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ABSTRACT

This document presents testimony given before the Senate Committee on Governmental Affairs concerning a General Accounting Office (GAO) review of education programs for youth designed to limit the spread of the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS). It notes that most American teenagers have received essential information on the causes of AIDS and how to minimize the risks of becoming infected with HIV. Nonetheless, the GAO investigation revealed gaps in the provision of AIDS education, and those gaps are discussed in this report. These findings from the GAO review of the school-based HIV education program nationwide are presented: (1) two-thirds of the nation's school districts offered HIV education; (2) smaller districts were less likely to provide HIV education; (3) HIV education was not provided at all levels, particularly in the upper grades, where the likelihood of sexual activity was greatest; (4) essential planning and monitoring data on students' knowledge, beliefs, and behaviors were inadequate; and (5) teacher training was often insufficient or lacking. Other findings presented are from the GAO review of education programs targeted at high-risk, out-of-school youth. From this review, it is concluded that the Centers for Disease Control's (CDC) Division of Adolescent and School Health has been slow to address HIV education needs; that the Division has primarily funded education agencies and the resulting out-of-school activities have been limited; and that the Division plans a new initiative to fund health departments to reach out-of-school youth that potentially duplicates another CDC Center's approach. (NB)

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# AIDS EDUCATION: Gaps in Coverage Still Exist

Statement of
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Human Resources Division

Before the
Senate Committee on Governmental
Affairs

## SUMMARY

Most American teenagers have received essential information on the causes of AIDS and how to minimize the risks of becoming infected with HIV. However, GAO found that there still were gaps in the provision of AIDS education.

In reviewing the school-based HIV education program nationwide, GAO found that

-- Two-thirds of the nation's school districts offer HIV education;

-- smaller districts were less likely to provide HIV education;

-- HIV education is not provided at all levels, particularly in the upper grades, where the likelihood of sexual activity is greatest;

-- essential planning and monitoring data on students' knowledge, beliefs, and behaviors are inadequate; and

-- teacher training is often insufficient or lacking.

In reviewing education programs targeted at high-risk, out-of-school youth, GAO found that

-- CDC's Division of Adolescent and School Health has been slow to address HIV education needs;

-- the Division has primarily funded education agencies and the resulting out-of-school activities have been limited;

-- the Division plans a new initiative to fund health departments to reach out-of-school youth that potentially duplicates another CDC Center's approach.

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss our review of education programs for youth designed to limit the spread of the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS). We focused our work on the lead federal effort--the HIV education program run by the Division of Adolescent and School Health (DASH), within the Centers for Disease Control (CDC). Without a human vaccine or cure available, education is the primary weapon against the profound medical and social costs of the HIV epidemic.

Most American teenagers have received essential information on the causes of AIDS and how to minimize the risks of becoming infected with HIV. However, there still are gaps in the provision of AIDS education. For example, AIDS education drops off sharply in the 11th and 12th grades, just as sexual activity tends to increase. In addition, students in smaller school districts are less likely to receive any AIDS education. Furthermore, AIDS education efforts are most clearly deficient where they are most clearly needed--in the high-risk out-of-school population, which includes runaway and homeless youth.

BACKGROUND

Many young people are engaging in sexual behaviors and drug use that place them at risk of HIV infection. Although few teenagers have AIDS, about 20 percent of people with AIDS are in their 20s. Because HIV's median incubation period is estimated at nearly 10 years, many of these people were infected with HIV while they were teenagers.

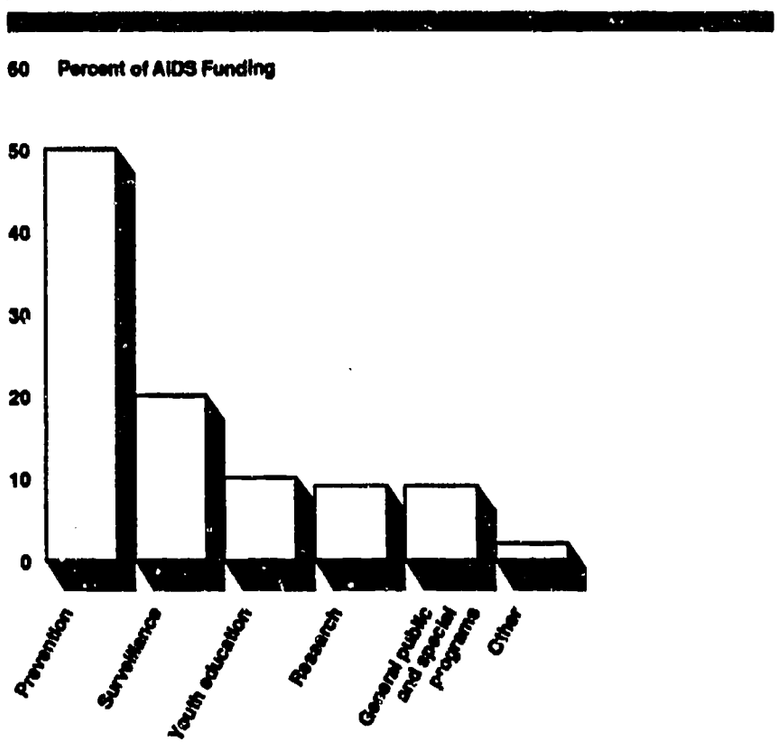
CDC has the lead responsibility for federal HIV education efforts. Its Center for Chronic Disease Prevention and Health Promotion, responsible for HIV education for school-age youth, initiated a nationwide HIV education program in late 1986. DASH, which is within this Center, provides technical and financial assistance through cooperative agreements to state and selected local education agencies and national organizations. These cooperative agreements are designed to help schools and agencies serving both in- and out-of-school youth develop HIV education programs. The education agencies and national organizations then design and operate their own programs.

CDC allocated $136 million of its fiscal year 1987 budget for all AIDS programs. Funding increased to about $438 million in fiscal year 1990. As shown in figure 1, about half of these funds were used for prevention activities, such as counseling and testing, health education and risk reduction, and minority initiatives,

which are administered by another CDC component, the Center for Prevention Services. About 10 percent of CDC's overall AIDS funding was targeted specifically for youth education activities in DASH.

Figure 1

**CDC Funding of AIDS Programs (FY 1990)**




My testimony today will cover DASH's efforts targeted to both in-school youth and out-of-school youth, which includes runaways, the homeless, migrants, and incarcerated youth.

## YOUTH IN PUBLIC SCHOOLS

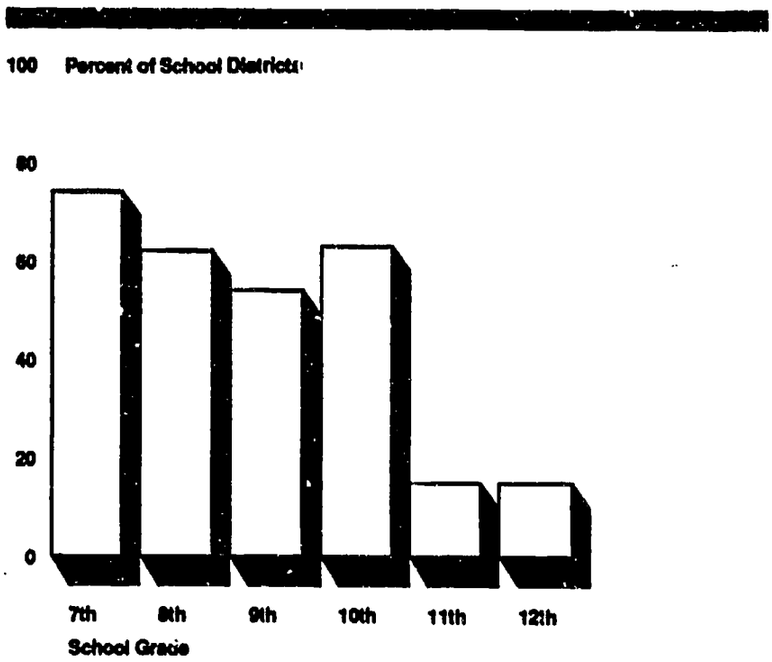
First, I will discuss efforts to provide HIV education to students in public schools nationwide. HIV education in the school setting attempts to give students the knowledge and skills they need to avoid HIV infection. DASH focused on public school students because most youth are in rather than out of school. Also, it reasoned that HIV education provided in the school system could influence behavior before youth dropped out of school. Our information is based largely on a telephone survey of a nationally representative sample of school district officials.

### HIV Education Is Not Provided at All Grade Levels

CDC recommended that students at every grade level receive age-appropriate HIV education to expand and reinforce knowledge. However, only 5 percent of school districts required that HIV education be provided at every grade level. Coverage is most extensive in the middle grades and less so in the upper grades. As figure 2 shows, only 15 percent of school districts provided HIV education in the 11th and 12th grades. This is troublesome because sexual activity is likely to increase at these grade levels. School district officials told us that already crowded curricula restricted their ability to provide HIV education at every grade level.

Figure 2

**Timing of HIV Education**




Two-thirds of public school districts nationwide required that HIV education be provided at some point in grades 7 through 12 during the 1988-89 school year. Of the districts that did not require HIV education, most were small, enrolling fewer than 450 students.

## Essential Planning and Monitoring Data Are Inadequate

For programs to set priorities, evaluate success, and improve operations, they must collect data on students' HIV knowledge, beliefs, and sexual and drug use behaviors.

However, over 80 percent of recipients of CDC funds did not collect this essential information. Only 11 percent of recipients met CDC standards for generalizable surveys dealing with students sexual and drug behaviors. CDC officials stated that essential information was not collected because this was the first program year for many states, and some lacked staff to conduct surveys. In some cases, recipients could not obtain state or local authorization to ask questions about students' sexual or drug use behavior.

## Teacher Training Is Often Insufficient or Lacking

Training for some HIV teachers was absent or often insufficient. CDC has not set any standards for the amount of training required to effectively teach about HIV, but educational authorities with whom we consulted recommended at least 12 hours of HIV training. One-fifth of HIV teachers received no specialized training. The remainder received some training, but it was often less than 12

hours. That is, teachers in two-thirds of the districts received training of 10 hours or less, with a median of 7 hours. Most school district officials we talked to wanted to provide more training to their HIV teachers.

## OUT-OF-SCHOOL YOUTH

Now I would like to turn to the status of HIV education for out-of-school youth. These youth are especially vulnerable to HIV infection because of the extraordinary stresses in their lives, their psychological problems, and the resulting high-risk sexual and drug behaviors they are more likely to engage in than other youth. Providing HIV education to these youth is difficult because they often are hard to locate and resistant to prevention messages. HIV education programs targeting out-of-school youth should provide information on HIV transmission and prevention and the skills to change high-risk behaviors. These programs are most effective when linked to others that provide for basic needs, such as food and shelter.

### DASH Slow to Address Out-of-School Youth

DASH has been slow to address the HIV education needs of out-of-school youth. Cooperative agreements with education agencies generally included funding for both in- school and out-of-school

youth, but DASH initially targeted efforts to the larger, easier to reach, in-school population. DASH provided no specific guidance on how recipients should approach out-of-school youth. Nor did it specify what portion of any particular cooperative agreement was to be spent on out-of-school youth.

State and local education agencies, the primary recipients of DASH funding, are not geared to serving out-of-school youth. These agencies received awards averaging less than $300,000 to meet the needs of both in-school and out-of-school youth. Most of the funding was used for in-school programs. About 5 percent of the funds awarded to education departments were used to fund out-of-school youth programs. DASH also funded six national organizations to target their efforts to out-of-school youth. These organizations received about 5.6 percent of total DASH funds for youth education.

## DASH-Funded Education for Out-of-School Youth Is Limited

DASH-funded HIV education efforts for out-of-school youth are limited. Few of the funded education departments targeted out-of-school youth for any HIV education services. Services needed, but usually not provided, included direct contact with out-of-school youth and design of appropriate HIV education materials or curricula. Recipients said this happened in part because they

lacked experience with these youth and the organizations that serve them. Moreover, those education departments that funded efforts outside the traditional school setting primarily targeted teenage parents or problem in-school youth, rather than homeless or runaway youth.

## By Relying on Health Departments DASH Plans to Expand Program

Because these efforts did not effectively serve out-of-school youth, DASH plans to fund six local health departments or other local agencies to serve as focal points for adolescent education activities. These designated agencies will coordinate community HIV education efforts in high-incidence cities. Another center in CDC, however, has a similar effort underway to educate high-risk youth.

## CDC's Center for Prevention Services Also Funds Health Departments to Target High-Risk Youth

The Center for Prevention Services also funds prevention programs in health departments and community-based organizations for populations at risk, including out-of-school youth. These include: (1) state and local health department prevention programs to support Health Education and Risk Reduction activities and

special Minority Initiatives, (2) AIDS Community Demonstration Projects to conduct research on community HIV education strategies, and (3) community-based organizations developing HIV prevention programs for minority and high-risk groups. We believe these programs potentially duplicate DASH's initiative to fund health departments to target out-of-school youth. Considering the urgent need to reach these high-risk youth, it may be preferable to concentrate efforts where the system is already in place to reach this high risk population, rather than waiting to develop a new initiative.

RECOMMENDATIONS

Concerning youth in public schools, we are recommending that the Secretary of Health and Human Services require the Centers for Disease Control to (1) take a leadership role in developing approaches to extend and reinforce HIV-related education for 11th- and 12th-grade students, (2) work with state education agencies to assist smaller school districts in overcoming resource or community barriers that prevent them from offering HIV education, (3) ensure that state and local grantees collect adequate survey data from students to evaluate and improve school-based programs, and (4) develop guidelines for the training of HIV teachers.

Concerning out-of-school youth, we are recommending that CDC consider whether the out-of-school youth component of DASH should

be merged with CDC's existing prevention programs within the Center for Prevention Services.

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This concludes my statement, Mr. Chairman. I would be happy to answer any questions you may have.