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ABSTRACT

This guide provides information to support state and local efforts to fight the Acquired Immune Deficiency Syndrome (AIDS) epidemic. The guide is divided into three sections: (1) the need; (2) the challenge: providing effective AIDS prevention education; and (3) developing a comprehensive state leadership role. An extensive bibliography of 66 references is included. (SI)

# *EFFECTIVE AIDS EDUCATION:*
# A POLICYMAKERS GUIDE

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# EXECUTIVE SUMMARY

The AIDS epidemic is an extraordinary crisis that demands an extraordinary response. One in five people with AIDS are in their twenties, meaning that many were infected with HIV while still in their teens. This threat to our youth poses a significant challenge to those who are responsible for educational policies and programs, particularly since merely providing information about the disease will not, by itself, stem the epidemic. In order to be successful, policymakers must meet the larger challenges that are reflected in the words "effective", "comprehensive" and "complete coverage", which appear frequently in this guide.

**Effective Education** means:

- Convincing young people to *change their behavior* to avoid exposure to the virus.

**Comprehensive Policies** mean:

- Addressing the many aspects of providing effective AIDS prevention education, including: grade levels to receive instruction, content of materials and programs, community involvement and support, staff qualifications, policies for infected students and school staff members, support for training and technical assistance, interagency cooperation, funding, monitoring, and evaluation.

- Avoiding routine solutions. AIDS is an extraordinary public health threat that requires rapid response and the support of long-term programs.

- Improving school health education so that students better understand health, disease, and the relationship between their behavior and their health.

- Building public support for policies and programs.

- Ensuring that AIDS education and more comprehensive health education receive continued support and focus.

**Complete Coverage** means:

- Ensuring that everyone is educated. This includes all youth, including those who are hard to reach and out of school, as well as the teachers, administrators, and other school personnel who must be educated to provide this coverage.

AIDS is expected to become the leading cause of death among young people in the next few years. It will endanger the health of the next generation of Americans and the fiscal resources of our society. These facts urge that we provide effective education about the disease as quickly as possible. Now is the time for policymakers to provide leadership.

## INTRODUCTION

The AIDS epidemic has presented the American people with a terrible dilemma. It requires us to provide information to young people that we may not feel comfortable discussing in the classroom — or even at home. But while we agonize about talking frankly about how the disease is transmitted and can be prevented, more young adults are becoming infected with a virus that may kill them.

The AIDS epidemic compels us — as decisionmakers and educators — to act swiftly to assure that our young people do not put themselves at risk. This is an enormous job, and there are no ready solutions. Because the AIDS epidemic is new, we do not have programs that have proven best in helping young people avoid infection.

Still, research points us in very promising directions. We need the support and assistance of parents, communities, and churches. Students must get the same message at home and at school. We need to improve health education, so that students better understand how to protect themselves from AIDS and other health threats. We need to teach students to take responsibility for themselves — to make sound decisions and to counsel their peers.

Even if all states provide sufficient resources to establish sound AIDS education programs in all schools, the final responsibilitiy for school programs will fall on local districts. Every district will need to decide how explicit its programs will be and obtain the support of parents and the community for its efforts. This will not be an easy task. We hope this book, and other publications listed in the Resource Section, will provide the information to support state and local efforts to fight a lethal disease.

# I. THE NEED

Epidemics are nothing new. The history of the human race is shadowed by periods when great numbers of people were afflicted by serious diseases. Even as recently as 1918, an epidemic of influenza killed 400,000 Americans and millions of people around the world.

AIDS is described as an epidemic because it has spread very rapidly. In 1981, 328 people in the United States had been diagnosed with AIDS. As of June 13, 1988, 64,986 people had been reported ill with this disease. With the medical advances of the late 20th century, many people may have assumed that epidemics would be prevented or quickly halted. This has not turned out to be true. There is no cure for AIDS, and it is not considered likely that a vaccine or cure will be available soon. Drugs, such as AZT, are being tested and used to help treat the disease.

But AIDS is preventable. The epidemic can be controlled by changes in people's behavior to avoid exposure to HIV.

## WHAT ARE AIDS AND HIV?

People develop Acquired Immune Deficiency Syndrome (AIDS) because their immune system has been damaged by the Human Immunodeficiency Virus (HIV). HIV is sometimes called "the AIDS virus". HIV does not usually make people ill by itself. Instead, it damages the immune system, making the body more vulnerable to infections. These infections — often called "opportunistic diseases" — comprise the illness diagnosed as AIDS.

When HIV enters the body, it invades and destroys T-cells, cells that are manufactured by the body to fight disease. As T-cells are destroyed, HIV reproduces and infects other cells. Eventually, as many T-cells are destroyed, the body's ability to fight disease is crippled. HIV may also attack and damage the central nervous system.

People can be infected with HIV for a long time — for years — without knowing it. They feel well and look well, *though they can pass the virus to other people.* But the virus is slowly damaging their immune systems, and many, perhaps all, will eventually become very ill. Many will die.

HIV infection is expressed in several ways:

- infection without symptoms.
- ARC, or AIDS-related complex. This illness consists of symptoms, such as fever, swollen lymph nodes, and weight loss, that indicate to doctors that HIV has damaged the immune system.
- AIDS. AIDS is diagnosed by the presence of serious diseases, such as Kaposi's sarcoma (a rare cancer) or pneumocystis carinii (PCP) pneumonia, and HIV dementia, that indicate that HIV has severely crippled the body's ability to fight infection.

No one knows if everyone who becomes infected with HIV will develop AIDS. Data indicates that between 20 and 30 percent of those who are HIV-infected will develop AIDS within six years. A mathematical model based on projections about the disease predicts that after 15 years, almost everyone infected with HIV will develop AIDS. Because there is no cure for AIDS, virtually all of those people would die. Still, since the virus acts slowly, it will be a number of years before researchers can determine how many HIV-infected individuals will develop AIDS.

It is estimated that up to one and a half million people in the United States are infected with HIV. In other words, for every person ill with AIDS, approximately 25 are HIV-infected. Over a million Americans are infected, don't necessarily know that they are infected, and are capable of passing the virus to others without anyone knowing it.

## HOW MUCH IS REALLY KNOWN ABOUT HIV?

A great deal is known about AIDS and the virus — HIV — that causes it. Though AIDS was not diagnosed in the United States until 1981, the first evidence of HIV was found in blood stored in Zaire in 1959 — a time when Americans were building bombshelters in their backyards and fearing nuclear holocaust.

HIV, the "AIDS virus", is not like most viruses that we commonly discuss. The flu virus, for example, causes disease quickly. But HIV works slowly and persistently — it stays in the body for years. Unlike the flu virus, HIV is fragile outside the body, where it is easily killed by detergent or bleach. People can build a protective immunity to a flu virus, but there is little protective immunity to HIV in many people.

We know that HIV, unlike a flu virus, is *not* spread by casual, everyday contact. Large group studies have been conducted by independent researchers in different cities. People with AIDS are questioned in detail about the ways they might have been exposed to HIV. The results of this research are strikingly consistent and support the statements made in this

section and the section following.

In a major study of HIV transmission, a group of researchers studied 101 family members of 39 AIDS patients who were living at home. The purpose was to study household members (family and others) who had daily, non-sexual contact with people with AIDS or ARC. Family members helped patients get dressed, eat, and take a bath. The family members reported the following (among many) non-sexual contacts with a person with AIDS or ARC:

| | |
|---|---|
| Shared drinking glasses | 48% |
| Shared towels | 37% |
| Shared the same toilet | 90% |
| Shared the same kitchen | 93% |
| Shared the same bed | 37% |
| Hugged the person with AIDS | 79% |
| Kissed the person with AIDS on the cheek | 83% |
| Kissed the person with AIDS on the mouth | 17% |

Despite close and long-term contact with a person with AIDS or ARC, none of these 101 family members became infected as a result. The study concludes by supporting the view that "transmission of the infection requires injection of blood or blood products or intimate sexual contact and that longstanding household exposure to patients with AIDS is associated with little or no risk of transmission . . ."

Despite these studies, people fear that the "AIDS virus" is spread through tears, saliva, or urine. It is important to know that HIV is not always found in the tears, saliva, or urine of infected persons; and when found in these fluids, it appears in very low numbers. In one study, HIV was found in the saliva of only one of 83 infected individuals. In addition, saliva is thought to block HIV from infecting healthy cells. But researchers note that transmission through tears or saliva is a "theoretical risk".

What does a scientist mean by the term "theoretical risk"? It means that an event has never happened, is unlikely to happen, but scientists will not state that it is absolutely impossible. For example, it is theoretically possible that someday a meteor could fall and destroy your school, but this event is very unlikely. On the other hand, the risk of becoming infected with cholera in the United States is not theoretical. Five cases of cholera were reported in this country last year, so the risk is real — not theoretical.

Transmission of HIV through tears or saliva is a theoretical risk. It has never happened and is unlikely to happen. Despite six years of careful tracking, researchers worldwide have found no cases of AIDS caused by contact with the tears, urine, or saliva of a person with the "AIDS virus". To the best of our knowledge, HIV has never been spread through saliva, tears, or urine.

## *HOW IS HIV TRANSMITTED?*

1. *Through sexual intercourse with a person who is HIV-infected.* This is the major means of transmission. AIDS is a sexually-transmitted disease. As of May 9, 1988, 67 percent of all people with AIDS became infected through sexual contact alone. Transmission occurs through intimate contact with an infected person (penis-vagina, penis-rectum, mouth-rectum, mouth-penis, mouth-vagina). Both semen and vaginal fluids can transmit the virus.

Up to now in the United States, most cases of infection through sexual contact have occurred among homosexuals. Anal sex is considered to be a particularly dangerous activity, since the lining of the rectum is thin and easily torn. But AIDS is not a "gay disease." Men can infect women, and women can infect men. HIV is being transmitted among heterosexuals in this country; and in other parts of the world, sexual intercourse between heterosexuals is the primary means of infection.

2. *Through sharing an intravenous (IV) drug needle with an infected person.* When needles (works) are shared between people who inject drugs such as heroin or cocaine, blood from one person can remain on the needle and be injected directly into the veins of another person. Unfortunately, this is a very efficient way to spread the virus.

It is not always easy to convince people to stop sharing needles. First, people share needles as part of the ritual of using drugs. Because drugs such as heroin or cocaine are illegal, users of these drugs live outside of normal society and must depend upon each other. Tight bonds of friendship are formed, and sharing needles is part of the bond they share. Second, people in many states need prescriptions to buy needles, and it is sometimes illegal to carry them. As a result, needles may be scarce. This problem is compounded when there are not enough drug treatment programs to handle all IV drug users who would like to end their addiction.

It is estimated that 60 percent of the IV drug users in New York City are infected with HIV. If, as has been estimated, 75 percent of IV drug users in New York City share needles, then the infection may reach virtually every needle-sharing IV drug user in the city. The infection rate among IV drug users in other cities is much less, but it is feared that once introduced into other IV-drug using communities, HIV will spread rapidly among drug users, their sexual partners, and their children. About 19 percent of all people with AIDS in this country were infected by sharing needles, though in the first 4 months of 1988, 25 percent of AIDS patients were infected in this way.

3. *Through passing the virus from an HIV-infected mother to her child in the womb or during delivery.* It is believed that about half of all babies born to HIV-infected mothers will also be infected with the virus. About 75 percent of children with AIDS who are believed to have been infected by their mother in the womb or through delivery are dead. Women who want to become pregnant but think that they may have been exposed to HIV should seek counseling and testing before pregnancy.

One case of a mother transmitting HIV to her child through breastfeeding has been reported in Australia, and two possible cases have been reported in Africa. Yet, HIV-infected mothers have also breastfed their babies without transmitting the virus. Until this risk has been more fully evaluated, the Public Health Service recommends that HIV-infected women avoid breastfeeding.

4. *Through exposure to blood or blood products.* People who are diagnosed with AIDS now and were infected through blood transfusions or blood products were most likely infected before screening procedures were started. The risk has been greatly reduced by the screening of potential blood donors and of the blood supply. However, many hemophiliacs were infected before the blood supply was screened because they must be injected with a clotting medicine (Factor 8) that is made from human blood. And because health care workers are routinely exposed to blood, they are at risk of HIV and other infections and must take special precautions. Researchers believe that the risk of acquiring HIV in a health care setting is low, though needlestick accidents present the most risk. Still, data indicates that the rate of HIV transmission following needlestick accidents is less than one percent.

Ninety-seven percent of reported AIDS cases were transmitted by the methods discussed above. Three percent of reported cases have an "undetermined" cause. This figure has not increased throughout the course of the epidemic and includes:

- patients on whom risk information is incomplete (due to death, refusal to be interviewed, or loss to follow-up),
- patients still under investigation,
- men reported only to have had heterosexual contact with a prostitute, and
- patients who were interviewed and for whom no specific risk was identified.

Since some ways of spreading AIDS are illegal or considered immoral by many Americans, it would not be surprising if some patients would not admit to having used intravenous drugs or to being a sexually active homosexual or bisexual.

## HOW IS HIV NOT TRANSMITTED?

- Not through casual, everyday contact — hugging, a kiss on the cheek, holding hands, shaking hands, eating dinner together in a restaurant, or sharing an office or classroom.
- Not through the air — through sneezing or coughing.
- Not through insects (mosquitoes) or contact with pets.
- Not through food that is prepared or handled by an infected person.
- Not through donating blood. Sterile needles and equipment are always used to collect blood donations.
- Not from swimming pools, drinking fountains, public toilet seats, or door knobs.

## HOW CAN SOMEONE AVOID GETTING AIDS?

It is easy to explain how to avoid getting an HIV infection:

- Abstain from sex and IV drugs.
- People who choose to have sex should stay in a mutually monogamous relationship with someone who is not infected with HIV.
- If someone is not in a mutually monogamous relationship and chooses to have sex, they should use a condom *always, correctly, and from start to finish*. Condoms are not 100 percent effective, but they can reduce the risk of infection from sexually transmitted diseases such as AIDS. Even when condoms are used, research indicates that having multiple sex partners, and not knowing those partners well enough to determine if they may be at risk of an HIV infection, may put one at greater risk.
- Users of IV drugs *should not share needles*. If needles are shared, then the

"works" must be cleaned with bleach before each use. Teenagers should not share needles for piercing ears. People should not get tattoos unless they are certain that the needles are sterile. Athletes who inject steroids must observe the same precautions.

For more information, see the Resources Section.

## THE NEED FOR AIDS PREVENTION EDUCATION: WHY ARE OUR YOUNG PEOPLE AT RISK?

Many of our teenagers are (or soon will become) sexually active. Although we would prefer otherwise, the average age of first intercourse in the United States is about 16. In a 1986-1987 survey, Minnesota adolescents reported that their average age at first intercourse ranged from 13.4 years for males in the Minneapolis/St. Paul metropolitan area, to 14.6 years for females in Minnesota as a whole.

Consider that:

- 1 in 7 teens contracts a sexually transmitted disease *each year.*
- 1 in 10 teenage girls becomes pregnant *each year.*
- Only one-third of sexually active teens use contraception regularly, and of these, less than one-fourth use condoms.

All of these young people are at risk.

Currently, less than one percent (under 300 adolescents), have been diagnosed with AIDS. This low number is very deceptive.

> 1 in 5 people with AIDS are between the ages of 20 and 29. The length of time — possibly 6 years or longer — between HIV infection and the diagnosis of AIDS means that *many young adults with AIDS were infected with HIV while they were teenagers.*

It would be easier to convince sexually active teenagers that they are at risk if the effects of an HIV infection were immediately noticeable. The long "incubation period" of HIV infection before AIDS or ARC develops gives a false sense of security. Infected teenagers feel no symptoms — sometimes for years — so that risky behaviors do not appear to have the dire consequences that we warn about. Teenagers and their friends can feel safe in continuing to experiment with sex and drugs, because none of them has "gotten AIDS and died". Adolescents are still learning to control their impulsive behavior and to recognize the consequences of not doing so.

# II. THE CHALLENGE: PROVIDING EFFECTIVE AIDS PREVENTION EDUCATION

## EDUCATION TO CHANGE BEHAVIOR

e take risks. They drive too fast, don't go to the dentist, work under stress, don't exe-

cise. If information alone could change behavior, no adults would smoke or be overweight. People should "know better," but they take these risks because they consider the consequences acceptable. Our mission is to convince youth and others that the consequences of an HIV infection are *completely unacceptable*. Behavior must be changed to avoid infection.

The challenge of AIDS prevention is to provide a program that will motivate young people to *change their behavior* to avoid exposure to HIV. This means asking teenagers:

- to delay the initiation of sexual intercourse until they are older.

  — If they are already sexually active and will not stop, they must use condoms correctly and always.

- to avoid using IV drugs.

  — If they can't stop using IV drugs, they should never share their needles. If they do share needles, they should clean their works with bleach before each use.

Health behavior is notoriously difficult to change. Sex and family life education courses have been shown to increase teenagers' knowledge, but to have little effect on teen pregnancy rates or age at first intercourse. Policymakers, program providers, and public health professionals are justifiably worried that AIDS prevention programs will have the same effect — producing more knowledgeable teenagers but little or no change in their behavior to avoid infection with HIV.

We know that simply presenting information is not enough. We know that showing one video or presenting one assembly about AIDS is not enough to change behavior. It is very important that teenagers receive the correct information about AIDS. But if they know everything about AIDS and do not change their behavior, the epidemic will not be stemmed.

## PROMISING APPROACHES TO CHANGING BEHAVIOR

There are many theories about what changes behavior, and there is no one method that everyone accepts as the best. A brief description of several approaches considered promising follows.

**Comprehensive Health Education** It seems that there is always a health-related issue that seriously affects our society. Crimes related to illegal drugs worry many Americans. Alcohol abuse, tobacco use, and teen pregnancy are all serious problems. AIDS has been sudden and dramatic in its impact, with a potential for bankrupting health budgets, killing over a million young Americans, and profoundly impacting our social behavior and values. We need more than just one more state mandate or health initiative. We need to see our next generation of children grow up healthy, and to have attitudes and habits that will keep them healthy.

If students do not understand germs and the immune system — and how their behavior can affect their health — they will have a difficult time understanding how to avoid an HIV infection. The School Health Education Evaluation (SHEE), conducted with the Centers for Disease Control from 1982 - 1984, provides evidence that exposure to school health education can effect changes in students' knowledge, practices, and attitudes, and that such changes increase with the amount of instruction. Thus, AIDS prevention education may be

more effective if it is coordinated within a comprehensive health education curriculum K-12. AIDS education can be integrated into a number of subject areas, including: communicable diseases, sexually transmitted diseases, alcohol and substance abuse, community health, emotional health, personal and family life, care of the body, self-image, and coping and decision-making skills. It should stress skill development rather than the simple presentation of facts. We recommend the Centers for Disease Control's *Guidelines for Effective School Health Education To Prevent the Spread of AIDS* as a very helpful document that discusses ways in which AIDS education and health education can be integrated.

However, one point is worth emphasizing: If schools do not already have comprehensive health educaton in place, state policymakers cannot afford to wait. AIDS prevention education should begin immediately.

**Community Support and Involvement** AIDS education programs at school need the support of parents, the church, and the community. Students need to get the same message at home that they are getting at school.

A rural, low-income county in South Carolina recently published results of a successful community-based project to reduce a high rate of teen pregnancy. Parents and church leaders attended mini-courses and worked with specially trained teachers to promote a variety of healthy behaviors. The media helped promote the project. Community awareness activities emphasized skills such as making informed choices and assuming personal responsibility for the outcomes of one's actions. The result — after 2 and 3 years — was a sharp reduction in the number of unintended teen pregnancies.

"Parent's Nights" at school can provide an opportunity for parents to discuss questions about AIDS with a medical expert, preview AIDS education curricula, and talk to teachers who will provide instruction. Encouraging task forces and community coalitions is another way to broaden involvement.

**Peer-mediated programs** Teenagers listen to what their friends say and turn to them for help. It can be difficult to convince teenagers to do something that their friends won't do. It can be more effective to change the way teenage groups feel about certain actions — to change a group norm — so that teenagers feel that it is acceptable to behave differently.

An example of a very successful program for changing group norms is the Students Against Drunk Driving (SADD) organization. In an increasing number of communities, SADD has helped teenagers change their views, so that it is no longer acceptable — among teens themselves — to drink and drive. The organization has created support for alternative behaviors, such as having a designated driver who does not drink at a party.

While we know about peer pressure among adolescents, there is research to show that upper elementary school-aged children are the most influenced by the opinions of their peers. Thus, to be effective, we must start programs that change attitudes and behavior norms at an early age.

**Psycho-social models** Tied into the approaches discussed above are other programs that teach strategies for resisting peer pressure. New "psychological-social" approaches have produced a 50 to 75 percent reduction in the onset of smoking among adolescents. Such programs focus on short-term, especially social, consequences that are important to students. They teach young people to become sensitive to peer pressure and to resist the pressure, using a high level of student participation, including role-playing and other active exercises.

**Targeting youth who have dropped out of school** Recent unpublished research by Joy Dryfoos points out that risk behaviors overlap. Young people who have academic problems are more likely to engage in risky health behaviors and to drop out of school. This and other research make a compelling case for establishing schools as centers for more comprehensive programs to improve the health and life prospects of youth. Inside of school and out, it can be a waste of time and money to address inter-related problems such as substance abuse, HIV transmission, teen pregnancy, and academic failure in a piecemeal fashion through unconnected policies and programs. It is through more innovative linkages — and more comprehensive health education — that we can have a major impact on preventing the spread of AIDS among young people.

The social costs of a 25 percent school dropout rate are enormous, and will continue to grow throughout the AIDS epidemic. Students who are at the fringes — who seldom attend school and are failing their classes — may also be involved in activities that will expose them to HIV. This crisis re-emphasizes the fact that schools must take a leadership role now in finding and assisting those students who are not actively engaged with school. No other institution has the same access to young people.

## STRESSING ABSTINENCE

AIDS prevention programs need to stress that abstinence from sex and drugs will provide the most reliable protection from HIV. Many of our teenagers are abstaining from sex and drugs, and it is important that programs support and encourage this behavior. We need to stress that early and irresponsible sexual involvement can have very serious consequences — AIDS and other sexually transmitted diseases, unintended pregnancies, and other health and emotional risks.

However, if AIDS education policies that stress abstinence are interpreted as prohibiting the teaching of other prevention methods, there will be serious problems with providing effective education. First, some teenagers are sexually active and will not stop, despite our warnings. These young people need to know how to protect themselves from HIV. They must know that correct and consistent condom use, though not 100 percent effective, is essential.

Second, if we do not present all the facts about AIDS, including the methods for preventing it, there is a danger that teenagers will ignore the information. They may interpret warnings about the health risks associated with sexual intercourse as more adult threats to "behave yourself or else." We need to convince teenagers that we are seriously concerned about their health now and in the future, when they do become sexually active. Young people need to be personally convinced of the risk and convinced of the need to protect their own health.

## MINORITY YOUTH

AIDS cases are not spread evenly throughout our population. Blacks and Hispanics are disproportionately affected. Together, they account for about 40 percent of all AIDS cases. Minority children account for about 77 percent of all pediatric AIDS cases.

There is a special need for materials and programs developed for minority youth to reflect cultural differences. The words used in curricula, pamphlets, and videotapes must be understood and accepted by those who will read them. These should be developed in cooperation with community groups that are in touch with their constituents' needs.

For example, booklets translated into Spanish will not be understood or accepted by every Spanish-speaking American. There is a need for bilingual personnel in AIDS prevention programs for Hispanics and other second language groups. Special barriers such as illiteracy, poverty, and poor health care in general need to be considered by those who enact policies and allocate funds.

## A SPECIAL FOCUS ON YOUTH WHO ARE DIFFICULT TO REACH AND MAY BE ENGAGED IN HIGH-RISK BEHAVIORS

Youth who might be involved in risky behaviors include runaways, young homosexuals, and IV drug users. There needs to be a special effort to ensure that these youth know how to avoid infection.

Runaways are disconnected from traditional social systems. They are not in school, probably do not speak to their families, and may be involved in illegal, high-risk activities such as drug use and prostitution. Community groups who work with runaways are developing strategies for educating these young people about AIDS. Good community groups can help connect runaways with their families, provide food and health care, and can provide information that disconnected youth can accept. Such services are intensive — requiring workers to comb city streets, talking to runaway teenagers in the places where they gather. Their activities need support from states.

Similarly, adolescent users of illegal drugs are a hard-to-reach population. They are at high risk of infection, but are outside the mainstream of traditional networks. Treatment facilities are frequently inadequate for handling all those who seek help. While IV drug users remain on waiting lists, they inject drugs several times each day, increasing their chance of becoming infected and spreading the disease. States need to support and expand organizations that offer outreach, counseling, and treatment for IV drug users.

Education programs need to be sensitive to the fact that homosexual and bisexual men have been disproportionately affected by AIDS. But discussions about homosexuality may pose problems for decisionmakers. Communities may strongly oppose programs that discuss homosexuality without condemning it. At the same time, young gays and lesbians are sitting in AIDS prevention classes at school, though friends, families, and teachers may be unaware of it. Gay and lesbian youth will disregard messages that condemn what they feel.

People who become aware of their homosexual orientation at an early age may attempt to hide from their feelings by starting sexual relationships, using drugs, or running away from home. These activities put them at risk for AIDS. Education programs need to recognize the very real health risks associated with the cultural isolation of young lesbians and gays. School programs can present information about homosexuality and bisexuality in a neutral manner. If this is impossible, other means of providing information to young gays and lesbians should be established. This will not be easy, however, in communities that strongly oppose it.

# III. DEVELOPING A COMPREHENSIVE STATE LEADERSHIP ROLE

## INTRODUCTION

AIDS will soon become the leading cause of death in young people (aged 20-49) nationwide. Just a decade ago, no one had ever heard of the disease. This is an extraordinary crisis that demands an extraordinary response.

Our goal is to quickly and effectively educate all young people about AIDS prevention. We cannot settle for less than "complete coverage" — which means that *every young person receives effective AIDS prevention education*. To accept less than complete coverage is to accept the continuing spread of AIDS and many preventable and painful deaths.

Many board members, legislators, and educators have realized the need to get information to students. But some do not fully comprehend the effort that will be required. The numbers of people who must contribute to the goal of complete coverage are staggering. There are over 40 million students in our public schools who can only receive effective instruction if the following people are well-informed and adequately prepared for the task:

- 95,000 school board members
- 1.5 million administrators
- 2.2 million teachers
- 1.5 million aides and guidance counselors
- 25,000 school nurses
- 1 million support staff (bus drivers, janitors, cafeteria workers, etc.)

But formidable numbers do not pose the major barrier to achieving the goal of complete coverage. The real obstacle is any tendency to treat AIDS prevention education as "just another new program." Many educators and policymakers seem jaded by the continuous stream of innovations, special programs, and reforms that they have been told to implement over the past several years. There have been so many special study groups and action plans formulated on other education issues that we risk thoughtlessly responding to this latest problem of AIDS with a standard approach — hire staff, have them write materials and conduct workshops — then move on to the next new program. But AIDS education is not Metric education, and our usual action plans will not be adequate for this task.

## CURRENT STATE ACTIVITIES IN AIDS PREVENTION EDUCATION

Last December, the National Association of State Boards of Education (NASBE) conducted a major state-by-state survey of actions to promote AIDS education. The updated findings are:

- 23 states and the District of Columbia now require AIDS instruction. In June of 1987, NASBE found that only 5 states had mandated AIDS instruction.

- Mandates for AIDS prevention education exist in: Alabama, Delaware, the District of Columbia, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Maryland, Michigan, Minnesota, Nevada, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Virginia, and Washington State.

- States have approached the mandates in different ways. AIDS education was mandated:

  — as part of comprehensive health education in: Alabama, Virginia, Rhode Island, New York, New Mexico, Delaware, Hawaii, Illinois, and Oregon

  — as part of instruction on sexually transmitted diseases in: Ohio and Iowa*

  — as part of sex education in Nevada, Kansas, and Kentucky

  — as a communicable disease in North Carolina and Michigan

  — as part of a health curriculum in Pennsylvania

  — by itself in: Oklahoma, Alabama**, Maryland, Georgia, Washington, and Tennessee

  * The state code requires education in sexually transmitted diseases and "current crucial health issues"; AIDS is both.

  ** For the first year of the program; thereafter, it will be part of mandatory comprehensive health education.

- All states that mandate AIDS education allow parents to exempt their children from the instruction.

- 16 states and the District of Columbia have mandates that specify the minimum grade level at which instruction about AIDS will occur:

  Alabama: grades 7 - 12
  Delaware: grades K - 12*
  District of Columbia: grades 4 - 12
  Hawaii: grades 7 - 12
  Illinois: grades 6 - 12
  Iowa: grades 7 - 12
  Kansas: elementary and secondary school
  Kentucky: K - 12
  Maryland: at least once in grades 3 - 6; once in grades 6 - 9; and once in grades 9 - 12
  Michigan: elementary and secondary schools
  New York: at the elementary and secondary level
  Oklahoma: grades 7 - 12
  Oregon: kindergarten through high school
  Pennsylvania: once in elementary, junior high, and senior high school
  Rhode Island: mandated objectives for grades 7 through 12
  Virginia: learning objectives in different subject areas in grades 5 - 12
  Washington: once a year beginning no later than the 5th grade

*AIDS education is not specifically included in the State standards until grades 9 -12

- Some states, such as Wisconsin, West Virginia, Massachusetts, and Maine are extremely active in providing AIDS education although it is not mandated.

- Most states have not yet set up programs for hard-to-reach youth who may be involved in high-risk behaviors.

- Most departments of education indicated that they had received no state funds for AIDS prevention education. Health departments were more likely to have received state funds for AIDS-related health projects, and in some cases they funneled money to departments of education for school AIDS projects. Lack of personnel and time was a common complaint.

## THE NEXT STEP: A COMPREHENSIVE STATE LEADERSHIP ROLE

As is apparent from the information above, state policymakers are responding to the AIDS crisis. But few states have developed comprehensive long-range plans for ensuring that all students are effectively educated. The remainder of this guide will discuss elements of a comprehensive state leadership role.

State policymakers have two very powerful tools for effecting change at the local level. First, they can set state policies that require local systems to enact policies or programs. Second, they can provide state appropriations to either underwrite the costs of local policies/programs or to serve as a fiscal incentive to get local systems to pay their own costs. State policymakers can also require audits and evaluations to assure that local school systems have complied with state policy and funding requirements.

Using state powers to set policies and provide funding are critical elements for achieving the goal of complete coverage of effective AIDS prevention education. But states must not rely solely on these traditional leadership roles. In addition, state policymakers should:

1. *Create a State Plan* for AIDS prevention education to ensure that local school systems and the state education agency have the capacity to implement policies for effective AIDS education.

2. *Build Public Support* for effective AIDS prevention education to minimize resistance to state and local policies and programs, as well as to support the public expenditures needed to quickly and effectively educate all young people about AIDS prevention.

3. *Provide Continuing Attention* to the issue so that AIDS education does not share the fate of so many education "bandwagons" that were abandoned after the first parade.

## LEADERSHIP ROLE #1: CREATE A STATE PLAN

Developing state plans to address various education issues is a familiar activity for policymakers and staff. Creating a state plan for effective AIDS education will provide an invaluable vehicle for accomplishing the following:

- a systematic review of what's needed to create state and local capacity to quickly

deliver effective AIDS education,

- early involvement of diverse groups and individuals whose later support will be essential for implementing the plan,
- a state policy framework that will provide leadership to local districts on this difficult issue, and
- an overall state action plan that outlines objectives, actions to be taken, a timetable, and resources (those that exist and those that must be created or appropriated).

Some states write plans that are basically policy documents, elaborating on statutory or regulatory provisions by providing specific guidelines. Other states view a state plan as an outline for action to be taken by state department staff, a state task force, and/or other state agencies. We suggest that you develop a plan that accomplishes both goals: policy guidance and a well-organized state plan.

We have outlined ten elements of a state plan for effective AIDS prevention education to assist your efforts.

## *Element #1 of the State Plan: The Overall State Policy Position*

*Decide if AIDS education will be required or recommended.* States have answered this question in different ways, and the answer will depend on the best way to assist local districts. Though it is, in many instances, unnecessary for states to exert control over curricular content, there are strong arguments for requiring instruction about AIDS prevention. First, this is more than an educational question; it is a public health emergency. Second, some local districts favor such a requirement, since it can prevent each community — one by one — from having to convince its constituents that a controversial educational topic is urgently needed and must be taught. Instead, time can be spent on involving the community in designing a program that will meet its needs and can be supported.

On the other hand, some states have extensive AIDS education programs without having required them. Some feel that a requirement would be resented and counter-productive. With or without a requirement, policymakers should discuss what they should do about districts that refuse to teach about AIDS prevention.

It is important to consider, however, that state requirements without strong support — funding, technical assistance, and materials — may not work and may well be resented.

*Decide the context for AIDS instruction.* Most states have required that AIDS prevention be taught within the context of other, already-required health subjects, such as K-12 comprehensive health education, communicable diseases, sexually transmitted diseases, or family life education. However, some of these subject areas have been required for the first time, in order to provide a context for instruction about preventing AIDS.

The AIDS epidemic has provided an opportunity for states to require comprehensive health education for the first time. There is a serious need to improve health education — to prevent not only AIDS, but drug abuse, teen suicide, unwanted teen pregnancy, and other health risks. In addition, AIDS education may be more effective when it is integrated within a more comprehensive program that establishes a foundation for understanding relationships between personal behavior and health. For example, education about AIDS may be

more effective when students at appropriate ages are more knowledgeable about community health, communicable diseases, and drug abuse. Students need to learn to make wise decisions, to communicate their thoughts, to resist peer pressure, and to build their confidence and self-esteem. A new generation of healthier, more confident students could have a significant impact on our society's future.

*Decide how to link AIDS prevention education with other state policies.* In addition to setting a context for AIDS instruction, states should provide local districts with a model for including AIDS education as an integral part of instruction in many subject areas. The State can consider:

- *Changing curricular standards* for a variety of subjects at the appropriate age levels. The State Department of Education can be instructed to develop guidelines for teaching about AIDS in a variety of subject areas. A health class can study information about preventing the spread of AIDS. A social studies class can study the societal implication of the epidemic. A history class can examine the roles of other epidemics in world history. A math class can study models for projecting the rate of infection.

- *Changing state goals regarding learner outcomes or high school graduation requirements.* AIDS education topics can be integrated into already-existing state-recommended or -required learning outcomes. Several states — including Nevada, Kansas, Delaware, Rhode Island, Wisconsin, and Minnesota — have already developed new or revised outcomes for learning that can be adapted by others.

  If a state is really committed to preventing not only AIDS, but drug abuse and teen pregnancy, it should seriously consider making comprehensive health education part of its state goals for students or high school graduation requirements. The advantage of this approach, as regards AIDS education, is that it gives teachers and students a chance to study the disease over the course of a school year, rather than as a one-shot "AIDS Awareness Day" approach. The former approach has a better chance of influencing students to change their behavior.

- *Changing the state testing program.* Since we all know that schools provide instruction in areas measured by either state-approved or -created achievement tests, policymakers should direct the developers of those tests to include items about HIV and AIDS.

- *Changing criteria for textbook selection.* If your state has a textbook approval system, we suggest that you develop criteria requiring acceptable texts in science, health, and relevant subjects to include AIDS prevention units. These units can be required to include strategies that are considered promising for changing student attitudes and behavior to avoid infection. If your process includes an independent textbook evaluation committee, you should, as state leaders, encourage the committee to develop its own criteria to ensure that effective AIDS education is included in approved textbooks. We know of no other action that will so pressure textbook publishers to include effective AIDS prevention education materials promptly.

## Element #2 of the State Plan: Funding and Other Incentives

Effective AIDS education cannot be delivered quickly to all students in your state without any additional cost. The question is: To what extent will the State underwrite these costs? In large part, this will depend on how many other education costs the State covers, as well as the amount of legislative support for special appropriations for AIDS education. And if local districts cannot raise needed revenues quickly, the State may have to assist.

State leaders can start by doing a fiscal analysis of what is needed to provide effective AIDS education to all students statewide in a short period of time. You can use this analysis to muster legislative support for special funds.

After determining how much state funding will be needed to initiate this program, you may need to consider:

- how you will distribute funds to local school systems,
- funds needed for state administration, and
- procedures for local application for state funding, such as requirements for information, allowable expenses, and the process of application approval.

In addition to procuring the funds to underwrite local start-up costs, policymakers should consider providing incentives for districts that are improving their health and AIDS education programs. Outstanding school or school district achievements can be recognized and publicized.

Though substantial resources will be needed to get AIDS education programs up and running, these are one-time start-up costs. After a few years, programs can be evaluated and refined, if necessary. At that point, policymakers can decide if any additional funds will be needed to improve and sustain what already exists.

## Element #3 of the State Plan: Policies Regarding Local Plans

States may wish to consider requiring local school districts to develop a plan for quickly and effectively delivering AIDS education. As part of this local plan, policymakers must discuss to what extent the State should require community involvement in local programs. Community support is essential to effective AIDS education, and thus should be strongly recommended — if not required — at the state and local levels.

The Washington State legislation requiring AIDS education states that: "Each district board of directors shall adopt an AIDS prevention education program which is developed in consultation with teachers, administrators, parents, and other community members including, but not limited to, persons from medical, public health, and mental health organizations and agencies . . ."

Similarly, Kentucky requires an education plan to be developed by "an advisory committee composed of an equal number of lay persons and professional resource personnel, appointed by the district superintendents." Parents must be included and other possible members are listed.

Decisionmakers need to discuss the role of community advisory committees. Will the committee develop an education plan? Or will it issue recommendations to the district

superintendent? Must the committee approve educational materials? Will the policy specify which groups must be represented, such as parents, teachers, youth-serving organizations, etc.?

Many policies recommend, and some require, that schools hold "parent's nights" so that parents can preview the school's AIDS prevention education program and any materials or videotapes that will be used. Policymakers can require that written notification be given for such a meeting and that meetings be held at times, such as evenings, when parents are most likely to be able to attend. By requiring or recommending school efforts to involve parents, policymakers can help encourage parental support for school programs — and more effective programs.

## *Element #4 of the State Plan: Policies Regarding AIDS Prevention Education: Content, Approaches, and Materials*

There are several policy issues regarding the content, instructional approaches, and materials to be used as part of AIDS education. These issues are discussed below.

*Decide which grade levels should receive instruction.* States have required instruction at different grade levels. Half of the states that have mandated AIDS education require instruction to start during elementary school. All begin instruction by 7th grade, though it is not specifically required in the Delaware State standards until grade 9. Because AIDS education may be most effective as part of a comprehensive health program for grades K - 12, it would make sense to include AIDS instruction throughout such a program. The age at which students should receive explicit information about AIDS prevention will vary by community.

There are good reasons to discuss AIDS with young children. They may have heard of the disease and may be frightened of it. As part of their general health classes, they can be told that AIDS causes some adults to get very sick, and that not many children have it. They can be told that AIDS is hard to get, and that they won't get AIDS by touching or being near someone who has it. Scientists and doctors are working hard to find a cure for the disease and to help people who are sick. The main point is to ensure that we don't damage children's sense of security by frightening them about things they don't necessarily understand and cannot control.

*Decide which topics and strategies are necessary.* The New Mexico State Board Regulation No. 87-11 requires that: "The instructional program shall include, but not necessarily be limited to: a) definition of AIDS, ARC, HTLV-III; b) the symptoms and prognosis of AIDS; c) how the virus is spread; d) how the virus is not spread; e) ways to reduce the risks of getting AIDS, stressing abstinence; f) societal implications for this disease; g) local resources for appropriate medical care; and h) ability to demonstrate refusal skills, overcome peer pressure, and use decision-making skills."

Consider that AIDS instruction may be more effective if it:

- is taught in multiple sessions each year,
- dispels myths,
- convinces students that they are personally at risk,

- clearly states the community and health values that are being emphasized,
- helps students identify the behaviors they must change or avoid,
- helps students practice and master the skills they need to change or choose their own behavior, and
- stresses prevention, rather than simply giving medical facts.

Policies should emphasize that effective AIDS prevention education is designed to change student behavior to avoid exposure to the HIV virus.

*Discuss age and developmental appropriateness.* A policy can require, and many state policies do require, that courses and materials be appropriate to the age and developmental levels of students. Some of the AIDS education materials that have already been developed are recommended for use by a wide range of age groups, and these materials need to be carefully analyzed before they are used. The needs and concerns of upper elementary school students differ dramatically from those of high school students.

*Determine which instruction materials are needed.* Policymakers must consider whether to require the development of AIDS education materials such as curricula, teacher's guides, or resource guides. In some states, a curriculum or teacher's guide has been developed by the state department of education and provided to local districts. States have shared curricula, so that each state does not have to start from scratch. Alabama is the only state with a mandatory state-wide AIDS curriculum.

Alternatively, funds can be provided to local districts for the development of materials. In Washington and Oklahoma, locally developed curricula must be approved for medical accuracy by the state department of health.

State departments of education have established resource libraries to provide districts with access to a range of materials, including curricula, videotapes, brochures, and teacher's guides.

*Consider the rights of parents who object to AIDS instruction in the schools.* Every state that requires AIDS prevention education allows parents to exempt their children from such instruction. This is approached in different ways, however. Not all policies mention this issue, under the assumption that parents have this right and that schools must help educate and involve parents in school programs. Most states require parents to provide a written request to exempt the child, though in Nevada, parents must supply written permission for their child to attend.

In New York, a parent who wishes to remove a child from such classes must assure that similar instruction will be provided at home. In Washington State, districts are required to hold meetings for parents to discuss AIDS education programs, and parents who wish to exempt their children must attend a meeting. Schools can be required to provide AIDS education materials to parents who prefer to provide the instruction at home.

## Element #5 of the State Plan: Policies Regarding the Qualifications of Staff Providing AIDS Education

Teacher preparation is a lengthy and costly concern, especially when schools do not

already have certified health instructors. Teachers who have never taught sensitive health subjects will need special training, as well as information to allay their fears about AIDS. They will need to answer explicit questions from students and deal with parental concerns, and will need effective materials and teaching strategies. Since the aim is to influence student behavior, as well as to impart information, teachers need to learn how to personalize the issue for students and convince them of the risk. Teachers need to identify and help students develop necessary skills such as decisionmaking, communication, and assertiveness with peers. Teachers need to know the best ways to help students practice these skills.

For some teachers, this will involve as much as four days of training. For teachers who are already trained as health instructors, less time will be needed. The Connecticut AIDS education program for school personnel has found that teachers require a minimum of six hours of training to teach about AIDS in the classroom. Policymakers and administrators sometimes do not realize how critical this training is to the effective implementation of AIDS education.

The Kansas State Board policy mandating sex and AIDS education requires the State Department of Education to develop standards for teacher preparation, and requires teachers to meet those standards once they have been developed and approved. The Nevada legislative mandate requires that "... courses may be taught only by a teacher or school nurse whose qualifications have been previously approved by the [local district] board of trustees."

Policymakers may also consider waiving teaching certification requirements so that trained individuals from outside a school system can provide AIDS education. Such individuals should not serve as substitutes for training teachers and setting up comprehensive school programs to prevent AIDS, but may be a stop-gap measure to ensure that AIDS prevention education begins immediately. They can supplement a program or provide instruction until teachers are trained. Trained personnel may include public health personnel, physicians, nurses, or representatives from youth-serving organizations.

## *Element #6 of the State Plan: Policies Regarding HIV-Infected Students and School Staff*

Most states have proposed guidelines to help local districts develop policies for evaluating the attendance/employment of HIV-infected students and staff members. However, these guidelines rarely discuss difficult issues such as confidentiality, federal laws on discrimination and the rights of the handicapped, state and local communicable disease laws, and school liability.

It is important that policies be specific. When superintendents have had to make decisions about HIV-infected students or teachers, they have often discovered that their policies lack sufficient detail and must be rewritten. This involves research, meetings, and consensus. And when policies must be rewritten, a child or teacher will often be asked to leave school in the interim. Confidentiality may be destroyed, and other legal issues may arise, as well.

For a detailed analysis of the subject, we suggest you read *A Guide to Developing Policies for HIV-infected Students and School Staff* (Fall 1988) by the National Association of State Boards of Education. This document will offer guidance from a number of public health, medical, legal, and education organizations on the following, often troublesome issues:

1. *Determine the general principles for an attendance or employment policy.* HIV-

infected students and staff members should generally be allowed to stay at school or at their job. Under which circumstances would their education programs or job assignments be changed? Do local districts know how to use available state and federal resources? Whom do they call for information or assistance?

2. *Discuss the connection between AIDS policies and existing communicable disease policies.* There are many diseases that are more communicable and threatening within a school setting than is AIDS. There is a need for states to assist districts to adopt sound communicable disease policies that will protect the health of students and staff, at the same time as protecting the rights of infected individuals. HIV can (and perhaps should) be discussed within the context of already-existing and sound communicable disease policies, but such policies should not treat AIDS (or an HIV infection) as if it were an easily communicable disease such as chicken pox.

3. *Set guidelines for infection control in the school.* It is essential that policies set routine procedures for sanitation and hygiene when handling all body fluids. They should also stress the need for training of all school staff in these routine procedures.

4. *Ensure that policies are not modeled after already-existing policies dealing with disciplinary problems, for example.* The policy for handling students and staff infected with HIV has a different purpose and must deal with different sorts of issues.

5. *Recommend a good due process procedure based on state and federal laws.*

6. *Provide guidance on pertinent federal legislation on discrimination and protection for the handicapped.*

7. *Describe the procedure for evaluating the placement of HIV-infected students or staff members.* Issues to consider:

   a. Who is first notified about the presence of an infected individual in the school?
   b. Does the student/staff member stay at school until a decision is made about their education program or job assignment?
   c. How will placement decisions be made? Consider that if a superintendent, public health official, the infected person or representative, and the relevant physician determine that an HIV-infected individual poses no threat to the school environment, convening an Advisory Board may not be necessary. There should, however, be provisions for regularly reviewing the case and a process for determining any changes that may need to be made in education programs or job placement.
   d. If there is an Advisory Board, make careful recommendations about its membership. If the panel is too large, it will be hard to reach consensus and also protect the confidentiality of the infected person. Yet, the concerned parties and necessary experts must be involved. In general, a public health official, the person's physician, the superintendent, a school representative, an advocate for the infected person, and the infected person or parent/guardian might be included. In addition, consider the following points regarding the Advisory Board:
      What are its responsibilities?
      What criteria does it use to reach a decision?
      What is the timeframe for the process?
      Who makes the final decision?

   What provisions should be made for reviewing the case from time to time? Does the policy discuss the provisions for instruction if a student is excluded from school?

10. *Describe an appeals process for superintendent decisions.*

11. *Discuss employment issues.*

12. *Give guidance on procedures for evaluating special education students.*

13. *Protect the confidentiality for persons infected with HIV.*

14. *Consider the question of local district liability.*

15. *Explain why routine testing is not considered necessary.*

## Element #7 of the State Plan: State Support for Training and Technical Assistance to Districts and School Staff

In order to quickly deliver effective AIDS education, the state plan must address current resources for providing training and assistance to local schools. This element of your plan should ensure that state education agency staff have the necessary support to carry out their role.

The agency will need sufficient staff who have the qualifications and experience to provide state leadership in this area. Their role will be to work with institutions of higher education, regional education centers, local districts, and those who will provide training and technical assistance to the above. The education staff will have to take a lead role in providing the kind of training that will increase local capacity to train their own staff. It is unrealistic for policymakers or the state education agency to expect the agency staff to be the primary trainer for AIDS educators in the state. The task is too big. Instead, they should focus their efforts on building the capacity of others.

A major barrier to this goal has been lack of state funding. State policymakers must work with other agencies and with legislators to discuss what effective state support will involve — and what it will cost. To be persuasive, this will require presenting a complete picture of what must be accomplished — number of teachers to be trained, number of school staff to be educated, numbers of students to be taught, number of out-of-school youth to be reached, etc. The urgency of the situation must be made clear. State statistics for teen pregnancy rates, sexually transmitted diseases, illegal drug use, and school dropout can help bolster arguments that teens are at risk.

## Element #8 of the State Plan: Interagency Cooperation

Given how quickly we need AIDS prevention education, it is unrealistic to expect departments of education to shoulder all responsibility for the programs. A critical component of the plan is an outline for cooperation with departments of health and other state agencies that have a role to play in dealing with the crisis.

As an example, departments of health can provide accurate, up-to-date information about AIDS, as well as about the nature and prevalence of cases statewide. They can also provide data about sexually transmitted disease and pregnancy rates, and can review state and/or local curricula for medical accuracy. Public health education efforts can be linked with school programs.

Social service agencies are involved with other important adolescent health issues such as teenage pregnancy, sexually transmitted diseases, health care for the homeless, and child abuse. Their programs and aims can link up well with AIDS prevention initiatives. Partnerships with state education associations can be valuable. These organizations can provide their members with information about AIDS and how they can contribute to AIDS education efforts in their state. Working with state medical and health associations can help members of these groups understand how best to work with school districts.

Working with youth-serving and parent organizations — and encouraging schools to do the same — can assist schools to provide AIDS education. Some organizations have developed materials and have trained instructors who can teach about AIDS. In addition, this offers another opportunity for encouraging community involvement and support of school programs.

## *Element #9 of the State Plan: An Outline of Action Steps, Persons Responsible, and a Timetable for the State Education Agency to Implement the Plan*

Because so many different activities must be simultaneously accomplished to implement the plan you have developed, we suggest that you develop an outline for action steps. Some elements to consider for a workable outline are:

- *Set measurable objectives.* Instead of "The state will improve the training of teachers who will provide AIDS education," write: "By 4/1/89, 300 teachers will have attended a 4-day in-service program on effectively teaching about AIDS and related health subjects."

- *Estimate the costs of different objectives and rank them according to their priority.* This will help ensure that the most important tasks are completed if funds run short.

- *Designate which units/individuals will have the lead or support responsibility for each task.*

- *Set careful timetables* so that deadlines can be met and work is distributed throughout the year.

## *Element #10 of the State Plan: Monitoring and Evaluating the Success of State and Local Programs*

Probably the most critical element of your plan will be how you hold yourself accountable for what you plan to accomplish. Policymakers need to know if AIDS education programs are meeting their primary goal: that students are, in fact, avoiding exposure to HIV as a result of the programs. Few AIDS education policies have discussed the issue of monitoring local programs and establishing criteria to evaluate the success of statewide efforts. Policymakers must determine which information must be gathered to determine the success of state leadership. One obvious statistic would be the decline, over time, of the number of new cases of sexually transmitted disease among teenagers and young adults.

Policymakers can require that information about AIDS be folded into the state accountabil-

ity system and included in tests required for graduation. But the question of whether AIDS instruction produces changes in student behavior is more complicated. One state's attempt to gather information on student attitudes and behavior was the *Minnesota Adolescent Health Survey* conducted in 1987 by the University of Minnesota Adolescent Health Program and the Minnesota Department of Health. Students were asked about their attitudes and behavior on a wide range of health-related issues such as mental health, eating behavior, sexual activity and identity, drug and alcohol usage, and relations with adults. Information gained from the survey will serve as valuable baseline data for program providers in the future.

There is no simple way that the effectiveness of AIDS prevention education programs can be measured, but it is important that state boards of education study this issue and raise it with other policymakers. They may wish to release special contracts for evaluation studies to institutions of higher education and/or public and private organizations with research capacity. These evaluation studies can track, over several years, the effectiveness of AIDS education and comprehensive health education in altering risk behaviors. States may consider supporting focus groups, where groups of teenagers are allowed, with complete confidentiality, to discuss school programs and how these have affected their own attitudes and behaviors. Focus groups can allow evaluators an opportunity to listen to different groups of young people frankly discuss their attitudes and describe their response to AIDS prevention programs.

## LEADERSHIP ROLE #2: BUILDING PUBLIC SUPPORT

Without a broad base of support, your efforts to improve AIDS prevention education may never overcome the objections of those who oppose it. It may be opposed on a number of grounds, including the issue of state versus local control, funding priorities, already-overburdened school districts, or the sensitivity of the subject matter.

**Seek the support of other educators.** Policymakers should look for support from other groups who are involved in education, especially associations representing school boards, teachers, school administrators, elementary and high school principals, school nurses, health educators, school guidance counselors, special education teachers, and the PTA. Members of these groups may belong to national organizations that are also actively supporting AIDS education and may bring additional resources and support to the project.

**Gain political allies.** Because AIDS education is a controversial issue, state boards will need allies in the governor's office and the state legislature. A supportive governor can make all the difference, but states have acted without the governor's active endorsement. Even if the governor does not choose to support the idea, it would be imprudent not to discuss the proposed policy with his/her office. Legislators are being pressured to take action and may be debating AIDS-related bills. State legislatures have required AIDS education, and such bills need input from the education community in order to incorporate elements considered crucial to program success — including funding.

**Cooperate with other interested state agencies and organizations.** Youth-serving and other community groups can be powerful allies. Their constituents may include parents and other influential community members, and they can help educate and organize these groups in support of a proposed policy action. The church is a valuable partner, and many church leaders have endorsed the need for education about AIDS. Other state agencies have programs that link up well with AIDS education initiatives.

**Create an advocacy network.** The right network of supporters is a powerful political tool

and can be persuasive in pushing for state action. This network can be formalized into a voluntary organization to promote community awareness and understanding of AIDS prevention. Such a network can:

- advocate a policy at the state level and through the media,
- give presentations about the policy to community groups,
- respond to requests for information, and
- develop a library of materials or brochures to be sent to those who request information.

**Commission a statewide poll to demonstrate support.** Nationwide polls show that a majority of Americans support education about AIDS at school. Such figures may be helpful in persuading state decisionmakers that the public is not as opposed to AIDS education as might have been thought. A Kansas poll showed that over 80 percent of its citizens support AIDS education in high school. A random telephone poll in Michigan showed that over 90 percent of its citizens favor school instruction about the characteristics of AIDS, how it is transmitted, and how it is prevented. Seventy-eight percent favor teachers discussing condoms.

**Use the media constructively.** AIDS is a "hot" media topic, and those involved in this field should expect media attention. It is better to anticipate this attention with a well-planned campaign. And the media can help educate the public — if state policymakers make an effort to establish good media contacts and provide them with information.

Advocacy groups should include a representative of the media who can ask local radio and television stations to develop and broadcast "spots" on AIDS. A media representative can help issue press releases, arrange interviews on television or radio, and help promote publicity for speeches in key cities statewide. The media has been a valuable and positive supporter in some states that have required AIDS education.

**Hold public meetings.** Even if they are not required, public meetings will allow opponents the opportunity to air their views. Without this opportunity, groups can justifiably charge that actions were taken "behind their backs." In the same way, parents who have not been invited to preview school programs may feel that a controversial subject has been "sneaked" into the curriculum. These charges, even if from a group representing a small number of people, can be amplified in the press and give the project a bad image.

Policymakers may be reluctant to invite the opposition to state its views. Yet those who have helped enact controversial policies encourage policymakers to include groups with opposing views early in the process. Opposing views will be aired eventually, and it is better that these be discussed and resolved, if possible, at the beginning.

*Identify the likely opponents.* Policymakers should find out, if possible, which groups will oppose a policy that promotes AIDS education and how many people they represent.

*Know these common arguments against AIDS prevention education:*

- AIDS prevention education, because it involves the discussion of sexual practices, is the duty of parents and churches. AIDS education at school violates parental authority and the separation of church and state.

- AIDS prevention education, with its discussion of methods of prevention such as condoms, will encourage teen promiscuity.
- AIDS prevention education in the classroom will not strongly promote abstinence from sex and drugs.
- AIDS and other health education subjects draw time away from other, more important academic "basics."
- AIDS prevention education should be a local option.

*Prepare answers to opposing views:*

- AIDS prevention education is a crucial public health issue above all else. This is not a backdoor attempt to push for sex education. We are faced with a lethal epidemic and our only method for controlling it is with education.
- The content of AIDS instruction will be locally determined. The policy encourages parental and community involvement in planning AIDS education programs.
- This is not a program that is designed to interfere with the rights of parents and the church to teach values related to sexuality and drug use. The support of parents and churches is needed to make AIDS prevention efforts successful.
- AIDS prevention education programs will stress that abstinence from sex and drugs is the best way to avoid infection with HIV.
- Proponents of AIDS prevention education agree that adolescents are engaging in sexual activity at too young an age and that they should be protected from unwanted early pregnancies, sexually transmitted diseases, and involvement with drugs.
- Research has shown that sex education has not reduced or increased the age at first intercourse.
- The viewpoints of different religions towards sexuality, marriage, pre-marital sex, contraception, and other sensitive issues can be discussed in AIDS prevention education classes.
- On the argument that AIDS prevention education interferes with other course areas: Information about AIDS can be taught in many subject areas. Health education is an obvious choice, but an economics class can calculate the health and other costs associated with the epidemic. A science class can study HIV or an epidemiologist's role in understanding disease.
- On the issue of state versus local control: The content of AIDS prevention education programs will be determined by local districts. AIDS education is being required by an increasing number of states to publicly stress its importance in helping to stem the epidemic. Such state leadership can assist local districts, which must convince parents and the community that this is an urgent issue. A state requirement can prevent every single district from having to convince its community that AIDS education is necessary. Instead, districts can devote their time to planning a program with community and parental involvement.

**Establish a state "SWAT" team to assist local districts with crises.** You may want to establish an assistance team to help local districts with difficult issues — such as public knowledge that an HIV-infected child or teacher is at school, or opposition to an attendance policy or education program.

Such a team was formed in Michigan. Ned Hubbell, the Assistant Superintendent for Public Affairs for the Michigan Department of Education (and a former journalist), organized the team. An action plan was designed for assisting schools that had admitted a child with HIV, giving special attention to handling the press.

In thinking about who would be affected by such an incident, the team decided that everyone in the community would need information. As a result, they decided to work with the media and publicly report that an HIV-infected child was attending school (but *not* the identity of the child or the name of the school). They decided to do so in order to give facts about the disease and explain the district's policy. The child's confidentiality would be protected.

In planning for a public announcement, the team gathered public relations experts and listed ten questions that reporters would likely ask.

1. Who is the student? Is it true that it's a white male who is 9 years old?
2. How long have you known about this student?
3. What are you going to do about it?
4. What is the danger of transmission?
5. How can you be sure that no one will get AIDS from the student?
6. Is the school a safe place for someone with AIDS? Are schools still safe for everyone?
7. Will you screen all employees and/or students for AIDS?
8. What if parents boycott the school?
9. Can the student eat in the lunchroom, ride the bus, engage in sports, use the public bathroom, etc.?
10. What have other schools done?
11. Is your action in line with the "handicapped" law?

The team's recommendations included:

*If you decide to hold a press conference, act quickly.* This will prevent rumors from circulating further.

*Hold the news conference at a neutral setting, not at a school* (to prevent reporters from disrupting the school). You also do not want to indicate which school the child attends. A better location is the offices of the public health department.

*Choose one primary spokesperson,* for example, the superintendent; the state team can write his/her remarks (these can be very brief). Resource people (public health official, physician, a school board attorney, the president of the school board) can accompany the spokesperson, make short statements if desired, and answer questions from reporters. All should be briefed on the questions listed above.

*Do not give any personal information about the child — including sex or age.* With Michigan's first case, only the school district — not the school the child attended — was announced. Questions about identity can be answered briefly, for example, "In accordance with the family's wishes, I cannot answer that question" or "We are liable to a lawsuit if we reveal that information".

*Hold the press conference so that it can be reported on the 6:00 news.* Press releases announcing the news conference should be issued at 9:00 on the morning of the conference. The conference itself should be held no later than 2:00 p.m. (and not earlier than 2:00 so that reporters cannot interview students as they leave school). If the press conference is held on a Friday afternoon, reporters cannot visit schools to interview students until Monday.

Press conferences should be preceded and followed by meetings for school staff and parents. Ideally, there will be a policy already adopted by the district for handling HIV-infected students and school staff, but if there is not, a policy should be adopted with broad community representation. AIDS prevention education for students is essential.

The Michigan team has assisted several districts. The state's first case received a good deal of publicity. When a second child was admitted in a different district, there was much less media interest.

## LEADERSHIP ROLE #3: PROVIDE CONTINUING SUPPORT AND FOCUS ON THE ISSUE

Effective AIDS prevention education for all students will not be accomplished by one big six-month campaign. Rather, it will require a sustained effort. We are committing ourselves to a long-range task. For some states, this task will include strengthening school health education generally, with a focus on preventing AIDS and at the same time reducing substance abuse, unwanted teen pregnancy, sexually transmitted diseases, and other threats to adolescent health. This will mean the implementation of more comprehensive school health education and integrating health policies and programs.

Therefore, we suggest that you:

**Request Progress Reports.** Asking for reports is one way that policymakers can ensure that their plans are being carried out. We suggest that state boards direct staff to put AIDS education on their agenda about every 6 months for a progress report. It is important to carefully consider the questions that you will want answered during these reports. First, the questions that you ask will explain your priorities to the staff. If you ask staff to report on the number of workshops that were held, your staff will make sure that they hold enough workshops. Second, the information you request should tell you whether or not effective AIDS prevention education is occurring statewide. The number of teachers trained will not necessarily give you this information.

Questions such as the following will help you determine whether effective AIDS education is occurring around the state:

1. How much progress has been made in achieving the state plan? The more specific and concrete your plan, the better measure it will provide.

2. How much progress has been made in providing *effective* AIDS education? Indicators might include:

   - decreases in rates of sexually transmitted diseases,
   - number of school districts reporting policies, action plans, and programs,
   - an increased number of schools that are making a conscious effort to design pro-

grams to change student behavior,

- results from surveys of student attitudes or behavior that indicate that student attitudes and behavior are changing to avoid exposure to HIV,
- student test results, and
- evidence of community and parental involvement in school programs.

3. Is there a need for the state to increase support for or modify current policies or programs?

If you are a legislator, we suggest you request a yearly progress report from the state board and the department of education.

**Continue to advocate AIDS prevention education.** Suggestions for keeping the issue alive:

- When you give speeches, mention the progress made towards educating all students effectively about AIDS.
- During budget discussions for the state department of education, ensure that support for the state AIDS prevention education plan and for sufficient staff in the department are items in the budget.
- When you are interviewed by the media about current and important issues in education, mention AIDS prevention.
- If your state has exemplary recognition programs for schools, highlight effective AIDS education programs when you are listing their other accomplishments.

# *IV. CONCLUSION*

"Complete coverage" has been a theme of this guide. All of our young people must know how to avoid HIV infection and feel a personal commitment to help stem the epidemic. Equally important, we must improve school health education. Earlier generations had neither the knowledge nor the medical expertise to cope with epidemics that caused misery for many people. It is time to stop taking for granted — and begin to use more effectively — the powerful tool of education as protection against disease.

AIDS is a disease that we all wish had never appeared. Difficult as the problems presented by AIDS are, state policymakers have already shown great courage in facing them. Some states have made impressive beginnings in providing AIDS prevention education. But thus far, no state can report that all its students are receiving effective instruction.

AIDS is changing our society. It will change the way that many people think and act, and the disease itself will touch many lives. People with AIDS and their families will need both compassion and support. As the next decade begins, we hope that every state will have worked to provide more comprehensive school health education. We believe that this will prove to be the most important way to assure that students are receiving effective instruction about the prevention of AIDS and other serious adolescent health problems.

# AIDS EDUCATION POLICYMAKERS GUIDE

# BIBLIOGRAPHY AND SOURCES FOR MORE INFORMATION

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