently are held separately from general elections; and educational personnel have separate credentialing mechanisms. Because of this political separation, schools

are in a sense detached from other government units. This tradition of political separation emerged during the municipal reform movement late in the nineteenth and early twentieth centuries when advocates of good government believed that the schools had to be protected from abuses of patronage and machine politics especially in urban centers. When the state legislature mandates an addition to the curriculum, (for example, health education), the state board of education may view this as a peripheral function of the school or perhaps even a political move. HIV/AIDS prevention education is a sensitive subject that causes anxiety to both the taxpayers and the politicians.

The United States Department of Education and the position of Secretary of Education were created in the late 1970's during the Carter administration as a political gesture in return for the National Education Associations support and campaign aid. Previously, the administrative branch of the Department of Education was headed by a Commissioner of Education within the Department of Health, Education and Welfare. The primary responsibility of the Secretary of Education is to represent the administration's viewpoint on educational matters and administer educational legislation passed by Congress. These tasks are usually accomplished by supporting research and collecting statistics related to educational programs. During the peak of the AIDS epidemic, 1985, President Reagan replaced

Secretary Terrell Bell who had resigned with William Bennett. Bennett introduced a particular leadership style and educational philosophy; Bennett announced that he was going to use the office as a "bully pulpit" to influence educational policy through rhetoric and pronouncements, and position papers.[7]

Concurrently, state educational leadership consisted of over half of the state school superintendents elected by popular vote while approximately half of the other state superintendents are appointed by state boards of education. At the local level, most district superintendents are appointed by district boards of education. These boards are generally elected in at-large and non-partisan elections.

The trend towards centralization of education varies from state to state. The U.S. Constitution does not retain the responsibility for education to the federal government. Consequently, the responsibility for public education rests with the individual state which legislates school districts, and general academic requirements. In addition, state boards of education mandate curricular objectives, set specific graduation requirements, and deliberate teacher certification issues. The state has greater authority and exerts greater pressure over local school districts than either the Surgeon General's Office or the Secretary of

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[7]J. Spring, Conflict of Interests, The Politics of American Education (New York: Longman, 1988): 56.

Education. Local schools operate in the context of laws, programs and regulations from state and federal governments. Despite a certain degree of state control over public education, local school districts enjoy considerable autonomy over the governance of their schools. Importantly, however the states and local districts share the costs of financing schools. Although local school districts are agencies of the state, each district adapts educational policies to the characteristics and needs of its population. For example, in cities with a high prevalence of IV drug abuse, the need to educate youth against behaviors that potentially place them at higher risk of contracting the HIV infection is greater than in a relatively drug free city.

The federal government has little influence over curricular issues but, the states, and even more so the local districts have considerable control over curricular issues, especially with regard to establishing minimal educational standards, or mandates to which local schools must adhere to in terms of needs and resources. For example, in states that do not mandate health education as a graduation requirement, the state department of education might defer to the local districts to determine what, if any, health education the local school district deems a requirement. Through the state foundation program and categorical aid, the state also can shape particular programs.

Funding of HIV/AIDS School Based Education

Very few states, in the mandates through 1989, allocated funds for HIV/AIDS prevention programs in the schools. Funding is an extremely important issue in education, especially in terms of state mandated areas. Federal funding, currently at approximately six percent of total public school revenues, is typically used to fund categorical programs, such as special education and vocational education. Accompanying federal funding carries the stipulation that acceptance of the fund requires compliance with federal regulations and reporting requirements. The Public Health Services expenditures on AIDS education increased from five million dollars in 1982 to 165 million dollars in 1989; and the National Institute for Health increased its budget on AIDS from three million dollars in 1982, to 752 million (one-half of their total budget) in 1990, which was allocated to State Health Departments and in turn to local health departments.[8]

The money for HIV/AIDS education has come primarily from cooperative grants from the Centers of Disease Control (CDC) which made awards to school based education beginning with seven million dollars in 1987 and expanded to twenty-five million dollars in 1989.[9] In addition, the CDC has

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[8]M. Gottlieb-Hutman, "Challenging AIDS," AIDS Patient Care (February 1990): 5.

[9]Government Accounting Office, "AIDS Education in Public Schools, (Washington, D.C.: GPO) (May 1, 1990): 2.

developed and funded a separate multimillion dollar project for prevention programs in schools and other organizations that serve youth. In 1987, eleven million dollars was designated for this type of program and, in 1988, the amount was increased to thirty million dollars.[10]

HIV/AIDS Criteria in State Policy Mandates

Five state policies are exemplars that meet criteria for good HIV/AIDS policies. These criteria stem from a synthesis of preceding federal guidelines, statements, reports and commissions regarding AIDS prevention. In spite of differing views concerning the types of instructional emphasis to be placed on various AIDS prevention methods and on specific moral messages, almost all educators agree that a growing need for AIDS education exists in the schools. In the absence of a vaccine or medical cure, preventative educational programs are the best defense against the spread of AIDS. With this statement as a foundation, essential criteria to be included in an HIV/AIDS state policy will be addressed briefly before discussing the examples of model state policies prior to 1990.

As reflected in a Domestic Policy Council memorandum, the scope and content of school AIDS education should be **locally determined,** and while the federal government should

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[10]D. D. Tolsma, "Activities of the Centers for Disease Control in AIDS Education," Journal of School Health 58 (1988): 133-136.

not mandate a specific curriculum, the curriculum should "**encourage responsible sexual behavior**--based on fidelity, commitment, and maturity, placing sexuality within the context of marriage," and that information provided by the federal government should "teach that children should not engage in sex."[11] While this suggestion provides direction and support for some local community members, others, including educators, may struggle with the moral tone. Moreover, health educators believe that school HIV/AIDS education should have an **objective, scientific base with an emphasis on personal responsibility for one's health** and the health of others, and that a specific, religious, sexual morality should not be promoted.

Some report authors like Surgeon General Koop, suggest that AIDS/HIV information begin to be included as part of any health and hygiene program at the **lowest grade possible**. Others, such as the consultants who prepared the CDC Guidelines, state that plans for addressing students' questions or concerns about AIDS be provided at the early elementary grades, as well as during each grade from elementary/middle school through junior high/senior high school. Because AIDS receives enormous media coverage, children do hear about it and need to have any irrational fears reduced. Students need to hear in the earliest

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[11]Domestic Policy Council memorandum, (Washington, D.C.), February 1987.

elementary grades that AIDS is difficult to get and cannot be contracted by being near someone who has the virus or AIDS. Most experts counsel that teachers should begin to give information concerning methods of virus transmission and prevention in the fourth or fifth grade when children have a greater interest and understanding of sexuality. Increasing evidence in the public health reports reaffirm the increased use of alcohol and drugs by younger children as well as the early onset of sexual activity (another reason why students need to be informed about AIDS and HIV virus contraction before they are faced with making choices about sexuality and drug abuse).

AIDS information has a **multi-disciplinary** appeal meaning that it can be taught in a variety of curriculum areas such as sexuality education, health science, biology, social studies, and home economics. If the material is presented only in the context of sexuality education, local controversy may ensue. The **context** in which AIDS/HIV information should be taught most logically seems to be part of communicable disease education within the health science unit or course which would include sexuality education that has as its primary goal promotion of low risk health behaviors.

As previously stated, the federal government does not mandate a specific **curriculum** but rather suggests a local curriculum be developed. The curriculum must give simple,

clear and direct information about AIDS transmission and awareness, and help students acquire self-esteem and assertiveness skills in order to choose to abstain from risk taking behaviors. Several commercial HIV/AIDS prevention curricula are available as are textbooks with units or chapters regarding HIV/AIDS. Some states have produced their own AIDS education curriculum guides composed in conjunction with local or state health and or education departments.

The counsel of an **advisory or community committee** can be utilized to design, implement, and facilitate community awareness of HIV/AIDS education and other curricular issues. In addition, some local communities, depending on their political climate, have adopted policies that require **parental permission** for HIV/AIDS instruction. Other schools in the beginning of the year send parents a letter which describes the general course content (including HIV/AIDS prevention education) their child will be following during the year, and inviting the parents to discuss any part of the content with the instructor.

Most of the early HIV/AIDS education has been taught within the health sciences, sexuality education or biological sciences. Often this material has been taught by physicians, nurses, or persons from the local health department. The instructional personnel has caused controversy because while the state recommends that HIV/AIDS

content be taught, not all states have provided appropriate or timely **inservice education** to prepare teachers to deal with the content. While the medical personnel know the medical aspects of HIV/AIDS, they are not necessarily trained as educators; the classroom teachers know their students and have the skills necessary to teach effectively yet are unsure of the medical content.

Evaluation, another component that is to be included in policy criteria, should include the actual material taught in the classroom at different grade levels and, ideally, the eventual outcomes of students--making healthy choices regarding their life style behaviors for life.

The criteria for analyzing AIDS education policy at the state level has evolved from federal policy recommendations and medical reports. Limited references on criteria for evaluation of anything related to AIDS have been developed. However, one recognized source of evaluation published by the National Coalition of Advocates for Students[12] is particularly concerned with what should be included in the development of or incorporated in an existing HIV/AIDS prevention program in a school situation. No perfect state policy on AIDS prevention education exists, but several states have made efforts to incorporate the federal recommendations into their specific policy statements.

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[12]National Coalition of Advocates for Students, Criteria for Evaluating an AIDS Curriculum, (Boston: National Coalition of Advocates for Students, 1988).

Selected Policies for HIV/AIDS Prevention in the Schools

Purposive sampling was used to select prototype states (New York, Florida, Rhode Island, Iowa, and Washington) because of their compliance with the federally recommended guidelines for HIV/AIDS instruction in the schools as well as the geographic and demographic areas they represent. Included are policy descriptions from states that have met the criteria of the federal recommendations and also have either unique characteristics deserving special attention or rank very high or low in terms of the numbers of AIDS cases per 100,000 population or their cumulative totals of AIDS cases for both adults and adolescents (anyone over the age of thirteen years of age).[13]

1. New York, from the northeastern section of the country, was selected as it is the state that ranks both second in overall population, and as the state that possesses the distinction of having the highest cumulative total of adult/adolescent AIDS cases (37,933) and the second highest rate of cases (44) per 100,000 population in the nation. This rate is second only to the District of Columbia which leads the nation with its overwhelming rate of 110 cases per 100,000 population or 5,056 cumulative AIDS cases in the Washington, D.C., area. Of the 37,933 cases reported in the state of New York, 32,959 are located in the

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[13]Centers for Disease Control (CDC), HIV/AIDS Surveillance: U.S. AIDS Cases Reported Through May 1991, (Atlanta, Ga.: Centers for Disease Control, 1991): 5.

metropolitan New York City area, ranking it the highest in the country with 79.9 per 100,000 population.

2. Rhode Island, a much smaller northeastern state, both in population (fortieth in the nation) and area, stands out as the first state to have required HIV/AIDS education. Its cumulative total of AIDS cases is 412 and its rate per 100,000 is 8.5 cases. Again, the majority of its cases (386) are localized in one geographic area, the city of Providence.

3. Florida, the southern representative, and seventh most populous state, ranks third highest in both the total cumulative number of adult/adolescent AIDS cases (16,269) distributed throughout multiple cities in the state, and its rate of cases per 100,000 population is 35.8 cases.

4. Iowa, the twenty-seventh in population, represents the midwestern heartland area and is one of the states with one of the lowest, 2.7 AIDS cases per 100,000 population and a cumulative total of AIDS cases of 257. (The governor proclaimed that he wanted his state to be proactive in its response to AIDS and in addition to the educational requirements, developed a philosophy statement on HIV/AIDS related issues.)

5. Washington, the twentieth in population, represents the far northwest in mandating HIV/AIDS education in the schools and, boasts their high school students are among the best informed about AIDS transmission in the country, based

on 1989 CDC study results.[14] Their cumulative total of AIDS cases is 2,440 and their rate per 100,000 population is 11.6; whereas the rate for Seattle is 21.0 with 1,849 AIDS cases.

New York

HIV/AIDS education was added to a pre-existing comprehensive health requirement. The State Board of Regents approved regulations requiring HIV/AIDS education on September 18, 1987.[15] The regulations required that HIV/AIDS education be incorporated within the pre-existing comprehensive health education requirement for elementary and secondary schools, for grades kindergarten through twelve (K-12). The instruction is required to provide factual information about the nature of the disease, methods of transmission and prevention, stress abstinence as the most appropriate and effective pre-marital protection against HIV/AIDS. Further, this instruction should be age appropriate and consistent with community values. Parents can exempt their children from the instruction concerning HIV/AIDS prevention by filing with the principal a written request which includes an assurance that the student will

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[14]Centers for Disease Control (CDC), " HIV-Related Knowledge and Behaviors Among High School Students - Selected U.S. Sites, 1989, MMWR 39 (no. 23, 1990): 385-97.

[15]Commissioner's Regulations. Subchapter G. Part 135. Health, Physical Education, and Recreation. Section 135. (September 18, 1987): 158-59.

receive such instruction at home. The classes on HIV/AIDS education are to be provided by regularly employed instructional personnel during existing class time. The local board of education or trustees are to provide appropriate training and curriculum materials for the instructional staff who provide such teaching and educational materials. A broad based advisory council in each community must make recommendations concerning the content, implementation, and evaluation of the program. The State Education Department has conducted the CDC recommended student survey measuring HIV/AIDS-related knowledge, beliefs and behaviors, and a survey of the availability of HIV/AIDS education at the local level.

Learning outcomes for HIV/AIDS education are recommended for grade levels K-12. Health instruction must be taught every year for grades pre-Kindergarten through grade six, and two half-year health courses must be taken by all students: one within grades 7-9, and one between grades 10-12.

The Health Education Syllabus provides program guidelines, relevant policies to health educators, and an AIDS Instructional Guide: Grades K-12. Also, the State Education Department provides training and assistance to districts through the state's regional Bureaus of Cooperative Services through which HIV/AIDS education trainers, supervised by the State Education Department, are

available as resource/inservice personnel. In addition, the State Education Departmaent operates a CDC-sponsored national "trainer of trainers" site which holds up to four workshops per year for HIV/AIDS education coordinators. These workshops integrate HIV/AIDS education into the context of existing comprehensive health education.[16]

Although the state of New York ranks number one in cumulative AIDS rates, approximately 33,000 of the approximately 38,000 AIDS cases reported, are in New York City.[17] The knowledge gathered from this data has been translated into action by the Board of Education for high school students in New York City, which authorized the dispensing of condoms on demand. This response is a case in point of the importance of gearing the instruction to the needs in a particular community by distributing condoms as an essential step in reducing the level of high risk behavior and the transmission of disease. Dr. Mathilde Krim of the American Foundation for AIDS Research (AmFAR) estimates that two of every hundred teenagers in New York City is HIV positive;[18] Dr. J. Emilio Carrillo, president, New York City Health and Hospitals Corporation, estimates that about two million New York City teens engage in high-

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[16]Joan Milowe, Project Director, AIDS Education, New York Department of Education, Personal correspondence, July 1990.

[17]CDC, HIV/AIDS Surveillance Report (July 1991): 6.

[18]Ibid.

risk sex or drug activity.[19] Therefore, the need for tangible methods, such as condom availability to reduce the transmission of HIV in this population at great risk is vital.

Rhode Island

HIV/AIDS education was added to the requirement for sex and family life by Senate Bill 182, passed on February 5, 1987, which requires the State Education Agency, in collaboration with the State Health Agency, to establish comprehensive HIV/AIDS education as a Basic Education Program requirement (BEP).[20] The HIV/AIDS education must provide students with information about HIV/AIDS infection and prevention, and stress sexual abstinence as the preferred means of prevention. A parent may exempt his or her child from the program by written directions to the principal of the school.

In Rhode Island, comprehensive health education is required for grades K-12. All public schools must administer a school health program that consists of a healthy school environment, services, and educational programs including twenty minutes of health or physical instruction per day. Learning outcomes for ten content

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[19] _____ "Hospital Executive Supports Teenage Condom Plan at Schools." AIDS Weekly (February 11, 1991): 5.

[20] State of Rhode Island, Senate Bill 182. An Act, Relating to Education in Prevention of AIDS. Section 1. Chapter 16-22-15 - AIDS education program (Feb. 5, 1987): 1.

areas of health education (community health, consumer health, environmental health, family life, growth and development, nutritional health, personal health, prevention and control of disease and disorders, safety and accident prevention, and substance use and abuse) are required. Sex and Family Life education was added to this requirement partly in response to the HIV/AIDS education requirement according to the chairman of the Board of Regents.[21] Also, instructional resources and outcomes for AIDS education for grades K-12 are provided. Further, every district must establish Basic Education Programs (BEP's) for each educational requirement, including HIV/AIDS education and BEP's that are evaluated through compliance reports and on-site evaluations conducted by teachers and administrators who volunteer to be peer evaluators. The volunteers are reimbursed for travel, and districts are reimbursed for the cost of substitute teachers. According to the Director of the Office of Physical and Health Education, the system of peer evaluators has proven effective, and many volunteers view it as a form of staff development.[22] All students take the state's health knowledge test in grades three, six, eight, and ten. This test includes questions about

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[21]A. Capostosto, chairman Board of Regents, Personal Correspondence, Reconsideration of the Board's Position of Sex and Family Life Education (March 5, 1987).

[22]Ken Glow, Director, Office of Physical and Health Education, Personal Correspondence, July 1990.

HIV/AIDS. The State Education Agency conducts the annual survey on the availability of HIV/AIDS education at the local level for the CDC.

The State Education Agency has provided training to nearly all health educators through regional workshops as Rhode Island is one of the few states that requires that instructors of HIV/AIDS education be certified in health education.

Rhode Island was the first state to require HIV/AIDS education and is one of the few states that is intent on reaching homosexual youth with HIV/AIDS educational programs. The State Education Agency also awards portions of its CDC grant money to groups working with homeless youth and to high-risk districts.[23]

Knowing that physicians, especially pediatricians, are considered by schools as resources in developing and instituting AIDS educational plans, two Rhode Island physicians, Doctors Brown and Fritz, conducted a review of the literature about AIDS and related subjects in order to assist colleagues in their task of educating youth about HIV/AIDS. They pointed out that "rarely has a project of this magnitude been undertaken with so little guiding data."[24] Although not definitive, their review included an

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[23]Ibid.

[24]Brown, L. & Fritz, G., "AIDS Education in the Schools: A Literature Review as a Guide for Curriculum Planning," Clinical Pediatrics 27 (no. 7 July 1988): 311-316.

extrapolation of literature from other fields, that allowed for general conclusions to be drawn. Some of the important generalizations that Doctors Brown and Fritz delineated to assist in AIDS education programs, were as follows: 1. Most of the AIDS specific studies have indicated that students have some general knowledge about AIDS but are ignorant about the specifics of transmission, an area that has been documented earlier. 2. Work done with high-risk groups have had positive effects on sexual and drug use practices. However, this assessment is controversial, especially with regard to large cities where the rate of HIV infection is continuing to rise in spite of educational efforts related to safer sex and drug related behavior. 3. The authors suggest that the more the content is integrated into the curriculum and the more parents get involved, the greater the effectiveness. 4. Providing students with coping skills is an equally important educational component to a discussion of HIV/AIDS facts alone. Students need to be helped to clarify their own attitudes, understand the ramifications of their decisions, and learn ways to decrease their risk of contracting HIV/AIDS. 5. Students need to learn how to deal with HIV positive people altering to some extent AIDS related prejudice. 6. Lastly, knowledge of developmental adolescent psychology, and age appropriate material must be applied to HIV/AIDS curricula. This approach is the preferred method cited in all of the federal

recommendations for HIV/AIDS education curricula.[25]

Iowa

The HIV/AIDS education was incorporated into the pre-existing comprehensive health education requirement as part of the human growth and development requirement, a comprehensive family life education program. The state legislature passed two AIDS related bills in July 1988. The first, Senate File (SF) 2157[26] requires a comprehensive HIV/AIDS prevention and intervention plan. Section 10 of SF 2157 requires that in cooperation with the department of education, the department of public health, develop and update a medically correct HIV/AIDS prevention curriculum for the schools, with parental consent required before teaching. A second bill, SF 2094, provides the specific details about the curriculum requirements.[27] SF 2094 requires that HIV/AIDS prevention be taught in grades K-12, with the material and methodology appropriate to the pupil's grade, age and maturity level. Although the bill does not discuss specific content areas, it does require each district to create a resource committee to make specific recommendations regarding curriculum and instruction. SF

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[25]Ibid., 315.

[26]Seventy-second Iowa General Assembly, Senate File 2157, (July 1988), 1-11.

[27]Seventy-second Iowa General Assembly, Senate File 2094, (July 1988), 1-6.

2094 requires instruction in human sexuality, sexually transmitted diseases (including AIDS), contraception, and family planning. In addition, it requires that the committee address such issues as self-esteem, responsible decision making, personal responsibility, goal setting, interpersonal relationships, and discouragement of premarital adolescent sexual activity. SF 2094 also requires that the State Education Agency provide model curricula in addition to resource materials for all grades. Teachers from local districts are encouraged to submit curriculum ideas to the State which may in turn incorporate their ideas into the model plan. Technical assistance to all districts is mandated both for the pedagogical questions and medical questions that arise. The regional area education agency offers periodic staff development for instructors of human growth and development course and each regional education agency offers training to district teams who in turn train local health educators. The district resource committee is also required to report its recommendations for implementing the program to the State Education Agency at least once every three years by law, but have been doing so on an annual basis. Also, the CDC student survey measuring HIV-AIDS related knowledge, beliefs, and behavior has been conducted annually.

The Iowa State Education Agency has prepared a document called I-ASC, (Immediate Assistance to Schools and

Communities) that is aimed at presenting a positive, rational approach to dealing with all aspects of the AIDS epidemic.[28] I-ASC addresses the more subtle, sensitive issues involved in teaching about the AIDS virus and serving HIV-infected students and school staff appropriately. More a statement of philosophy than of policy, the I-ASC document has suggestions for becoming an "AIDS pro." Specifically: pro-people, pro-tector, pro-vider, pro-active, pro-motor, pro-fessional, and pro-ductive.[29]

Florida

On July 6, 1988, House Bill 1519, the Comprehensive AIDS Bill, was passed by the Florida legislature[30] which mandated incorporating HIV/AIDS education into two pre-existing requirements. The first requirement is Life Management Skills, a half-year course that must be taken in either grade nine or ten in order to graduate; the second is a comprehensive health education requirement.

The Comprehensive AIDS Bill adds the prevention of HIV/AIDS and other sexually transmitted diseases to its Life Management Skills course which already includes drug education. The bill also authorizes districts to provide

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[28]Elaine Edge, Consultant for AIDS Education, Iowa Department of Education, Personal Correspondence, July 1990.

[29]Ibid., 5.

[30]Laws of Florida, Chapter 88-380, House Bill 1519, July 6, 1988.

HIV/AIDS education including modes of transmission, risk factors and means to control the spread of HIV/AIDS as part of health education. Although the inclusion of HIV/AIDS information is required in comprehensive health education, (K-12), it is also to be included in appropriate health, science and other classes, while the inclusion of family life education placement is left up to districts. Although the policy leaves grade levels and curriculum development up to the local districts, the bill requires that abstinence from sexual activity outside of marriage be taught as the expected standard for all school aged children. The mandate suggests the instruction include, but not be limited to, the known modes of transmission, signs and symptoms, risk factors associated with AIDS, and means to control the spread of AIDS. The instruction shall be appropriate for the grade and age of the student and shall reflect current theory, knowledge, and practice regarding AIDS and its prevention.[31] The policy also allows parents to exempt their children from such instruction with written permission and requires that in-service programs on health education (including HIV/AIDS information) be provided to teachers, counselors, and other school staff. Each school district is to take an active role in providing parent and community AIDS education and awareness programs through the

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[31]Ibid., 10.

PTA and other community groups.

The State Health and Education Agencies have held HIV/AIDS workshops at statewide conferences for principals, administrators, and school board members as well as trained local health education supervisors. Once trained, these local supervisors then provide teacher training and staff in-service. The Florida policy describes the content of teacher training, with respect to current theory and knowledge, and practices regarding substance abuse, AIDS identification and referral procedures, legal issues, peer counseling, methods of teaching decision-making skills, and building self-concept. The comprehensive health education program requires special teacher training and staff inservice on health topics which includes HIV/AIDS. The State Education Agency also uses five exemplar programs at demonstration sites to disseminate model practices statewide and includes staff from these programs in training sessions.

The Prevention Center, the section within the State Education Agency that is responsible for administering the HIV/AIDS education program, emphasizes the use of peer education with minority, high-risk, and out-of-school youth, as well as with high school, community college, and university students. The Prevention Center keeps all educators updated about AIDS information with SATNET, an

electronic mail system.[32]

Learning outcomes for comprehensive health education evaluate AIDS information for grades six through eight, and Life Management Skills course for high school groups. The State Education Agency conducts the annual CDC survey to ascertain availability of HIV/AIDS education at the local level, to obtain statistics, and to identify and evaluate AIDS curricula in the school districts.[33]

Noteworthy in the Florida Comprehensive AIDS Law is the mandatory education required of other health care professionals such as physicians, nurses, dentists, psychologists (as a provision for license renewal) and for all state employees including law enforcement and correctional officers. The Bill also includes detailed sections related to testing and confidentiality requirements, non-discrimination legislation, treatments, research and planning for the future, public health and criminal justice measures, insurance and health maintenance organizations.

Washington

HIV/AIDS education in Washington became a requirement as part of the same legislation as the subset on education

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[32]Mae Waters, Comprehensive Health Education/AIDS Project Director, Personal correspondence, July 1990.

[33]Ibid.

on sexually transmitted diseases. Washington's AIDS Omnibus Bill of March, 1988, requires that each district adopt a locally developed plan for HIV/AIDS education in the schools.[34] Washington is one of the very few states which appropriated money from the state budget for the first year.

KNOW: AIDS Prevention Education: An HIV/AIDS Curriculum Manual, for grades five through twelve is a model curriculum with accompanying learning outcomes compatible with the State Education's Agency's outcomes for comprehensive health education. KNOW, also makes suggestions about the nature of HIV/AIDS instruction in early elementary grades.[35] If a district decides to use or develop a curriculum other than KNOW or to use materials other than those approved by the State Education or Health Agencies, the curriculum must be reviewed for medical accuracy by the State Health Agency's Office on HIV/AIDS. The KNOW curriculum for HIV/AIDS education is designed to teach students which behaviors such as drug use and sexual intercourse, with or without condoms, place a person dangerously at risk of infection and methods to avoid such risk. In Washington, such education must stress that sexual abstinence is the only certain prevention method and that condoms and other artificial means of birth control are not

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[34]Washington, AIDS Education in the Common Schools, Omnibus Bill, Part IV, section 401, (March 1988): 4-7.

[35]Pamela Baldwin, AIDS Education Coordinator, Personal Correspondence, July 1990.

a completely reliable means of protection. Additionally, instruction must begin no later than grade five and must be taught every year in grades five through twelve.

Districts are required to conduct at least a one hour presentation on the program materials, curricula and materials to be used for HIV/AIDS education to parents one month prior to teaching AIDS prevention education in any classroom. This presentation is to be made during evening and weekend hours. No student is required to participate in HIV/AIDS prevention programs provided the parent or guardian has attended one of the district presentations and objects in writing to the student's participation.

Washington is one of the few states mandating HIV/AIDS prevention education that does not have a health education or physical education requirement. Nevertheless, the State Education Agency's guidelines for comprehensive health education are distributed to, and used widely by districts and do include learning outcomes for K-12. In 1977, the Superintendent of Public Instruction produced Suggested Guidelines for Including Education about Human Sexuality in School Curricula, a guide for local program development.[36]

Continuing education requirements for all school employees now must include appropriate training about HIV/AIDS. The bill recognizes that locally elected school directors (superintendents) need to have a significant role

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[36]Ibid.

in establishing a program of HIV/AIDS education in their districts. The State Education Agency conducts two day regional workshops for administrators and teachers. The State Education Agency also conducts the CDC recommended student survey measuring HIV/AIDS-related knowledge and beliefs and a survey of the availability of HIV/AIDS education at the local level. Furthermore, the State Education Agency has developed a curriculum for youth in correctional facilities and outreach centers (informal alternative school sites). The current state curriculum has been translated into Spanish, and an organization to work with migrant children and their families on HIV/AIDS prevention has been contracted.[37]

A recent article stated, that Washington state high school students were among the best informed in the nation on the myths and realities of HIV, according to the Washington State Department of Health.[38] The tenth and twelfth graders correctly answered questions in a CDC study.[39] Nearly 2600 students in more than ninety randomly-selected school districts in Washington participated in the study that included a total of thirty-one states and the

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[37]Ibid.

[38]_____"Washington High School Students Better Educated on HIV", CDC AIDS Weekly (August 20, 1990): 10.

[39]Centers for Disease Control (CDC), "HIV-Related Knowledge and Behavior Among High School Students - Selected U.S. Sites, 1989," MMWR 39 (no. 23, 1990): 385-97.

District of Columbia and 1,175,227 students.

The descriptions of HIV/AIDS education in the preceding five diverse states reflects much of what is being mandated at the state level and ultimately implemented at the local level. Commitment by school administrators, educators, local school boards, parents, school nurses, and local health departments to provide accurate information about AIDS and the transmission of the AIDS virus is evident, but students must take the next step in converting knowledge into personal behavior.

CHAPTER 5

SUMMARY, CONCLUSIONS, RECOMMENDATIONS

Summary of study

The acquired immunodeficiency syndrome (AIDS) and the human immunodeficiency virus (HIV) that causes the disease are acknowledged to be at epidemic proportions throughout the world. Sexually transmitted diseases, including AIDS, are a real threat to our young people. However, it is critical to remember that these diseases are to a very large extent preventable. Unlike other devastating plagues throughout human history, these diseases are not transmitted by the air we breathe, the food and water we eat and drink, or by airborne insects over which we have little or no control. Personal behaviors, totally within our control, are the primary means of transmission as well as prevention. Helping students understand and adopt prevention behaviors is the goal.

While the youth of today are potential targets for the disease, the numbers of adolescents with HIV/AIDS represent less than one percent of total cases in the United States. This percentage increases twenty fold to persons in their twenties, many likely infected in their teens. The incubation period between acquiring the AIDS virus (HIV) to

the onset of AIDS the disease may be many years, a time a person may feel quite well and not even know they have been infected, and yet be capable of spreading the virus to others. During the past decade since AIDS was first described, the causative virus (human deficiency virus) that infects and destroys the immune system (T cells) has been discovered and identified and reliable diagnostic tests for determining the presence of HIV have been developed. Results of research have produced various pharmacological treatments that slow the onset of symptoms and treat the complications of AIDS that actually kill (the opportunistic infections and cancers associated with HIV/AIDS). The mechanisms of virus transmission and the means of avoiding or preventing the spread of HIV have been identified as well. The majority of persons diagnosed with HIV/AIDS have engaged in behaviors referred to as "high risk activities" that are preventable. For example, unprotected sexual (heterosexual or homosexual) activities and the sharing of needles with infected persons are the most common means of virus spread known.

The United States government was very late in developing a national strategy to combat AIDS. The Public Health Service assumed the responsibility of tracking the incidence, determining the causes, and developing effective diagnostic and treatment procedures. Various governmental and national reports (from the Secretary of Education, the

Surgeon General, the Presidential Commission on AIDS, the Centers for Disease Control (CDC) and the National Academy of Science) were issued in 1986 and 1987, all stressing the urgent need to embark on a massive program of HIV/AIDS prevention education for all people as an intervention to reduce the spread of HIV infection. More broadly, the reports emphasized that the earlier good health habits were taught to children in the schools as a nearly universal experience for all American children, the more likely youth would adopt healthy habits, including means of protecting themselves from HIV/AIDS.

Despite existing federal and state laws that require free and uniform public education and equal access and clear recommendations from the CDC, the actual implementation of HIV/AIDS education evokes strong emotions in the public school setting. That AIDS education is often so off the mark can be explained by the American near lack of experience as a culture in providing comprehensive, quality sexuality education for children. Furthermore, to provide education specific enough to speak directly to those most private of all behaviors that transmit this deadly virus is to provoke a confrontation between the issues of health, sexual behavior in the most explicit of terms, drug abuse, death and dying, and even issues of race, discrimination and poverty. This impasse occurs within the context of a variety of cultures, religions and moral values and must be

addressed within the premise that the publics' health rights supersede parental rights. At the same time there are signs that loco parentis is diminishing in some areas but not in others. An example of this is the extension of school building hours, supervision and meal plans to accommodate disadvantaged or working parents.

The literature related to adolescent psychology and behavior and the importance delegated to HIV/AIDS prevention education correlates with reluctance on the part of many adolescents (and adults, too) to modify behaviors that contribute to HIV infection. Further, the nature of the adolescent experience creates additional challenges, regardless of how skillfully adults carry out their protective role. Cognitive education alone appears inadequate in producing the desired behaviors. Health care professionals, religious leaders, community organizations, political leaders, celebrities in the media, and parents cannot do it alone. When talking about HIV/AIDS, teenage pregnancy, school health prevention or any issue important for young people, team-work and collaboration is the key. Teaching methods must communicate convincingly that everyone--even the inviolable adolescent--is at risk. The period between kindergarten and high school graduation is an extensive span when one considers the vast changes that occur developmentally. Not only must the obvious age changes be considered but also the level of physical and

psychological maturity, geographical, socio-economic, and cultural differences in student populations. These factors must be analyzed when teaching methodologies and suggested interventions are utilized in the various grade levels to present HIV/AIDS content.

A review of the fifty states' educational policies regarding HIV/AIDS education revealed that through the 1989-90 school year, twenty eight states and the District of Columbia had mandated HIV/AIDS education in the schools. Curricula have been designed, programs have been implemented, and many children have been taught. Although there are variations in policy language, the majority of policies identified key components that should be addressed in an HIV/AIDS school-based instructional program. These components consisted of information dedicated to HIV/AIDS prevention, including a lecture or presentation discussing the disease AIDS, the means of viral spread and methods of viral prevention. Monogamy (eight states) and abstinence (nine states) were encouraged in most of the state mandates and parental rights regarding exemption of their children from class instruction in HIV/AIDS content were acknowledged in all state mandates. Many of the state policies also included specifics regarding teacher preparation and the grade and age level at which information should be taught. There were no relationships between the numbers of AIDS cases per states and legal mandates for AIDS education.

The high incidence areas were concentrated in those states with large urban populations.

Shortcomings in most of the state policies included issues related to evaluating the effect information had on any change in student behavior, chronology (how often and at what grades should HIV/AIDS information be presented), and questions regarding funding an additional curricular program. The lack of outside resources was evident in some of the policies. This deficiency left untrained teachers to teach unfamiliar content and overlooked services of other health care workers (nurses and physicians). As educators, it is also important to recognize that there is often a difference in what we intend to teach, what we actually teach, and what ultimately is learned.

Five states policies (New York, Florida, Rhode Island, Iowa and Washington) were chosen and analyzed because of the completeness of their HIV/AIDS policy/mandate regarding HIV/AIDS education in the schools. Generally, of the twenty-eight states that led the way in school-based HIV/AIDS education, twenty states already had instituted either family life or comprehensive health education into their state curriculum plan. This education is designed around age appropriate themes in which sexuality, for example, is presented as a positive and healthy life force and as a complex component of one's personality and identity.

While states such as New Jersey, California, and Texas,

have heavily populated urban areas experiencing high rates of HIV/AIDS, these states as of 1989 had not mandated HIV/AIDS education in the schools. Nevertheless, at the local level, school districts have been instrumental in implementing policies early in the epidemic. The San Francisco school district was the first in the United States to begin teaching students about HIV/AIDS in the school setting; their curriculum would become a prototype for other school district programs.

General Conclusions

An explosion of knowledge in all areas of health and disease prevention has translated into health information becoming an even more relevant part of the school curriculum; this trend necessitated a more pervasive participation of medical and health professionals--nurses, physicians, and psychologists--in health education. The HIV/AIDS epidemic was the catalyst which caused many states to initiate health education in their schools' curriculums.

While the numbers of AIDS cases have remained at the same proportion nationally, there has been an increase in HIV infection in certain high risk behavior groups. As recently as October, 1991, Dr. Lawrence G. D'Angelo, chairman of the department of adolescent medicine at Children's National Medical Center in Washington, D. C., reported at the meeting of the American Society of

Microbiology that infection rates in urban teenagers had risen 250 percent from 1987 to 1991; that the rates of new cases in females had doubled from 21 per 1,000 in 1988 to 41 per 1,000 in 1990 while the male case rate had decreased from 36 per 1,000 to 27 per 1,000 during the same period. In addition, HIV infection rates rose among poor youths, especially African-Americans; currently, one percent are infected by age 21.[1] Charles Schuster, director of the National Institute on Drug Abuse, reported that Hispanics, who make up nine percent of the general population, account for 16 percent of the population infected the HIV virus.[2] This information coupled with the rise in sexually transmitted diseases, unplanned pregnancies and increased alcohol and drug use in teenagers has increased concurrently during the period that education about AIDS and its prevention was implemented.

The health education literature continues to report that adolescents feel that this disease cannot happen to them. These same adolescents are able to perform very well on tests evaluating how well they have retained information taught in a class on HIV/AIDS, including content on risk factors, means of transmission, and prevention. On the

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[1]P. Peck, "AIDS Rate Soars For Urban Teenagers," Chicago Sun-Times (2 October 1991, sec. 1): 1.

[2]"Surgeon General urges Hispanics to tell kids about AIDS," Daily Herald (September 8, 1991, section 1): 10.

other hand, when these same adolescents respond to questions regarding their own personal behavior or life style changes after learning methods to avoid acquiring HIV/AIDS, their answers imply a lack of internalization or personal relevance associated with the seriousness of HIV/AIDS and do not indicate a change in behavior.

In addition, the HIV/AIDS programs described are based on a traditional educational curriculum. Consequently, runaway and homeless youth who are extremely high risk teens are under served by existing programs. Moreover, none of the mandates address the crucial nature of HIV/AIDS education and interventions for this group.

Although schooling is a nearly universal experience, the absenteeism in urban elementary and secondary schools--an area in which HIV/AIDS infection is greatest--is extremely high. Minority youth and those in poor communities such as runaway and homeless youth, are in greater peril as their absenteeism interferes with HIV/AIDS education and prevention. This particular issue is not resolved within the traditional curricular program.

The increase in sexually transmitted diseases among teenagers and unwanted pregnancies as well as a rise in teen HIV infection rates causes concern over the effectiveness of the educational efforts to curtail these undesirable occurrences. The other major source of transmission centers around drug use and needle sharing, including needle

usage to pierce ears or to tattoo, a popular gang practice. In addition to the direct risk to teenagers themselves, female adolescents who become pregnant and are infected either prior to, or during, the pregnancy also risk infecting their babies before birth.

A purely cognitive approach to HIV/AIDS education will have difficulty effecting behavioral change because society and its agents, (the media, for example) promulgate and cherish an image of sexual behavior opposite that presented in school health education. Television shows and advertisements present seductive behavior, its accoutrements, and irresponsible sexual practices; also any problems that arise from such situations are settled happily, healthily and quickly (in less than an hour).

Lastly, the United States Constitution with its strict division of federal power into three branches of the government (legislative, executive, and judicial), has fostered diffusion of responsibility, confusion and delay by federal agencies to address the problems. The delay in the formulating and implementing a HIV/AIDS policy is an example of the effects of divided accountability. Also, one observes reluctance on the part of legislators and federal leaders to deal with controversial subjects. For example, neither House of Congress took notice of the toll AIDS was accumulating--no promulgation of even a task force--in the first five years of the epidemic. The only effort made by

the executive branch was President Reagans's pronouncement that "It's not how you do it, don't," and that was subsequent to the Surgeon General Koop's Report and Secretary of Education Bennett's statement. Guidelines to implement a policy allotting time, resources, and finances' to enkindle seriousness of purpose in combatting the HIV/AIDS epidemic--essential components--were not initiated by any major branch of the federal government until 1986.

Recommendations for school-based HIV/AIDS education

The AIDS epidemic has entered its second decade, the 1990's, with teens of today being referred to as the second wave or next generation of persons living with HIV/AIDS. At no other time in history has society experienced a public health crisis so interwoven with human values and attitudes; never have the social ramifications of personal actions been so problematic. A principal function of public health agencies has always been to inform the community about disease and to promote health, placing much of the responsibility on individuals to act in light of the facts presented. In the absence of a vaccine, effective treatment, or cure, the only weapon against AIDS is a preventive measure--education.

What protects a child from HIV/AIDS is not only the use of knowledge or isolated social skills, but rather the interaction of these elements which are developed and strengthened by the bonds between school, family and other

socialization agents. Ultimately the school-based route to prevention of HIV/AIDS will work only if schools are effective socialization agents: effective in meeting children's needs for autonomy, belonging, and competence thereby enabling children to build the motivation and social competence they will need to avoid the many kinds of high-risk behavior over a period of many years. This concept includes a need for out of school reinforcement of the HIV/AIDS prevention message by significant others--parents, clergy, scout leaders and those affiliated with other youth associated activities. In addition, as the disease continues to impact on more of society, both teachers and students need to be making critical connections in ongoing discussions of current events, politics, health care, science, literature, mass media, religion, social studies, geography, and other topics.

The National Coalition of Advocates for Students (NCAS) has established guidelines for evaluating existing curricula (Appendix E), and the Centers for Disease Control (CDC) have developed assessment criteria (Appendix F) to monitor the extent to which local school HIV/AIDS programs are providing effective health education about AIDS. It would behoove educators to examine these two documents in order that program evaluations are accurate and complete, and the assessments valid indicators of HIV/AIDS prevention interventions. Utilizing this information can assist in

enabling future programs to teach and evaluate interventions and ramifications.

"Young children do not learn enough about sex in school," according to Debra Haffner, director of the Sex Information and Education Council of the United States (SIECUS) who states, "America in the 90's can be characterized as sexually diseased."[3] A SIECUS task force is recommending and preparing guidelines for implementation of a broader plan to teach students from kindergarten through grade 12 about sex. This material needs to be presented within the context of abstinence yet present the facts and controversies with enough information so that children can begin to develop their own healthy attitudes.

Hafner believes that sex education belongs not only in the school but also in the home. The family should be the first school of health education, with open discussion of unsafe sexual practices, drug abuse, and homosexuality. Parents need to talk openly to their children and instill the family's values, morals, and good health habits. The earlier children are taught good health habits, the more likely they are to adopt those habits. At an early age, children tend to listen, respect, and internalize what their parents, a teacher or nurse have to say, rather than later,

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[3]"Broader sex education is proposed," in (Chicago Tribune, October 17, 1991, sec. 19): 10.

when as adolescents they tend to not want to hear or heed advice.

Health education must take place in practical application throughout the day, whether washing hands after using the washroom or choosing appropriate after-school-snacks. Maintaining physical fitness, coping with stress, preserving mental health, and controlling substance abuse (especially alcohol ingestion and its effect on one's judgement) are also essential information to be inculcated so that children will become healthy adults. In addition to a healthy life style, health education should be required to address psychological concepts such as self-esteem, problem solving skills, and decision making skills. Social supports and interpersonal communication skills are essential and integral approaches to health maintenance in general and more specifically, HIV/AIDS prevention. Lastly, teachable moments are to be seized upon by parents or teachers when questions associated with sexuality, reproduction or other related subjects are suggested.

The effect of the myriad forms of media available to everyone is a concern. A significant increase in the numbers of many public service announcements related to HIV/AIDS have been aired, as well as an increase in the number of television shows designed to heighten an awareness of the disease while eliciting compassion for the person with AIDS and their situation. On the other hand, the more

prominent message, for example, unsafe sex, as viewed from the printed media, movies, advertisements, music videos or television shows is flagrant disregard for the prevention message.

Suggestions for Future Research

Future research needs to examine the actual plans, opportunities, and policies regarding HIV/AIDS information dissemination in those states not mandating HIV/AIDS education. Questions to be addressed are: 1) How are these states meeting the HIV/AIDS education challenge; and 2) Do these states have alternative directives that guide their HIV/AIDS education endeavors in the schools; 3) Do those states that have comprehensive health education and sex education programs from kindergarten to grade twelve, including such information and learning activities related to drug use, alcohol consumption, tobacco utilization, imprudent diet patterns, physical inactivity, unsafe sexual practices as well injury related behaviors have less morbidity and mortality than those states that do not have this type of educational program; and 4) Evaluate the usefulness of locally based, non-traditional (even controversial) approaches to curb the spread of HIV/AIDS in high risk teenagers such as the dispensing of condoms in the schools of New York City.

Additional studies need to be conducted relative to the needs of high risk youth. Examples of studies would be:

1) The needs of specific groups of high risk youth such as runaways, the homeless, or the institutionalized and the design of alternate intervention strategies to be incorporated into HIV/AIDS education programs to serve these adolescents; 2) The identification of current peer education programs which have successfully modified other undesirable adolescent behaviors adopting salient elements into HIV/AIDS education programs in school settings; and 3) The factors that effect the learning needs of youth of various cultures, social, and/or religious parameters of various high risk ethnic groups so as to provide HIV/AIDS education in a terminology and in an environment that is less threatening and more acceptable.

Many unanswered questions relating to program efficacy remain. Studies assessing students' cognitive knowledge about HIV/AIDS exist and show a high level of cognition regarding technical information about HIV/AIDS. What is not well documented is whether or not these educational programs alleviate fears and discount myths about AIDS: 1) Do they change perceptions about personal susceptibility, risk of contracting or spreading HIV infection; and 2) Do they affect attitudes about people with AIDS? Not only should such studies be initiated but also closely followed up with frequent re-evaluations at specified intervals.

Research endeavors need to focus on the media as a means of education and information as well to examine and

use the effect the media has on its viewers such as the heightened awareness and compassion they see when, unfortunately, a celebrity is stricken or a tragedy occurs--the story of a young boy, Ryan White; a sexy male actor, Rock Hudson; the testimony of a young female, Kimberly Bergalis; or most recently, a super-star basketball hero, Magic Johnson to stir and move attitudes and emotions and hopefully action.

With the AIDS epidemic here to stay for the near foreseeable future, an increasing number of youth being infected with the virus translates into the expanded role of caring for adolescents and young adults with AIDS. As all but one policy stated that HIV/AIDS education be implemented by classroom teachers, a suggestion for future research would be to compare the impact or efficacy of HIV/AIDS education inculcated by a health care professional such as a nurse. As to HIV/AIDS education presented by other educational professionals, nurses are an untapped source of assistance for a school or community as they can be involved in local AIDS councils, advisory boards, educational programs in the schools for teachers, students and parents, as well as in leading self help groups for those affected with HIV/AIDS in their community. Understanding the values, the educational and health care needs of the local community are essential components in a successful AIDS awareness program. This will provide nurse advocates with information

and a local power base from which to pursue state and national AIDS issues such as mobilizing educational, political and professional resources.

In conclusion, AIDS is a terrible disease and will remain a major world wide public health challenge that our children and society will inherit well into the twenty-first century. At present, no vaccine nor cure exists and mortality is very high. The only way to halt the disease now is to prevent infection initially. The opportunity to make a significant impact on students, to inform them about this disease, how it can be prevented, and then persuade them to follow prevention guidelines, is an essential challenge for teachers, nurses, and health educators to impart. For the sake of their present and future health, students deserve accurate information about the disease and how they can prevent acquiring the AIDS virus, the most essential part of the successful battle against the spread of the disease.

AIDS cases in adolescents and adults under age 25, by exposure category, reported September 1989 through August 1990, September 1990 through August 1991, and cumulative totals through August 1991, United States

	13-19 years old						20-24 years old					
	Sept.1989-Aug. 1990		Sept. 1990-Aug. 1991		Cumulative total		Sept. 1989-Aug. 1990		Sept. 1990-Aug. 1991		Cumulative total	
Exposure category	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**	**No.**	**(%)**
Men who have sex with men	30	(20)	29	(17)	186	(25)	823	(53)	722	(47)	4,262	(55)
Intravenous (IV) drug use	20	(13)	23	(14)	92	(12)	278	(18)	310	(20)	1,307	(17)
Men who have sex with men and use IV drugs	4	(3)	6	(4)	32	(4)	148	(9)	101	(7)	692	(9)
Hemophilia/coagulation disorder	47	(31)	44	(26)	220	(30)	31	(2)	39	(3)	195	(3)
Heterosexual contact:	31	(21)	30	(18)	102	(14)	188	(12)	221	(14)	793	(10)
Sex with IV drug user	*21*		*23*		*69*		*116*		*134*		*457*	
Sex with bisexual male	*1*		*—*		*3*		*9*		*8*		*54*	
Sex with person with hemophilia	*1*		*2*		*3*		*5*		*3*		*17*	
Born in Pattern-II[1] country	*2*		*2*		*15*		*23*		*15*		*121*	
Sex with person born in Pattern-II country	*—*		*1*		*1*		*4*		*4*		*10*	
Sex with transfusion recipient with HIV infection	*1*		*—*		*1*		*5*		*2*		*8*	
Sex with HIV-infected person, risk not specified	*5*		*2*		*10*		*26*		*55*		*126*	
Receipt of blood transfusion, blood components, or tissue	7	(5)	9	(5)	52	(7)	18	(1)	19	(1)	109	(1)
Undetermined[2]	12	(8)	27	(16)	53	(7)	79	(5)	134	(9)	346	(4)
Total	**151**	**(100)**	**168**	**(100)**	**737**	**(100)**	**1,565**	**(100)**	**1,546**	**(100)**	**7,704**	**(100)**

[1] See technical notes.

[2] "Undetermined" refers to patients whose mode of exposure to HIV is unknown. This includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation.

Source: AIDS/HIV Weekly Surveillance Report (Sept. 29, 1991): 5.

APPENDIX B

COOPERATIVE AGREEMENTS AWARDED CDC, SEPTEMBER 1987

National School Boards Association

American Association of School Administrators

National Rural and Small Schools Consortium

American School Health Association

National Congress of Parents and Teachers

National Coalition of Hispanic Health and Human Service Organizations

National Organization of Black County Officials

Association for the Advancement of Health Education

National Association of Runaway and Youth Shelters

National Coalition of Advocates for Students

American College Health Association

Education, Training, and Research Inc.

Center for Population Options

Council of Chief State School Officers

National Association of State Boards of Education

From: D. Tolsma, "Activities of the Centers for Disease Control in AIDS Education," Journal of Public Health, 58 (4), 134.

APPENDIX C

CDC CURRICULUM GUIDELINES

Early Elementary School

Education about AIDS for students in early elementary grades principally should be designed to allay excessive fears of the epidemic and of becoming infected.

AIDS is a disease that is causing some adults to get very sick, but it does not commonly affect children.

AIDS is very hard to get. You cannot get it just by being near or touching someone who has it.

Scientists all over the world are working hard to find a way to stop people from getting AIDS and to cure those who have it.

Late Elementary/Middle School

Education about AIDS for students in late elementary/middle school grades should be designed with consideration for the following information.

Viruses are living organisms too small to be seen by the unaided eye.

Viruses can be transmitted from an infected person to an uninfected person through various means.

Some viruses cause disease among people.

Persons who are infected with some viruses that cause disease may not have any signs or symptoms of disease.

AIDS (an abbreviation for acquired immunodeficiency syndrome) is caused by a virus that weakens the ability of infected individuals to fight off disease. People who have AIDS often develop a rare type of severe pneumonia, a cancer called Kaposi's sarcoma, and certain other diseases that healthy people normally do not get.

About 1 to 1.5 million of the total population of approximately 240 million Americans currently are infected with the AIDS virus and consequently are capable of infecting others.

People who are infected with the AIDS virus live in every state in the United States and in most other countries of the world. Infected people live in cities as well as in suburbs, small towns, and rural areas. Although most infected people are adults, teenagers can also become infected. Females as well as males are infected. People of every race are infected, including whites, blacks, Hispanics, Native Americans, and Asian/Pacific Islanders.

The AIDS virus can be transmitted by sexual contact with an infected person; by using needles and other injection equipment that an infected person has used; and from an infected mother to her infant before or during birth.

A small number of doctors, nurses, and other medical personnel have been infected when they were directly exposed to infected blood.

It sometimes takes several years after becoming infected with the AIDS virus before symptoms of the disease appear. Thus, people who are infected with the virus can infect other people—even though the people who transmit the infection do not feel or look sick.

Most infected people who develop symptoms of AIDS only live about 2 years after their symptoms are diagnosed.

The AIDS virus cannot be caught by touching someone who is infected, by being in the same room with an infected person, or by donating blood.

Junior High/Senior High School

Education about AIDS for students in junior high/senior high school grades should be developed and presented taking into consideration the following information.

The virus that causes AIDS, and other health problems, is called human immunodeficiency virus, or HIV.

The risk of becoming infected with HIV can be virtually eliminated by not engaging in sexual activities and by not using illegal intravenous drugs.

Sexual transmission of HIV is not a threat to those uninfected individuals who engage in mutually monogamous sexual relations.

HIV may be transmitted in any of the following ways: a) by sexual contact with an infected person (penis/vagina, penis/rectum, mouth/vagina, mouth/penis, mouth/rectum); b) by using needles or other injection equipment that an infected person has used; c) from an infected mother to her infant before or during birth.

A small number of doctors, nurses, and other medical personnel have been infected when they were directly exposed to infected blood.

The following are at increased risk of having the virus that causes AIDS and consequently of being infectious: a) persons with clinical or laboratory evidence of infection; b) males who have had sexual intercourse with other males; c) persons who have injected illegal drugs; d) persons who have had numerous sexual partners, including male or female prostitutes; e) persons who received blood clotting products before 1985; f) sex partners of infected persons or persons at increased risk; and g) infants born to infected mothers.

The risk of becoming infected is increased by having a sexual partner who is at increased risk of having contracted the AIDS virus (as identified previously), practicing sexual behavior that results in the exchange of body fluids (i.e., semen, vaginal secretions, blood), and using unsterile needles or paraphernalia to inject drugs.

Although no transmission from deep, open-mouth (i.e., "French") kissing has been documented, such kissing theoretically could transmit HIV from an infected to an uninfected person through direct exposure of mucous membranes to infected blood or saliva.

In the past, medical use of blood, such as transfusing blood and treating hemophiliacs with blood clotting products, has caused some people to become infected with HIV. However, since 1985 all donated blood has been tested to determine whether it is infected with HIV; moreover, all blood clotting products have been made from screened plasma and have been heated to destroy any HIV that might remain in the concentrate. Thus, the risk of becoming infected with HIV from blood transfusions and from blood clotting products is virtually eliminated. Cases of HIV infection caused by these medical uses of blood will continue to be diagnosed, however, among people who were infected by these means before 1985.

Persons who continue to engage in sexual intercourse with persons who are at increased risk or whose infection status is unknown should use a latex condom (not natural membrane) to reduce the likelihood of becoming infected. The latex condom must be applied properly and used from start to finish for every sexual act. Although a latex condom does not provide 100% protection—because it is possible for the condom to leak, break, or slip off—it provides the best protection for people who do not maintain a mutually monogamous relationship with an uninfected partner. Additional protection may be obtained by using spermicides that seem active against HIV and other sexually transmitted organisms in conjunction with condoms.

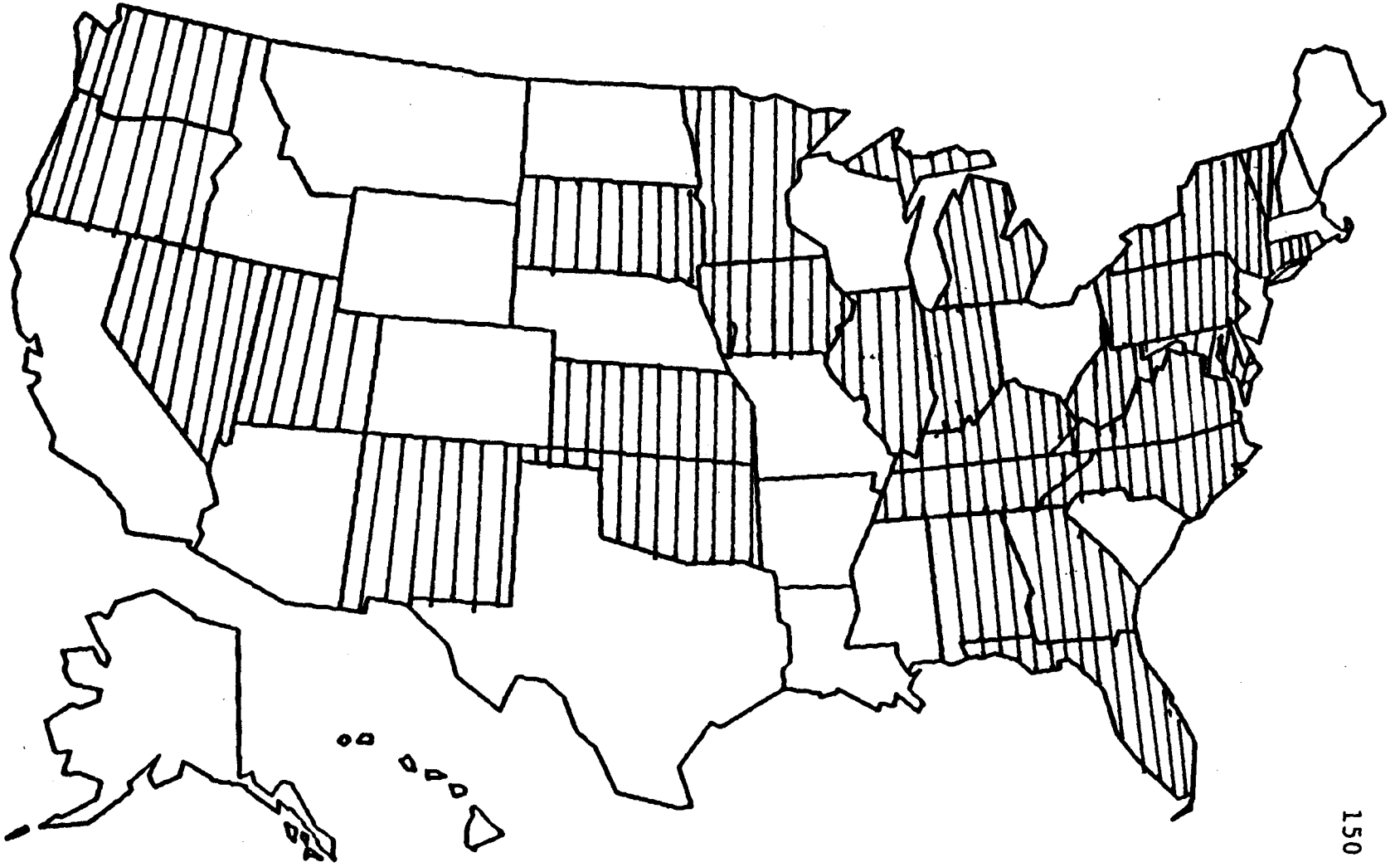
Behavior that prevents exposure to HIV also may prevent unintended pregnancies and exposure to the organisms that cause Chlamydia *infection, gonorrhea, herpes, human papillomavirus, and syphilis.*

Persons who believe they may be infected with the AIDS virus should take precautions not to infect others and to seek counseling and antibody testing to determine whether they are infected. If persons are not infected, counseling and testing can relieve unnecessary anxiety and reinforce the need to adopt or continue practices that reduce the risk of infection. If persons are infected, they should: a) take precautions to protect sexual partners from becoming infected; b) advise previous and current sexual or drug-use partners to receive counseling and testing; c) take precautions against becoming pregnant; and d) seek medical care and counseling about other medical problems that may result from a weakened immunologic system.

Source: Centers for Disease Control, Guidelines for Effective School Health Education to Prevent the Spread of AIDS, Morbidity and Mortality Weekly Report (37: suppl. S-2, 1988): 715.

APPENDIX D

STATES MANDATING HIV/AIDS EDUCATION



APPENDIX E

CRITERIA FOR EVALUATING AN AIDS CURRICULUM

Adolescents and young adults are now a primary risk group for contracting Acquired Immune Deficiency Syndrome (AIDS). At least 50% of all teenagers are sexually active; most will have more than one sexual partner, and some will be experimenting with drugs. Regardless of whether adults approve of the behavior, young people's lives may be at risk. Public schools must assume a key role in giving youth the information they need to avoid contracting this deadly disease.

Teaching about AIDS should take place within the context of a comprehensive health education or family life/sex education course. Such a course should present the positive aspects of sexuality as well as its dangers. An AIDS curriculum must be appropriate to the chronological and developmental age of the student and should be taught in small groups of 20 or fewer students.

Below is a checklist for parents, child advocates, school board members, teachers and administrators to evaluate existing AIDS curricula and to advocate for the establishment of high quality curricula. An effective AIDS curriculum should elicit "yes" answers to the following questions:

CRITERIA FOR EVALUATING AN AIDS cont.

CURRICULUM CONTENT

For students in grades 6 and up, does the curriculum give simple, clear and direct information about AIDS transmission and prevention?

Does the curriculum help students acquire the necessary self-esteem and assertiveness to choose to abstain from sexual intercourse?

Does the curriculum inform all students about effective ways to prevent infection when they become sexually active including information about condoms and their correct use?

Does the curriculum focus on teaching students how to make healthy sexual decisions and no just on the medical aspects of AIDS?

By emphasizing high-risk behaviors rather than high-risk groups, does the curriculum strongly convey the message that ANYONE can get AIDS regardless of race, sex, age or sexual orientation?

Does the curriculum affirm that people have natural sexual feelings?

Are several class periods provided to give each student multiple opportunities to rehearse making decisions based on the information they have learned about AIDS?

Does the curriculum allay young children's fears of AIDS?

Does the curriculum give young children a foundation for more detailed discussion of sexuality and health at the 6th grade level and later?

CRITERIA FOR EVALUATING AN AIDS CURRICULUM cont.

DEVELOPMENT AND IMPLEMENTATION

Does the program provide for adequate staff training to teach the curriculum?

Are staff helped to examine their own attitudes about sexuality and AIDS?

Are staff given accurate and detailed information about AIDS?

Are staff trained in the concrete skills needed to teach effectively as AIDS curriculum?

Is the same information given to limited English proficient students in their own language?

Is the information provided appropriately to students with hearing and visual impairments and to students with severe disabling conditions?

Is the curriculum updated regularly to incorporate new information as it becomes available?

Has sufficient community and parental support been generated to give teachers the backing they need to teach sensitive material in a direct manner?

Does the curriculum facilitate an on-going dialogue with parents on these issues?

Taken from, National Coalition of Advocates for Students, Criteria for Evaluating an AIDS Curriculum, Boston: 1988, p. 3-4.

APPENDIX F

CDC ASSESSMENT CRITERIA

Program Assessment

The criteria recommended in the foregoing "Guidelines for Effective School Health Education To Prevent the Spread of AIDS" are summarized in the following nine assessment criteria. Local school boards and administrators can assess the extent to which their programs are consistent with these guidelines by determining the extent to which their programs meet each point shown below. Personnel in state departments of education and health also can use these criteria to monitor the extent to which schools in the state are providing effective health education about AIDS.

1. **To what extent are parents, teachers, students, and appropriate community representatives involved in developing, implementing, and assessing AIDS education policies and programs?**
2. **To what extent is the program included as an important part of a more comprehensive school health education program?**
3. **To what extent is the program taught by regular classroom teachers in elementary grades and by qualified health education teachers or other similarly trained personnel in secondary grades?**
4. **To what extent is the program designed to help students acquire essential knowledge to prevent HIV infection at each appropriate grade?**
5. **To what extent does the program describe the benefits of abstinence for young people and mutually monogamous relationships within the context of marriage for adults?**
6. **To what extent is the program designed to help teenage students avoid specific types of behavior that increase the risk of becoming infected with HIV?**
7. **To what extent is adequate training about AIDS provided for school administrators, teachers, nurses, and counselors—especially those who teach about AIDS?**
8. **To what extent are sufficient program development time, classroom time, and educational materials provided for education about AIDS?**
9. **To what extent are the processes and outcomes of AIDS education being monitored and periodically assessed?**

Source: Centers for Disease Control, Guidelines for Effective School Health Education to Prevent Spread of AIDS, Morbidity and Mortality Weekly Report (37: suppl. S-2, 1988): 717-721.

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