DOCUMENT RESUME

ED 316 006 EC 230 012

TITLE Summary of the National Forum on HIV/AIDS Prevention Education for Children and Youth with Special Education Needs (Reston, Virginia, January 31-February 2, 1989).

INSTITUTION American Alliance for Health, Physical Education, Recreation and Dance. Reston, VA. Association for the Advancement of Health Education.; Council for Exceptional Children, Reston, Va.

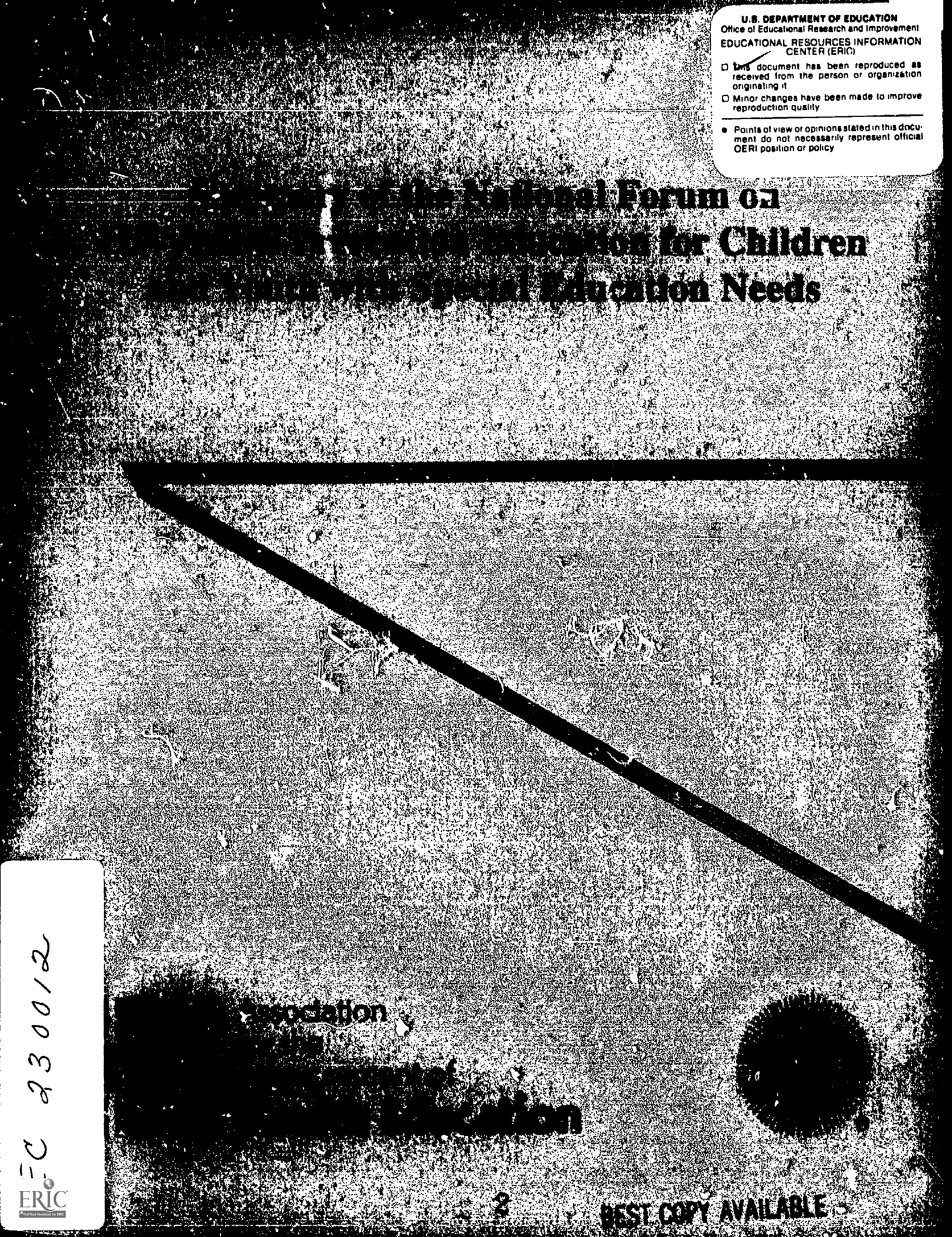
SPONS AGENCY Centers for Disease Control (DHHS), Atlanta, GA. Div. of Adolescent and School Health.
PUB DATE Feb 89
GRANT U63/CCU302780-02
NOTE 38p.
PUB TYPE Reports - Descriptive (141) -- Viewpoints (120) -- Collected Works - Conference Proceedings (021)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Acquired Immune Deficiency Syndrome; At Risk Persons; *Disabilities; *Educational Policy; *Educational Practices; Elementary Secondary Education; Epidemiology; Needs Assessment; *Prevention; *Public Policy; Risk; Special Needs Students; Student Needs

ABSTRACT

Representatives from more than 25 national organizations and governmental offices assessed the state of education for prevention of human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) in light of the needs of special education students. This forum report provides presentation highlights and summarizes small group discussions and forum conclusions. The following presentations are highlighted: "Centers for Disease Control--Overview of the Division of Adolescent and School Health and HIV and AIDS Prevention Education" (Dave Poehler); "The Council for Exceptional Children--Overview of Exceptional Students" (Frederick Weintraub); "Association for the Advancement of Health Education--Comprehensive School Health Education" (Gus Dalis); and "Pediatric HIV/AIDS--Epidemiological Overview" (Michal Young). Small group discussions focused on determination of the extent to which children and youth with handicaps are at risk for HIV infection, identification of the most appropriate curricular delivery approaches to meeting the HIV/AIDS prevention education needs of children and youth with handicaps, and determination of the extent and methods by which prevention education needs of this population currently are being met. Conclusions and recommendations in the areas of policy, training, curriculum, and instruction are presented. A list of forum participants and a list of 25 suggested readings conclude the report. (JDD)

[illegible] National Forum on [illegible] Education for Children [illegible] Special Education Needs



[illegible] Association

[illegible] Association

SUMMARY OF THE NATIONAL FORUM ON HIV/AIDS PREVENTION EDUCATION FOR CHILDREN AND YOUTH WITH SPECIAL EDUCATION NEEDS

Reston, Virginia

January 31 - February 2, 1989

Conducted by the

Association for the Advancement of Health Education
an association of the
American Alliance for Health, Physical Education,
Recreation and Dance

and

The Council for Exceptional Children

Sponsored by the
Division of Adolescent and School Health
Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control

This report was completed with support provided by a cooperative agreement (Number U63/CCU302780-02) with the Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control, Atlanta, Georgia 30333. It is not copyrighted. Duplication is encouraged.

EXECUTIVE SUMMARY

The National Forum on HIV/AIDS Prevention Education for Children and Youth with Special Education Needs was hosted in February 1989 by the Association for the Advancement of Health Education (AAHE) in collaboration with The Council for Exceptional Children (CEC). Representatives from more than 25 national organizations and governmental offices assessed the state of HIV/AIDS prevention education in light of the unique needs of special education students. The following are conclusions of the forum.

- All children, including special education students, need health education, which includes HIV/AIDS prevention education.
- Health educators and special educators should work together in delivery of HIV/AIDS prevention education for children and youth with special needs.
- HIV/AIDS prevention education for children and youth with special needs is a shared responsibility of state departments of education and health, local school boards and health departments, school administrators, teachers of health education and special education, and parents/guardians of children with special needs.
- National and state level policies about communicable disease and HIV/AIDS prevention should be utilized to focus attention on the need for education.
- Policies for implementing HIV/AIDS prevention education for children and youth with special needs should be developed at the local level.
- Professional organizations in health education and special education should develop guidelines for health education including HIV/AIDS prevention education for children and youth with special needs.
- Misunderstandings and misconceptions about HIV/AIDS need to be clarified for professionals, parents of children with special needs, and children with special needs.

- Special education teachers need preservice/inservice training in health education and HIV/AIDS prevention education.
- Health education teachers need preservice/inservice training in effective instructional strategies for special learners.
- HIV/AIDS prevention education should be incorporated into training programs for parents of special education students.
- There is a lack of educational/curricular resources in comprehensive health education and HIV/AIDS prevention education for children and youth with special needs.
- HIV/AIDS prevention curriculum and materials should be developed or modified so that the different types of disabilities — cognitive, sensory, physical, behavioral — are addressed.
- Local education agencies should select HIV/AIDS prevention curricula and materials appropriate for children andyouth with special needs.
- Objectives on HIV/AIDS prevention education and health education should be written into Individualized Educational Plans (IEP).
- HIV/AIDS prevention education should focus on behavior.
- When youth with special needs are employed in settings where they might be at risk for HIV infection, they should receive appropriate risk reduction training.

Recommendations regarding needs in the areas of policy, training, curriculum, and instruction have been extrapolated from conclusions reached at the forum.

CONTENTS

INTRODUCTION

The National Forum on HIV/AIDS Prevention Education for Children and Youth with Special Education Needs was hosted in February 1989 by the Association for the Advancement of Health Education (AAHE) in collaboration with The Council for Exceptional Children (CEC). Representatives from more than 25 national organizations and governmental offices assessed the state of HIV/AIDS prevention education in light of the unique needs of special education students.

Three forum objectives were identified as follows:

- Determination of the extent to which children and youth with handicaps are at risk for HIV infection
- Identification of the most appropriate curricular delivery approaches to meeting the HIV prevention education needs of children and youth with handicaps
- Determination of the extent and methods by which the HIV prevention education and general health education needs of this population currently are being met.

These objectives provided direction for small group discussions as participants were asked to consider a series of questions related to each objective.

In addition to small group discussions, speakers offered the following presentations:

- Overview of HIV/AIDS Prevention Education
- Overview of Special Needs Groups
- Overview of Comprehensive School Health Education
- Pediatric HIV/AIDS – Epidemiological Overview

This report provides presentation highlights and summarizes small group discussions and forum conclusions. Additionally, it includes a listing of forum participants and suggested essential readings.

CENTERS FOR DISEASE CONTROL – OVERVIEW OF THE DIVISION OF ADOLESCENT AND SCHOOL HEALTH AND HIV AND AIDS PREVENTION EDUCATION

Dave Poehler, Ph.D., School Health Education Specialist

Of the total population of 247 million persons in the United States, about 62 million, or 25 percent, are in schools and colleges. Schools and agencies that serve out-of-school youth could provide appropriate and efficient means to help young persons avoid behaviors that are likely to result in chronic or infectious diseases or injuries. To help schools and other agencies implement disease prevention and health promotion programs for adolescents and youth, in 1988 the Centers for Disease Control (CDC) established the Division of Adolescent and School Health. The goal of this division is to prevent priority health risks that result in mortality, morbidity, and disability during youth or adulthood. The division is committed to Comprehensive School Health Education as a method in implementing HIV and AIDS education prevention.

The Division of Adolescent and School Health has implemented six systems to help schools, and other organizations that serve youth, provide effective education about HIV, and to integrate HIV education into more comprehensive programs of school health. These systems are:

A *system of national programs of twenty national organizations* work through their constituents to help schools and other agencies nationwide to implement effective disease prevention and health promotion programs. These organizations receive fiscal and technical assistance from CDC and serve as a coalition to guide CDC strategies to implementing HIV education and comprehensive programs of school health.

A *system of state and local programs of seventy state, territorial, and local education agencies* work with their respective health departments to help schools and other agencies implement effective disease prevention and health promotion programs. These agencies receive fiscal and technical assistance from CDC to help train teachers, develop policies, select materials, and involve parents in HIV education and comprehensive programs of school health.

A *materials development and dissemination system* has been established to identify, develop, and provide information about interventions that can be used to help school- and college-aged populations avoid risks for disease and injury. CDC provides techni-

cal assistance to help organizations develop HIV-related materials, conduct conferences and workshops about HIV and other school health issues, develop materials as needed, and maintain a database of HIV-related educational materials for teachers and youth.

A *system of training and demonstration centers* has been established to train school and community personnel in implementing state-of-the-art interventions that can help young people avoid HIV infection and other important health problems. Two national centers provide training for state education agency teams, and one national center provides training for local education agency teams, from across the nation. Additionally, fourteen regional training centers train school and community personnel in their regions to implement comprehensive school health education curricula.

A *survey research system* has been established to help state and local education agencies monitor the percentage of schools that provide HIV education and comprehensive school health education, and the percentage of students that receive HIV education. State and local education agencies are also helped to monitor the changes in prevalence of health knowledge and health risk behaviors among high school students over time.

An *evaluation research system* has been established to help state education agencies assess and consequently improve their disease prevention and health promotion programs, to conduct quasi-experimental research about the effectiveness of specific disease prevention and health promotion interventions, and to identify principal determinants of health risk behaviors.

In conclusion, CDC is depending on a vast network of education and health agencies to carry o he work of meeting HIV and AIDS prevention education needs of all children and young adults. The Division of Adolescent and School Health is supporting the efforts of this national forum to help assure that children with special needs receive education about HIV.

THE COUNCIL FOR EXCEPTIONAL CHILDREN – OVERVIEW OF EXCEPTIONAL STUDENTS

Frederick J. Weintraub, Assistant Executive Director

Exceptional children comprise a significant proportion of school children (10-12 percent) ranging in age from birth through 21 years. They encompass four general groups of disabilities:

- Physical disabilities
- Cognitive and learning disabilities
- Behavioral disabilities
- Sensory disabilities.

Each of these four groups can be divided into two categories. The first category consists of students with disabilities that require no special education programs as long as there are appropriate environmental and instructional modifications to regular education programs. An example would be a child with a visual impairment who can benefit from regular education with supplementary aids such as large print books. The second category is comprised of children with disabilities who have unique instructional needs, making it difficult to benefit from regular education. These are the students who require special education. Exceptional children exist in public and private schools, in state schools, correctional facilities, in both integrated and segregated settings.

As we examine the special education needs of exceptional students, we ask two basic questions. First, to what degree is the child able to benefit from the regular education curriculum, and how should the curriculum be changed? Second, to what degree does the child require specialized methodologies necessary to learn the appropriate curriculum?

There are several other factors to think about in planning HIV/AIDS prevention education for exceptional children. Evidence suggests that some of these students are more susceptible to suggestions, thoughts, and ideas presented to them by their peers. Thus, they often get into trouble with drugs and have behavioral problems in school. In addition, some of these children receive more intensive levels of medical intervention than others and have a greater risk for infection.

ASSOCIATION FOR THE ADVANCEMENT OF HEALTH EDUCATION — COMPREHENSIVE SCHOOL HEALTH EDUCATION

Gus T. Dalis, Ed.D., President

Society is crises oriented to problems of the moment, whether it be drugs, HIV infection, teenage pregnancy, or suicide. When a health crisis occurs, society turns to health care and school education for solutions to specific crises. As for school health instruction, there is just so much time in a school day to attend to crises of the moment. All too frequently, the result is superficial instruction related to crises of yesterday supplanted by superficial instruction related to the crisis of today. Health instruction becomes fragmented and disjointed.

Comprehensive school health education is a framework used for designing meaningful programs for children and youth. This framework consists of a master plan that addresses health content areas such as HIV/AIDS, cancer, cardiovascular health, and nutrition. In such a plan, education in one area such as HIV/AIDS is integrated into areas such as drug use and abuse, sex education, and disease and disorders. The end result from the utilization of a comprehensive school health education program is a greater understanding of interrelationships among these health crises.

In addition, comprehensive school health education programs go beyond a focus on relevant health information. They also stress personal and social skill behavior development in such areas as decision making, assertiveness, self control, stress reduction, refusal, and communication.

By focusing on relevant health content and behavior through planned repetition in grades K-12, children and youth are taught information, skills, attitudes and practices necessary to promote healthful living.

In essence, comprehensive *school health education* is that education in a school setting that diminishes health compromising behaviors and enhances health promoting behaviors.

Comprehensive health education (instruction) is one of three traditional interdependent components of the *school health program.* The other two include health services and healthful school environment. Purposes of each of these components complement

and are complemented by procedures and activities of the others. Although such a program is school based, it is recognized that not just school personnel and students, but their families and communities, must be involved in its planning, implementation, and evaluation.

In every state, school health services and healthful school environment are supported by an elaborately detailed framework of specific mandates and permissive legislation. However, laws concerning health instruction are few, often ambiguous, and even mandates are largely left to local option for enforcement.

Comprehensive school health education exists nationwide far more in theory than in practice. The critical need for HIV/AIDS prevention education provides an opportunity to put the theory of comprehensive school health education into practice.

PEDIATRIC HIV/AIDS — EPIDEMIOLOGICAL OVERVIEW

Michal Young, M.D., Neonatologist

HIV infection is a major challenge in pediatric medicine. It is caused by a retrovirus that may lie dormant for 7-10 years or longer before the disease manifests into AIDS.

The first case of pediatric AIDS occurred in 1982, and there is no cure in sight at this time. Of the 84,503 cases of AIDS in children and adults, 1,118 cases are less than five years old and most are Hispanic or Black. In the 13-19 age group, there are 338 reported cases of AIDS. In the 20-29 age group, there have been 13,417 cases reported.

Three problematic areas related to HIV/AIDS present major challenges to physicians. The first is that once someone is exposed, it may take from six weeks to six months before antibodies/antigens are produced. After the virus becomes active, it causes irreversible damage to the T-4 lymphocytes, but it may be many years before opportunistic infections overcome the impaired immune system.

A second challenge is that diseases in pediatric AIDS include primary infections which comprise the immune system. The wasting syndrome (greater that 10 percent weight loss) includes chronic diarrhea, fever, and weakness. In encephalopathy dementia and developmental regression, the patient has not yet had bacterial infections but the disease is progressing.

There are three basic categories for pediatric HIV infection:

- P0 is considered indeterminant and generally includes children less than 15 months of age that have tested HIV positive and are asymptomatic. A diagnosis is dependent on signs and symptoms.
- P1 is used for children past 15 months of age and considered asymptomatic. However, T-4 cells may be depressed. Lymphocytes may be abnormal but the patient may not be clinically ill.
- The P2 category is symptomatic, involving signs of weight loss and bacterical infections. The patient is beginning to regress and has recurrent bacterial disease.

The third challenge is that there are different secondary diseases and concerns in pediatric and adolescent HIV infection. Also, the diagnostic process is different in those less than 15 months old, the presence of both antibody and antigen and impairment of both cellular and humoral immunity is needed. A positive HIV culture would make the diagnosis, but usually is not obtained until the infant is very ill. With children five years of age and older, the disease is acquired through sexual contact, IV drug use, or blood transfusion. In this older group the presence of HIV antibodies alone will show if a child is infected.

Considering the latency period for development of AIDS, the current 20-29 age group was at risk in the 13-19 year period. Thus, we must introduce sex and drug education at an earlier period. Most adolescents have the view that "it won't happen to me." Most do not consider "crack" to be a risk because it is not taken intravenously, but they don't consider the promiscuity that goes along with "crack." Most cases report their first homosexual encounter between the ages of 11-12 and heterosexual encounter between 9-14.

What is significant is that HIV infection is preventable. Sex education and drug education in childhood could go a long way toward preventing perinatal and pediatric HIV infection and AIDS.

DETERMINATION OF THE EXTENT TO WHICH CHILDREN AND YOUTH WITH HANDICAPS ARE AT RISK FOR HIV INFECTION

OUTCOME OF SMALL GROUP DISCUSSIONS

Four questions guided discussion of this forum objective:

- How is HIV infection transmitted and spread?
- With what we know about the transmission and spread of HIV infection, are there personal, social, and physical situations that children with handicaps encounter which would place them in an "at risk" situation for HIV infection? If so, what are these?
- What kinds of employment environments or conditions might increase the possibility of youth with handicaps being at risk for HIV infection?
- Are there factors that would limit the ability of children and youth with handicaps to be aware, or become aware, of being "at risk" for HIV infection?

Small group discussion of each question provided an opportunity to clarify basic information about HIV infection as well as to examine situations of children and youth with special needs and determine their risk for HIV infection. The following thoughts are drawn from the small group discussions.

How is HIV infection transmitted and spread?

The single most important source of the HIV pathogen is blood. The two other fluids implicated as sources are semen and vaginal secretions. Known routes of transmission are vaginal and anal intercourse and nonintact skin exposures. Intravenous use of needles contaminated with blood from an HIV-infected person is an example of a method of exposure to HIV. This occurs primarily among drug users of illicit drugs. There are misconceptions about how HIV is transmitted. Professionals need to be careful about *how* information about HIV is communicated. Opportunities for feedback on what is communicated about HIV are essential so that misinformation and misconceptions are not perpetuated.

With what we know about transmission and spread of HIV infection, are there personal, social, and physical situations that children with handicaps encounter which would place them in an "at risk""situation for HIV infection? If so, what are these?

It is behavior that puts a person "at risk" for HIV infection. It is not that someone has a handicap. This is a significant distinction. "At risk" behavior may occur as the result of lack of education about HIV transmission. It also may be the result of growing up in situations lacking appropriate modeling behaviors. The visually handicapped cannot see the behaviors which could put them at risk.

Society generally views handicapped children as asexual. This point of view may set up barriers to implementing sex education. For example some group homes may permit sexual relationships with the same sex under certain conditions. This practice suggests that risk reducing procedures be taught to residents.

The need for social acceptance is a factor which may place persons at greater risk. They may be in social situations where they are encouraged through peer pressure to use drugs intravenously or to engage in unsafe sex. Impulsive behaviors may also place them at risk.

In some educational situations, a lack of understanding of HIV/AIDS prevention education on the part of teachers may hinder the educational process. Also, some living situations may place children and youth at risk if caregivers are not screened for sexual misconduct.

What kinds of employment environments or conditions might increase the possibility of youth with handicaps being at risk for HIV infection?

Precautions in terms of employment should be universal procedures and should not be limited to employees with handicaps. There is a need for intensive staff development for settings where there is a high risk of coming in contact with HIV. Research supports the fact that mentally retarded persons have less chance of being careless if they have appropriate instruction.

Are there factors that would limit the ability of children and youth with handicaps to be aware, or become aware of being "at risk" for HIV infection?

A primary source of information about HIV infection and skills to prevent infection is the educational environment. All children and school-aged youth need health education which includes HIV/AIDS prevention education. This is not systematically being provided for all children with handicaps. It is the responsibility of state departments of education and local school systems to establish effective programs for understanding the prevention of HIV infection.

Among children and youth with handicaps, cognitive, sensory, physical and behavioral needs must be addressed so that learning can be effective. This involves inservice for both health education teachers and special education teachers. Special education teachers need more health and HIV education and health education teachers need to learn strategies for teaching special education students. Special communication to families is important also. This would be informational in nature and could encourage

them to become involved in the educational process. Resource materials for schools, such as those in other languages, Braille, and on audio and video tape, are essential.

Other community sources such as youth groups and churches are encouraged to work with exceptional children in HIV/AIDS prevention education. This could reinforce the educational system's teaching.

Community resources such as schools, churches, health care institutions, correctional institutions, group homes, health departments, voluntary agencies, and youth groups can work individually and cooperatively to develop strategies to bridge gaps in educating children and youth with handicaps about HIV/AIDS.

IDENTIFICATION OF THE MOST APPROPRIATE CURRICULAR DELIVERY APPROACHES TO MEETING THE HIV/AIDS PREVENTION EDUCATION NEEDS OF CHILDREN AND YOUTH WITH HANDICAPS

This discussion was guided by five questions:

- What curricular delivery approaches traditionally are used in education of children and youth with special education needs?
- Are there complex concepts about HIV infection that would necessitate modification of curricular approaches? If so, what are these modifications?
- How would delivery approaches need to be modified according to the handicap of the individual?
- Who should be responsible for seeing that HIV/AIDS prevention education occurs? Who would be the person to do the actual instruction? What is the role of home, family, educator?
- Should special materials for HIV/AIDS prevention education be developed for children and youth with handicaps? What? Why or why not?

Discussion of each question provided an opportunity to examine basic educational issues surrounding HIV/AIDS prevention education needs of children and youth with handicaps.

What curricular delivery approaches traditionally are used in education of children and youth with special education needs?

Curricular delivery approaches need to be individualized according to the child's needs. For example, students with cognitive disabilities may require repetition or concrete instruction. However, bright students with physical disabilities may easily comprehend abstract concepts. Students with sensory impairments learn better when multisensory approaches are used.

Several approaches traditionally effective in the classroom could be used in the special education class, e.g. inviting a person with AIDS as a guest speaker, group discussion, peer tutoring, or role playing.

Are there complex concepts about HIV infection that necessitate modification of curricular approaches? If so, what are these modifications?

Terminology is probably the most difficult aspect of HIV/AIDS prevention education. Ideas related to infection are abstract and it is difficult to communicate the time factor in development of the illness. Social factors might involve religious preferences and cultural and value differences. Modifications could involve establishing a comfortable environment for teaching HIV infection prevention and not recommending particular methods or behaviors, but providing facts.

If curriculum modification is undertaken, it should be done by educators with special education and health education backgrounds. The curriculum should focus on behavior, including sexual behavior and drug use/abuse. Curricular goals should address both cognitive and affective domains.

How would delivery approaches need to be modified according to the handicap of the individual?

HIV/AIDS prevention education can be modified in the same ways as other topics. These modifications include:

- Using a developmental sequence of material
- Matching teaching methods to students learning needs
- Using multisensory approaches
- Reinforcing instruction
- Using a variety of testing methods

Some delivery approaches might need audio tape while others might need Braille. One factor to be remembered is that regardless of cognitive ability, special needs children still grow chronologically. Both cognitive and chronological education needs must be met in HIV/AIDS prevention education.

Who should be responsible for seeing that HIV/AIDS prevention education occurs? Who should be the person to do the actual instruction? What is the role of home, family, educator?

Primary responsibility for HIV/AIDS prevention education rests at the local level. However, support at the state level is essential. HIV/AIDS prevention education is mandated in 28 states, but implementation is diverse and sporadic. State departments of education and health, as well as mental health agencies have an excellent opportunity to establish policy and guidelines for their constituents. School boards need to be supportive also. Additionally, school/community cooperation, which involves parents, is a necessity.

Ideally the person to do the actual instruction would be the special education teacher. This would require inservice for teachers in health education. If students were being instructed by a health educator, that teacher would need cooperation from the special education teacher. The special education teacher could then follow up and reinforce instruction by the health educator.

Schools need to accommodate various learning situations for special education students. If students are mainstreamed, it is essential that the classroom teacher is communicating with the special education resource teacher. There should be options for delivery of instruction because it will differ from place to place. It would be beneficial if professional organizations in health education and special education would develop guidelines for instruction about HIV/AIDS prevention education for children and youth with special education needs.

The family and school need to be involved cooperatively in educating about HIV/AIDS prevention education. The school should provide information for families and have them participate as much as possible. Development of materials for parents should be done cooperatively with parent groups. Other health agencies within the community can assist in parent education.

Should special materials for HIV/AIDS prevention education be developed for children and youth with handicaps? What? Why or why not?

Materials need to be developed for some children and youth with handicaps; however, some currently available materials on HIV/AIDS prevention education can be adapted.

Priority should be given to developing new materials for children and youth who are mild to moderately mentally retarded and for those mildly emotionally disturbed. In addition, development of new materials should be undertaken for children with learning disabilities.

Current educational materials can be modified through modality adaptation and/or changing the level of concept presentation and terminology. As materials are adapted and modified, care should taken that content is not lost.

DETERMINATION OF THE EXTENT AND METHODS BY WHICH HIV/AIDS PREVENTION EDUCATION AND GENERAL HEALTH EDUCATION NEEDS OF THIS POPULATION CURRENTLY ARE BEING MET

Discussion of this objective was guided by the following six questions:

- Is HIV/AIDS prevention education currently included in health education? If not, where is it included? Where might it best be included in the curriculum?
- To what extent is health education routinely taught to children and youth with handicaps?
- What topical areas or concepts customarily are included in health education?
- Are there needs in the area of health education which are not being met? If so, what are they?
- How can we ensure that HIV prevention education and health education needs are being met for all children and youth with handicaps?
- Is there a need for policies regarding these issues to be developed at the national, state, and local levels? If so, what?

Discussion of these questions provided an opportunity for participants to analyze the current education of children and youth with special needs and become aware of health education as a basic need for these children.

Is HIV prevention education currently included in health education? If not, where is it included? Where might it best be included in the curriculum?

The local school district determines whether or not HIV/AIDS prevention education is included in health education. At the state level, health education is required in 25 states and HIV/AIDSprevention education is required in 28 states. How these requirements are fulfilled is dependent upon the local school system.

Many times health education is integrated into other academic courses such as science, psychology, and home economics. If HIV/AIDS prevention education is included in health education and special education students are mainstreamed, some students may not have this instruction since they may be pulled back to the special education classroom.

Ideally, HIV/AIDS prevention education should be within the curriculum for health education and all children should have adequate instruction in this content area. Special education teachers need to be actively involved in this instruction. Perhaps a national survey should be conducted to determine the extent of health education and HIV prevention education in schools with children and youth in special education.

To what extent is health education routinely taught to children and youth with handicaps?

The extent to which children and youth with handicaps are taught health education varies with each school system. This is an issue which needs leadership to ensure that health education is available for children and youth with handicaps. In many school districts, health educators and special educators are not routinely working together in development of health education delivery. School administrators need to reduce barriers to collaboration which may exist.

What topical areas or concepts customarily are included in health education?

The following topical areas form the framework for a health education curriculum. HIV/AIDS prevention education could be emphasized in the areas of prevention and control of disease and disorders, substance use and abuse, and family life. However, it could be approached through any of these areas, as long as it is covered.

Community Health – study of ways in which individuals contribute positively and negatively to the overall health status of the many communities of which each is a member, and how they can employ support systems of these various communities to assist in protection, maintenance, and promotion of personal health status.

Consumer Health – examination of the many factors that influence selection and use of health services, products, and information. It includes establishment of personal criteria for selection of health services and usage that are conducive to good health.

Environmental Health – investigation of causes, effects, and methods of eradication of all external factors (e.g., pollution, over population, radiation, hunger, waste disposal, etc.) which negatively affect human health. This study is approached on both a local and worldwide basis and employs a model that examines the totality of relationships between humans and their environment.

Family Life – investigation of the multiple roles and personal lifestyles of individuals as members of family and larger societal units. Changes in responsibilities and privileges that each person encounters during the life cycle are studied in addition to the multitude of factors that influence expression of human sexuality. Biological, sociological, and psychological variables affecting total development of the personality and interpersonal relationships are studied.

Growth and Development – study of the functions and structure of human body systems, their interdependence, and how they function as a whole and contribute to health status from birth to death.

Nutritional Health – study of the principal nutrients necessary to maintain basic body needs and how nutrients can best be provided. It includes consideration of essential components of a balanced diet, need for a wide variety of foods, influence of peers, family, culture, and media on what the individual does or does not consume.

Personal Health – exploration of lifestyle activities individuals undertake that influence their health. The focus is on problem-solving techniques, achievement of positive self-concept, and acceptance of responsibility for those personal health actions over which the individual has some control (e.g., care of teeth and gums, eyes, ears, skin, hair, as well as balance between rest and physical activity).

Prevention and Control of Disease and Disorders – investigation of factors contributing to the incidence of major chronic and communicable diseases and disorders that affect individuals and communities. Study focuses on measures for prevention, early detection, and control of such health problems.

Safety and Accident Prevention – exploration of methods that can be employed to reduce or eliminate hazardous conditions in all aspects of daily life. Studies of techniques for first aid and emergency care are included.

Substance Use and Abuse – examination of appropriate and inappropriate uses of chemical substances that are commonly used. These include substances legally available such as alcohol, tobacco, or over-the-counter drugs, and those illegally available through a variety of sources.

Are there needs in the area of health education which are not being met? If so, what are they?

Discussions centered on many needs in health education for children and youth with handicaps. The following unmet needs were identified:

- Comprehensive school health programs should be available for special education children and youth.
- Additional materials on health education are needed for special education children and youth.
- Sex education should be taught to special education children and youth.
- Social skills and decision making skills should be taught to special education children and youth.

One way of addressing these needs would be to create an advisory committee at the local level to evaluate the health education program for children and youth with hand-

icaps. That committee could make recommendations to the school board regarding policy, instruction, inservice training, and materials.

How can we ensure that HIV/AIDS prevention education and health education needs are being met for all children and youth with handicaps?

Individualized Education Plans (IEP) could include objectives for HIV/AIDS prevention education as well as objectives for health education. In areas where there are parent training centers, HIV/AIDS prevention education and health education could become a focus.

The process of developing the IEP could include the school nurse, health educator, and special education teacher. This would ensure inclusion of critical health education and HIV/AIDS prevention objectives. Professional organizations at the national level such as the Association for the Advancement of Health Education and The Council for Exceptional Children could initiate action with the National Council for the Accreditation of Teacher Education (NCATE) to include health education as a requirement for preparation of elementary teachers and special education teachers.

Is there a need for policies regarding these issues to be developed at the national, state, and local levels? If so, what?

Some policies currently are in existence at the national, state, and local levels. These policies have been developed by a variety of professional organizations, government agencies, and school districts. It would be advisable to have sample policies that are supportive of HIV/AIDS prevention education and health education compiled and made available at the local level. Local school boards then could assume a stronger leadership role in responding to community needs.

CONCLUSIONS

- All children, including special education students, need health education, which includes HIV/AIDS prevention education.
- Health educators and special educators should work together in delivery of HIV/AIDS prevention education for children and youth with special needs.
- HIV/AIDS prevention education for children and youth with special needs is a shared responsibility of state departments of education and health, local school boards and health departments, school administrators, teachers of health education and special education, and parents/guardians of children with special needs.
- National and state level policies about communicable disease and HIV/AIDS prevention should be utilized to focus attention on the need for education.
- Policies for implementing HIV/AIDS prevention education for children and youth with special needs should be developed at the local level.
- Professional organizations in health education and special education should develop guidelines for health education including HIV/AIDS prevention education for children and youth with special needs.
- Misunderstandings and misconceptions about HIV/AIDS need to be clarified for professionals, parents of children with special needs, and children with special needs.
- Special education teachers need preservice/inservice training in health education and HIV/AIDS prevention education.
- Health education teachers need preservice/inservice training in effective instructional strategies for special learners.
- HIV/AIDS prevention education should be incorporated into training programs for parents of special education students.
- There is a lack of educational/curricular resources in comprehensive health education and HIV/AIDS prevention education for children and youth with special needs.
- HIV/AIDS prevention curriculum and materials should be developed or modified so that different types of disabilities – cognitive, sensory, physical, behavioral – are addressed.

- Local education agencies should select HIV/AIDS prevention curricula and materials appropriate for children and youth with special needs.
- Objectives on HIV/AIDS prevention education and health education should be written into Individualized Educational Plans (IEP).
- HIV/AIDS prevention education should focus on behavior.
- When youth with special needs are employed in settings where they might be at risk for HIV infection, they should receive appropriate risk reduction training.

RECOMMENDATIONS

POLICY

- There is a need for compilation and dissemination of model policies for HIV/AIDS prevention education and comprehensive health education for children and youth with special education needs.
- These policies need to be entered into a variety of data bases, e.g. the Combined Health Information Database (CHID), Educational Resources Information Center (ERIC), and the National AIDS Information Clearinghouse.

TRAINING

- There is a need for preservice and inservice training for both health educators and special educators.

Preservice

a) training material for higher education classes

b) training of trainers for higher education faculty

c) promoting collaboration among departments of health education and special education

Inservice

a) training materials for teachers and administrators

b) training of trainers for professional development specialists at the school district level

c) within local education agencies collaboration among coordinators of health education and special education programs

STATEWIDE ACTIVITIES

- State Education Agencies should

a) determine training needs within the state

b) facilitate and coordinate training within the state.

CURRICULUM

- Determine the number and source of existing comprehensive health education curricula which include HIV prevention.
- Identify model curricula in comprehensive health education and HIV/AIDS prevention education appropriate for special education populations.
- Develop strategies for compilation and dissemination of model curricula.
- Support development of new curricula or modification of existing curricula as needed.

INSTRUCTION

- Develop strategies for ensuring that special education students receive appropriate comprehensive health education instruction whether it be in health education classes or special education classes.
- Develop mechanisms that facilitate collaboration between health education and special education teachers in providing instruction.
- State and local education agencies need to ensure that health education materials for special education students address their learning requirements.

PARTICIPANTS

Ellen Abramson
Maryland State Department of Education
Baltimore, Maryland 21201
Phone: 301/333-2496

Sandy Ball
Alexander Graham Bell Association for the Deaf
3417 Volta Place, NW
Washington, DC 20007
Phone: 202/337-5220

George Barros
Rhode Island Department of Education
Special Education - Program Services
22 Hayes Street
Providence, RI 02908
Phone: 401/277-3505

Jan Beck
National Association of State Directors of Special Education
2021 K Street, NW, Suite 315
Washington, DC 20006
Phone: 202/296-1800

Rick Berkobien
Association for Retarded citizens of the U.S.
2501 Avenue J
Arlington, TX 76006
Phone: 817/640-0204

Ellen Bonaguro
School of Health and Sport Sciences
Ohio University
Athens, OH 45701
Phone: 614/593 -1226

John Bonaguro
School of Health and Sport Sciences
Ohio University
Athens, OH 45701
Phone: 614/593 -1217

Nancy Bond
Coordinating Center for Home and Community Care, Inc.
P. 0. Box 613
Millersville, MD 21108
Phone: 301/987-1048

LaVerne Buchanan
The George Washington University Department of Education
Teacher Preparation & Special Education
2201 G Street, NW, Suite 524
Washington, DC 20052
Phone: 202/994-2787

John Burger
National Education Association
100 Colony Square, Suite 200
Atlanta, GA 30361
Phone: 404/875-8819

Lee Coleman
Handicapped Childrens Early Education Program
U.S Dept. of Education Office of Special Education Programs
400 Maryland Avenue
Washington, DC 20202-2732
Phone: 202/732-1166

Gus Dalis
Los Angeles County Office of Education
9300 E. Imperial Hwy.
Downey, CA 90242
Phone: 213/922-6321

Devon Davidson
National Coalition of Advocates for Students
100 Boylston Street, Suite 737
Boston, MA 02116
Phone: 617/357-8507

E. Wayne Fortune
National Organization of Black County Officials, Inc.
NOBCO Main Project
Fulton County DFACS
800 Peachtree Street, NE, Suite 505
Atlanta, GA 30365
Phone: 404/894-5730

Katherine Fraser
National Association of State Boards of Education
1012 Cameron Street
Alexandria, VA 22314
Phone: 703/684-4000

Carol Frattali
American Speech-Language-Hearing Association
10801 Rockville Pike
Rockville, Maryland 20852
Phone: 301/897-5700

Brenda Greene
National School Boards Association
1680 Duke Street
Alexandria, VA 22314
Phone: 703/838-6756

Helene Gruber
Association for Children and Adults with Learning Disabilities
4156 Library Road
Pittsburgh, PA 15234
Phone: 412/341-1515

John Henning
American Medical Association
535 N. Dearborn Street
Chicago, IL 60610
Phone: 312/645-4566

Wanda H. Jubb
Michigan Department of Education
Box 30008
Lansing Michigan 48909
Phone: 517/373-2 589
Representing The Society of State Directors of Health, Phys. Educ., and Recreation
c/o Simon McNeeley
9805 Hillridge Drive
Kensington, MD 20895
Phone: 301/949-222 6

William Kane
American College of Preventive Medicine
1015 l5th Street, NW
Washington, DC 20005
Phone: 202/789-0003

Satwant Kaur
Center for the Study of Handicapped Children and Youth
2900 Van Ness Street, NW
Howard University
Holy Cross Hall - Suite 100
Washington, DC 20008
Phone: 202/686-6426

Helen Kern
Division of Health Education
Arkansas Department of Health
4815 West Markham
Little Rock, AK 72205
Phone: 501/661-2495

Representing Association of State and Territorial Directors of Public Health Educa-
c/o Cheryl Cortines Lakey
President Texas Department of Health
1100 West 49th Street
Austin, TX 78756
Phone: 512/458-7406

Dianne L. Kerr
American School Health Association
7263 State Rte. 43, P.0. Box 708
Kent, OH 44240
Phone: 216/678-1601

Donna H. Lehr
Department of Exceptional Education UW-Milwaukee
P. 0. Box 413
Milwaukee, Wisconsin 53201
Phone: 414/229-4615
Representing The Association for Persons with Severe Handicaps
7010 Roosevelt Way, NE
Seattle, WA 98115
Phone: 206/523-8446

Ann Nolte
Department of Health Science
Illinois State University
Normal, IL 61761
Phone: 309/662-4263

James Owens
National Commission on Correctional Health Care
2000 North Racine, Suite 3500
Chicago, IL 60614

John Palmer
National Association for Minority Citizens with Disabilities
Human Services Triangle
3508 West North Avenue
Milwaukee, WI 53208
Phone 414/442-0522

Dave Poehler
Division of Adolescent and School Health
Center for Chronic Disease Prevention
Health Promotion Centers for Disease Control
1600 Clifton Road, NE
Atlanta, GA 30333
Phone: 404/639-3824

Marilyn Prehm
Special Education/Arlington County Schools
1426 N. Quincy Street
Arlington, VA 22207
Phone: 703/358-6040

Michelle Prumo
Pupil Services Branch
Maryland Dept. of Education
200 W. Baltimore Street
Baltimore, MD 21201
Phone: 301/333-2819
Representing National Association of School Nurses
Box 1300
Scarborough, ME 04074
Phone: 207/883-2117

Kathy Roy
National Council on Disability
800 Independence Avenue, SW, Suite 814
Washington, DC 20591
Phone: 202/267-3846

Edward T. Ruch
American Foundation for the Blind
1615 M Street, NW, Suite 250
Washington, DC 20036
Phone: 202/457-1487

Robert Thews
Life Link
2025 I Street, NW, Suite 417
Washington, DC 20006
Phone: 202/833-3070

Stephen Thomas
Dept. of Health Education
University of Maryland
2387 PERH Bldg
College Park, MD 20742
Phone: 301/454-4312

Michal Young
Dept. of Pediatrics
D.C. General Hospital
1900 Massachusetts Avenue, SE
Washington, D. C. 20003
Phone: 202/675-5285

Mark Weber
Center for Population Options
1012 l4th Street, NW, Suite 1200
Washington, DC 20007-3852
Phone: 202/347-5700

The Council For Exceptional Children
1920 Association Drive
Reston, VA 22091
Phone: 703/620-3660

Elizabeth Byrom
Directo · of Special Projects

Jeptha Greer
Executive Director

Ginger Katz
Senior Secretary for the AIDS Curriculum Project

Bruce Ramirez
Special Assistant for Ethnic and Multicultural Concerns

Frederick J. Weintraub
Assistant Executive Director Dept. of Government Relations

Association for the Advancement of Health Education
1900 Association Drive
Reston, VA 22091
Phone: 703/476-3437

Cynthia Musillo
AIDS Education Project Coordinator

Becky Smith
Executive Director

Fay Woolwine
Program Assistant

Recorders:

Marcia DiTrapani
Karen Hilder
Rene Kimzey
Laura Rice
Nancy Schwinner

ESSENTIAL READINGS

A unified approach to health teaching. (1983). Position statement. Reston, VA: Association for the Advancement of Health Education.

AIDS. (1989). (Special issue). *Health Education,* 19(6).

AIDS/HIV Infection Education. (1988). (Special issue). *Journal of School Health, 58*(8), p. 1.

AIDS: Are children at risk? (1986). Washington, DC: American Association of Colleges for Teacher Education. (ERIC Document Reproduction Service. Fact Sheet No. 16).

Being at ease with handicapped children. (1984). Reston, VA: Clearinghouse on Handicapped and Gifted Children. (ERIC Document Reproduction Service).

Brown, L. K. & Fritz, G. K. (1988). AIDS education in the schools: A literature review as a guide for curriculum planning. *Clinical Pediatrics, 27,* 311-16.

Burnette, J. (1987). *Adapting instructional materials for mainstreamed students* (contract No. 400-84-0010). Reston, VA: The Council for Exceptional Children.

Centers for Disease Control. (1988). Guidelines for effective school health education to prevent the spread of AIDS. *Morbidity and Mortality Weekly Report, 37* S-2. Atlanta, GA: Centers for Disease Control.

Coalition of National Health Education Organizations. (1988). *Instruction about AIDS within the school curriculum.* Position paper. New York: National Center for Health Education.

Cortese, P., Everst, R., Jubb, W., Nickerson, C., Pollock, M., Simon, B., & Wantz, M. (1984). *Comprehensive school health education.* The National Comprehensive School Health Education Guidelines Committee. Reston, VA: Association for the Advancement of Health Education.

Criteria for evaluating an AIDS curriculum. (1988). Boston: National Coalition of Advocates for Students.

Diclemente, R. J., Boyer, C. B., & Morales, E. S. (1988). Minorities and AIDS: Knowledge, attitudes, and misconceptions among Black and Latino adolescents. *Public Health Briefs*, 78, 55-57.

Disabilities: An overview. (1987). Reston, VA: Clearinghouse on Handicapped and Gifted Children. (ERIC Document Reproduction Service. Fact Sheet No.420).

Fineberg, H. V. (1988). Education to prevent AIDS: Prospects and obstacles. *Science, 239*(4840), 592-596.

Fineberg, H. V. (1988, October). The social dimensions of AIDS. *Scientific American, 259*, 118-134.

Heyward, W. L. & Curran, I. W. (1988, October). The epidemiology of AIDS in the U. S. *Scientific American, 259,* 72-81.

Lifson, A. R. (1988). Do alternative modes for transmission of human immunodeficiency virus exist? *Journal of the American Medical Association*, 259(9), 1353-1356.

Luty, E. T. (1988). Controversial topics in a health education program. *Health Education*, E, 39-44.

Kolbe, L. , Jones, J. , Nelson, G. , Daily, L. , Duncan, C. , Kann, L. , Lawrence, A. , Broyles, B., & Poehler, D. (1988). School health education to prevent the spread of AIDS: Overview of a national program. *Hygiene*, 7 (3), 10-13.

Managing communicable and contagious diseases. Policy statement. Reston, VA: The Council for Exceptional Children.

Steps to help your school set up an AIDS education program. (1988). Boston: National Coalition of Advocates for Students.

Tolsma, D. (1988). Activities of the Centers for Disease Control in AIDS education. *Journal of School Health*, 58(4`, 133-136.

Turner, N. H., McLaughlin, J., & Shruh, J. C. (1988). AIDS education: Process, content, and strategies. *Health Values*, 12, 6-12.

United States Department of Health and Human Services, Public Health Service, Centers for Disease Control, Office of the Deputy Director (AIDS). (1988). *AIDS and Minorities*. Washington,DC: National Conference on the Prevention of HIV Infection and AIDS among Racial and Ethnic Minorities in the United States.

Walters, L. (1988). Ethical issues in the prevention and treatment of HIV infection and AIDS. *Science, 239*(4840), 597-603.