DOCUMENT RESUME

ED 342 735 SP 033 593

AUTHOR Nash, Margaret A.; Dunkle, Margaret C.
TITLE How Four States Put HIV/AIDS Instruction in the Classroom: Alabama, Maryland, Nebraska and Washington.
INSTITUTION Council of Chief State School Officers, Washington, DC. Resource Center on Educational Equity.
SPONS AGENCY Center for Chronic Disease Prevention and Health Promotion (DHHS/CDC), Atlanta, GA. Adolescent and School Health Div.
PUB DATE Feb 90
CONTRACT U63-CCU-3028851-02
NOTE 36p.
PUB TYPE Reports - Descriptive (141)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Acquired Immune Deficiency Syndrome; Curriculum; Elementary Secondary Education; Government Role; *Health Education; Health Promotion; *Instructional Leadership; *Policy Formation; Profiles; *Program Effectiveness; State Departments of Education; State School District Relationship; Teaching Methods
IDENTIFIERS Alabama; Maryland; Nebraska; Washington

ABSTRACT

This study profiles four diverse states (Alabama, Maryland, Nebraska, and Washington) where successful programs have been developed and implemented to provide Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) instruction to elementary and secondary school students. The report identifies common factors and strategies for success and is organized into nine sections: (1) building a broad base of support; (2) providing strong leadership; (3) developing partnerships between health and education; (4) understanding local and state roles; (5) integrating HIV/AIDS instruction into a broader context; (6) resolving ethical differences; (7) reaching those most at risk; (8) state profiles of Alabama, Maryland, Nebraska, and Washington; and (9) methodology. State profiles include numbers of students and school districts, the racial/ethnic make-up of the student body, the incidence of AIDS, summaries detailing the mandate for HIV/AIDS instruction, and an outline of curriculum goals. A structured telephone interview was developed and state level policy makers and local level teachers were asked questions about: background; development of instructional policy; curriculum content; curriculum development; and implementation and evaluation. Interviewees were also asked what advice they would offer to other states just beginning the instructional process. (LL)

HOW

Four States Put HIV/AIDS Instruction *in the* Classroom

ALABAMA

MARYLAND

NEBRASKA

WASHINGTON

February 1990

THE COUNCIL OF CHIEF STATE SCHOOL OFFICERS (CCSSO)

is a nationwide non-profit organization of the 57 public officials who head departments of public education in every state the District of Columbia, the Department of Defense Dependents Schools, and five extra-state jurisdictions. CCSSO seeks its members' consensus on major education issues and expresses their views to civic and professional organizations, to federal agencies, to Congress, and to the public. Through its structure of committees and task forces, the Council responds to a broad range of concerns about education and provides leadership on major education issues.

Because the Council represents the chief education administrator, it has access to the educational and governmental establishment in each state and to the national influence that accompanies this unique position. CCSSO forms coalitions with many other education organizations and is able to provide leadership for a variety of policy concerns that affect elementary and secondary education. Thus CCSSO members are able to act cooperatively on matters vital to the education of America's young people.

The CCSSO Resource Center on Educational Equity provides services designed to achieve equity in education for minorities, women and girls, and for disabled, limited English proficient and low-income students. The Center is responsible for managing and staffing a variety of CCSSO leadership initiatives to provide better educational services to children and youth at risk to school success.

This report was prepared by
Margaret A. Nash and Margaret C. Dunkle
of the Equality Center
for the HIV/AIDS Prevention Education Project,
Resource Center on Educational Equity,
Council of Chief State School Officers.

This report was completed with support provided by a cooperative agreement
(Number U63-CCU-3028851-02) with the Division of Adolescent and School Health,
Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control,
Atlanta, Georgia 30333.

TABLE OF CONTENTS

INTRODUCTION

The following pages highlight major factors in the story of how four diverse states—Alabama, Maryland, Nebraska, and Washington—succeeded in providing HIV/AIDS instruction in elementary and secondary classrooms. It is a story of leadership, vision, consensus, and compromise.

The story is not yet complete. It will continue as more is learned about how children and youth learn the consequences of risky behaviors, as political authorities respond to the spread of HIV infection and the increasing number of AIDS cases, and as medical researchers move closer to cures.

Three of the states—Alabama, Maryland, and Washington—have *mandates* to teach HIV/AIDS prevention in schools. The fourth state, Nebraska, *recommends* HIV/AIDS instruction. There the state department of education is supporting legislation to require instruction in HIV/AIDS as well as nine other health areas.

This study is a part of the Council of Chief State School Officers' national project to help state education agencies effectively address education about AIDS and HIV infection. This project is funded by the Division of Adolescent and School Health of the Centers for Disease Control. The study was conducted, and the report written, by Margaret A. Nash and Margaret C. Dunkle of the Equality Center.

This report identifies common success factors and brings them to life with anecdotes, examples, and quotations. Strategies for success include building a broad base of support, providing strong leadership, developing partnerships between health and education, understanding local and state roles, integrating HIV/AIDS instruction into a broader context, and resolving ethical differences.

This report also points to a continuing challenge for states, school districts, and schools—to design curricula and programs that

are effective with those most at risk of HIV infection, including low-income and minority children and youth, and youth having sexual preferences that are identified as gay or lesbian. While the challenge of addressing these sensitive needs is difficult, it must be met because these are the young people who most need information, support, and services to prevent HIV infection.

The final sections of this report profile the states studied and summarize the survey methodology.

BUILDING A BROAD BASE OF SUPPORT

The cornerstone of each state's effort to put an HIV/AIDS curriculum in place is building a broad base of support. This means involving a wide range of people, agencies, and organizations—and listening to what they have to say. The methods used by Alabama and Washington are illustrative.

"Public input was sought. It was a 'we' effort, not a 'Thou shalt.'"

Alabama's department of education held four regional public hearings to discuss the pros and cons of the HIV/AIDS curriculum. As many as 100 people attended each hearing. The department also sent draft copies to PTAs, local school superintendents, and libraries for parents and community groups to preview.

Even prior to these hearings, Alabama's education department sought public comment on drafts of the curriculum. An assistant state superintendent "called people around the state and asked them to get folks together to read the draft. 'They can be pro-AIDS education [or] anti-AIDS education. I don't care. Just get me thinking, reasonable people.' We went through the draft page by page, really paying attention to pages that were likely to be controversial, and explained why we treated it in the way we did."

"That was an invaluable step," the assistant state superintendent added. The message went out in a ripple effect across the state:

"there was no hiding, it was all above board, and, if you've got anything to say, come say it."

"The idea is consensus, not having one way, one method to fight AIDS...."

In Washington state, disparate groups came together when the governor set up a task force to make recommendations for HIV/AIDS legislation. The person assigned by the department of social services to organize this task force pulled together people from every constituency, including hospitals, public health, education, and the gay community. "The legislation would not have been possible if it hadn't been for that process of everybody sitting down and talking and knowing where each other was coming from," a task force member said.

Washington's AIDS Omnibus Bill had bipartisan sponsorship. "Avoid the dogma on both sides," advised a staff member of the Washington State Senate Committee on Health Care. "Avoid the politics. Get Republicans and Democrats on each side who know something about health and get them involved. Work it as a bipartisan issue right from the beginning."

PROVIDING STRONG LEADERSHIP

Leadership to implement a school HIV/AIDS curriculum came from many sources in the four states studied—education agencies, legislatures, advocacy groups, and community organizations. At the same time, in each state one or two pivotal people either got the ball rolling to begin with, or gave it a needed kick to keep it from getting stuck.

In Alabama, the key staff person on HIV/AIDS credits the assistant state superintendent with both recognizing the need for school action and providing the staff, time, and resources to get the job done. She "appointed people, [allotted] work time, and gave the impetus" to the job of writing the HIV/AIDS guidelines.

In Maryland, administrators in local school districts with high numbers of AIDS cases urged the state superintendent to change the state requirement (called a bylaw) that sex

education could not be taught earlier than the seventh grade. Understanding that this was a serious need, the state superintendent asked a staff health education specialist to re-draft the provision.

The legislature took a leadership role in Maryland, as well. Just prior to the re-drafting of the bylaw, the legislature asked the department of education to move ahead on HIV/AIDS instruction. The combination of local concern, the state superintendent's interest, and the recognition of the problem by the legislature created a situation ready for action.

"The one student intern assigned to the effort is an extraordinary young woman....Her remarkable combination of intelligence, dedication, hard work, and world class bureaucratic maneuvering turned ...[the] effort into a first class model of public policy development."

In Nebraska, the HIV/AIDS curriculum began with one state education agency staff person and her supervisor. At a health and physical education conference in the spring of 1986, this staff person saw a film on AIDS, and informally talked with others about AIDS as an issue for schools. "I came back from the conference and said to my supervisor, 'We need to be pro-active, rather than reactive.'" The supervisor then approved the time and resources so that the staff person could set up a curriculum-writing task force.

In Washington state, the catalyst for action came from two unexpected sources: the serendipitous assignment of a talented young woman to head a task force on AIDS, and the bipartisan support of the AIDS bill in the legislature.

In July, 1987, the governor appointed a task force to recommend strategies and policies regarding AIDS. The head of the social services department, who was charged with overseeing the task force, "handed it over to a 23-year-old gal just out of an internship." According to a task force member: "She was tapped for the job just three to four hours before the first meeting. There was no expectation that this task force was going to go anywhere. But this woman was extraordinary.... I've worked in government for twenty years and I never saw a more creative, energetic process."

This young woman pulled together people from several constituencies: hospitals, public health, the gay community, and education. The result of this task force was a 225-page report full of background information, policy recommendations, and analysis of a wide range of AIDS-related issues. This report became the core of the AIDS Omnibus Bill.

The second source of leadership in Washington came from state legislators—a Republican Senator and a Democratic Representative who worked together to make HIV/AIDS a bi-partisan issue. Then-Senator Deccio remarked, "Given...my deep conviction that it was already past time to do something to address the epidemic, Representative Braddock and I agreed on a dangerous and cunning political strategy used only rarely in the political world: we decided to write a bill that made sense."

DEVELOPING PARTNERSHIPS BETWEEN HEALTH AND EDUCATION

Successfully implementing an HIV/AIDS curriculum requires a conscious and sustained effort to build the personal relationships and institutional supports that make interagency cooperation possible. This is especially true for the sister departments of health and education, where overlapping turf and missions make clashes seemingly unavoidable.

"[The department of health] stood by our side throughout.... We have a tremendous personal relationship."

Speaking of the department of health, an Alabama education staff person said: "They stood by our side throughout....We have a tremendous personal relationship." Another member of the education department who worked on the HIV/AIDS curriculum commented that "the department of public health assigned four staff members to be available to us at any time we needed."

Agencies in Maryland managed to avoid the fierce battles for turf and credit that often mar interagency projects. The work was such a

cooperative venture that some members of the Interagency Committee on AIDS did not even know who instigated the changes on HIV/AIDS in the education bylaw. Wherever the idea came from, one committee member said, "it seemed that everyone just worked together."

UNDERSTANDING LOCAL AND STATE ROLES

Local control over curricula, a hallmark of public schools in the United States, ensures that controversial topics will be dealt with in a way that is sensitive to local concerns. Each of the states studied showed a strong commitment to local control of the HIV/AIDS curriculum.

"Locals need guidance, leadership, and training. There's no real resistance. They say, 'If you show us the way, we'll do it.'"

The Alabama State Board of Education mandates specific objectives—not a specific curriculum—that local school districts must meet in a range of health areas, including HIV/AIDS. The state-suggested curriculum (called the *Alabama Course of Study: Health Education*) includes a section on HIV/AIDS. While each school must teach about HIV/AIDS in grades five through twelve, they can use either the state curriculum or any other curriculum that meets the mandated goals.

Maryland places a strong emphasis on local autonomy. The department of education developed guidelines for HIV/AIDS instruction, recommending specific goals and sub-goals. Each of the state's twenty-four jurisdictions is then responsible for developing its own HIV/AIDS curriculum. In this way, jurisdictions with high rates of teen pregnancy, AIDS, and STDs can teach about HIV/AIDS-related issues as early as the third grade. All jurisdictions must begin this instruction by the fifth grade.

Local school systems do not always just do the minimum to meet state requirements. The bylaw in Maryland requires that information about HIV/AIDS be taught once in elementary school, once in middle school, and once in high school. But "many do it once in elementary and twice in middle school and

high school. Some do every grade level starting at the fourth," according to a state health specialist.

Local autonomy also can mean that politically controversial topics such as discussions of "safer sex" may sometimes be included in the curriculum and at other times not included, where the judgement is that this instruction belongs only in families. According to a health coordinator in one Maryland county, some groups "thought abstinence and monogamy were the only things that should be taught...[so] we don't talk about condoms. There's a strong focus on abstinence."

The work on AIDS must be done by local people. 'You don't need itinerant experts coming in telling you what to do."

The Washington legislature addressed local control by providing communities three curricular choices: use the state curriculum, use a state-approved commercially-written curriculum, or write their own. Locally written HIV/AIDS curricula must be submitted to the Office of AIDS in the Washington Department of Social and Health Services for approval for medical accuracy.

INTEGRATING HIV/AIDS INSTRUCTION INTO A BROADER CONTEXT

Nearly everyone interviewed for this study spoke of the need to integrate HIV/AIDS instruction into a broader context. For some, this meant including information about HIV/AIDS in the curriculum. For others, this meant including HIV/AIDS instruction as one piece of a plan covering a range of AIDS issues.

"The fact that AIDS got national public attention has helped us sell comprehensive health to those who weren't convinced before. It gave us leverage; it increased credibility to give health its own area weighted equally with math and English."

While none of the four states in this study began working on HIV/AIDS instruction as a part of comprehensive school health instruction, all now agree that HIV/AIDS instruction needs to be integrated into comprehensive health. In Alabama and Nebraska, the HIV/AIDS curriculum provided the incentive for the education departments to push for comprehensive health instruction.

In Alabama, HIV/AIDS education arose as an issue separate from other health issues. The department of education wrote an HIV/AIDS curriculum, and "[w]hen the board adopted our AIDS *Unit of Instruction*, they said it would be taught once. Then they added a sentence that changed our lives: that thereafter it would be taught as part of comprehensive health. We didn't *have* comprehensive health. [This change] came out of a recognition that you really don't need to teach AIDS, you need to teach comprehensive health."

Speaking of the need for comprehensive health instruction, one health educator said, "I think it would be more beneficial if schools talked about AIDS in the context of behaviors. It takes a lot to change behaviors; one day or one week that they spend on AIDS isn't enough. If they incorporated AIDS into [discussions of] general behaviors, the message would be more consistent."

"I think health and wellness should be integrated across the curriculum. ...It's part of science. It's part of everything we teach."

Nebraska's department of education wants the legislature to require more comprehensive health instruction, now that most schools are teaching about AIDS. "We've raised the level of awareness...so that now teachers and administrators are asking when we can have comprehensive health [rather than the very limited "comprehensive health" mandate that is currently law]. [Teachers want to] integrate AIDS into it and teach kids how to live long and well."

In some schools, instruction in HIV/AIDS is treated as an "add-on," another special topic to squeeze into the school year. Many teachers hope that comprehensive health instruction will provide a clearly-defined place for HIV/AIDS lessons. "AIDS is one more thing we have to teach and don't have a place for it, just like drug abuse, child abuse, and so on....If we have comprehensive health, we'll have a reasonable place for these topics. AIDS may help make that happen."

In Maryland, the desire of state education agency staff for comprehensive school health instruction actually slowed enactment of the state law mandating HIV/AIDS instruction.

The legislature was clamoring for HIV/AIDS instruction. The state department of education testified against the proposed legislation to enable a committee drafting guidelines for comprehensive health instruction to complete the task. The health specialist representing the education department promised the legislature that HIV/AIDS would be addressed in the context of the comprehensive health guidelines within six months to a year.

However, the legislature did not wait and enacted an emergency HIV/AIDS regulation in October 1987. This enabled instruction in HIV/AIDS to start the following school year. Meanwhile, the proposed HIV/AIDS bylaw change was going through the formal approval and public comment process at the state board of education.

Maryland's state board of education will consider the requirement ("bylaw") for comprehensive school health instruction in 1990.

In Washington, the issue of HIV/AIDS instruction was one piece of an AIDS Omnibus Bill that also dealt with testing, confidentiality, and quarantining. A state House of Representatives staff person advises that any HIV/AIDS legislation "should be comprehensive. It's a mistake to focus on one aspect" of the AIDS crisis, such as just education, or just testing.

RESOLVING DIFFERENCES

HIV infection and AIDS raise moral and ethical issues about which there are strong convictions. Implementing HIV/AIDS curricula successfully requires understanding the entire range of value systems on sexuality and sex education.

The differences in values usually center on discussions of timing (how early HIV/AIDS will be taught) and content (how explicit the curriculum will be).

"We're in a Bible Belt state and we had a lot of opposition to thinking about AIDS, period...."

In Alabama, conservative groups did not want the curriculum to use sexually explicit language, such as the term "anal intercourse." Yet everyone agreed that the curriculum should be medically correct. One person on the curriculum writing team reported: "It was a stroke of genius on the part of the team: we had a chart of transmission that showed exit points and entrance points of the virus. We used the terms penis, vagina, etc. Teachers had to say, 'any combination of exit and entry points creates exposure to the virus.' That way we got the message across without having to use unacceptable terms like 'anal intercourse.'"

The Maryland departments of education and health wanted the state board of education's bylaw to mandate that *every* child receive HIV/AIDS instruction. In response to parents' objections, the board instead allowed parents to opt their child out of HIV/AIDS instruction.

"We had people testifying for the AIDS curriculum who represented both the ACLU and the Eagle Forum. A minister later told us, 'Lady, that wasn't an accomplishment, that was a miracle.'"

Washington state handled this same situation a little differently. The AIDS Omnibus Bill allows parents to exclude children from HIV/AIDS instruction, but only after the parents attend a meeting where they actually read the curriculum. After attending such a meeting, parents are more educated on the issues and few actually opt their children out of HIV/AIDS instruction.

Since Washington state was dealing with an omnibus AIDS bill, tradeoffs happened on a much larger scale. "We traded quarantine and testing for education and prevention," according to a key legislative aide. Other compromises during the legislative process included starting mandated HIV/AIDS instruction in the fifth grade, rather than in kindergarten as the original sponsors wanted. Curricular content changed, too: "Part of the price of getting the AIDS curriculum was adding the language that it 'shall emphasize that the only sure means to prevent AIDS is abstinence.'"

REACHING THOSE MOST AT RISK

While all four states have had great success in putting HIV/AIDS instruction in the classroom, much remains to be done. Perhaps the greatest continuing challenge is designing curricula that effectively reach those young people most at risk—including low-income and minority children and youth, and youth whose sexual preference is identified as gay or lesbian.

AIDS is of particular relevance to minority and low-income youth. Blacks constitute about 11 percent of the U.S. population; 25 percent of AIDS cases are among blacks. Hispanics are about 6 percent of the population; 15 percent of AIDS cases are among Hispanics.

The states surveyed in this study, however, had not explicitly given sufficient attention to reaching minority and low-income students or addressing their special needs.

Few minority group members were actively involved in writing the state HIV/AIDS curricula. When asked about the involvement of minority and low-income groups, responses included: "Not as a group"; "Not specifically, no"; and "We don't single out any specific groups."

"We have no recognized students as [gay or lesbian]. We've never discussed it. In fact, I think you're the first person who's asked me this question."

Gay, lesbian, and bisexual youth are especially susceptible to HIV infection. They represent a substantial number of young people. An estimated five to ten percent of the population have a sustained homosexual preference. A much larger percentage, estimated at 30 to 40 percent of the population, has a homosexual experience at some point in their lives. Such experiences are often during adolescence—a great period of change and experimentation.

It is imperative that school HIV/AIDS curricula and programs address potential behaviors of homosexual and bisexual youth.

Yet, addressing these issues is politically difficult, even in states that have pioneered HIV/AIDS instruction. When asked if any gay

and lesbian groups participated in drafting the policies and curricula, most states responded, "No." One respondent said in surprise, "I doubt we have any such groups in our state." One exception was Washington state, where part of the initial pressure for legislation came from local gay groups.

When asked how their state's HIV/AIDS curriculum addresses the special needs of gay and lesbian youth, answers included:

- "Probably not as much as it should. I think it tries to make people sensitive to other's beliefs and their decision-making. It lets kids see you're not bad if you're different. But it's something we're going to have to look at if we're really serious about this."

- "[Originally in the HIV/AIDS curriculum] we put in hotlines for kids, including one for the gay and lesbian hotline. We got flak for it, so we took it out."

One person reported that, because their AIDS program is federally funded, they are prohibited from mentioning homosexuality in any way that makes it seem acceptable. However, this restriction (the Helms Amendment) was replaced over a year ago by a provision that simply prohibits schools from directly *promoting* any sexual activity, heterosexual or homosexual.

* * * * * *

Helping America's children and youth learn about HIV/AIDS cannot be put off until tomorrow. The four states in this study have tackled this challenge head on—and have made great progress. Understanding their achievements can help others.

A difficult ongoing challenge is to find effective ways to reach those young people most at risk of HIV infection, especially low-income and minority children, and gay and lesbian youth.

The spirit of leadership, vision, consensus and compromise that has enabled progress thus far will be needed for states, communities, and schools to address issues of HIV/AIDS and comprehensive school health programs in the years ahead.

The four states studied are diverse—demographically and geographically, as well as in the process they went through to put HIV/AIDS instruction in the classroom.

The catalyst for an HIV/AIDS curriculum came from varying sources in the four states. In *Alabama*, a member of the state board of education asked the health department to recommend a curriculum on HIV/AIDS. But the board found the two curricula the health department recommended to be too sexually explicit. The superintendent had his staff write an HIV/AIDS curriculum, which the board adopted in 1987. The board required school systems to teach HIV/AIDS as a separate unit to all students in grades 7-12 in 1987, and then to integrate instruction about HIV and AIDS into comprehensive health instruction. This led the department of education to write a comprehensive health instruction curriculum.

In *Maryland*, legislation mandating HIV/AIDS instruction in schools was introduced in 1986. The department of education opposed this legislation, since it was drafting a "framework" for comprehensive health and wanted instruction on HIV and AIDS integrated into this larger context, not treated separately.

Meanwhile, local urban and suburban school districts with a high numbers of AIDS cases wanted current requirements (called a bylaw) changed so that they could begin teaching sex education to children at grade three, rather than grade seven. Representatives of these local school districts went to the state superintendent, who instructed his staff to re-draft the sex education bylaw to permit this earlier instruction, as well as require each local jurisdiction to develop an HIV/AIDS curriculum. The provisions were approved by the legislature and the state board of education in March, 1987. Staff at the department of education expect to present the comprehensive health instruction framework to the board for consideration in 1990.

The state director for health and physical education in *Nebraska* began development of HIV/AIDS education after attending a 1986 conference. She secured the support of her supervisor and led the team that wrote an HIV/AIDS curriculum, which many Nebraska schools have been using since 1987.

The Nebraska state board of education has requested that the legislature expand the mandate for health instruction to cover ten areas, including the prevention and control of such diseases as AIDS. The department of education is currently revising its AIDS guide, as well as expanding its health education guide to cover HIV/AIDS.

In *Washington* state, pressure from the community was the catalyst for legislation on AIDS. In 1987, the governor set up a task force to make recommendations. The chairs of the Senate and House Health Care Committees worked together to draft a bi-partisan AIDS Omnibus Bill that was enacted in 1988. This law covers a wide range of issues related to HIV and AIDS, and includes a mandate for instruction about HIV/AIDS in grades 5-12.

Following are summaries that detail each state's mandate or recommendation for HIV/AIDS instruction, outline the goals or objectives of the curriculum, and highlight specific features in order to provide a flavor of the HIV/AIDS curriculum.

ALABAMA PROFILE*

students		734,000
districts		130
racial/ethnic make-up of student body	White	64%
	Black	35%
	Other	2%
incidence of AIDS	5.3 per 100,000	

MANDATES AND RECOMMENDATIONS

In 1987 the state board of education mandated that all students in grades 7-12 receive the five-day *AIDS Unit of Instruction: Grades 7-12* during the second semester of the 1987-88 school year.

After the state board of education adopted the *Alabama Course of Study: Health Education* (a comprehensive health curriculum) in May, 1988, every school was required to teach the HIV/AIDS unit to each student twice—once in the 7th grade and once in high school. This state *Course of Study* includes instruction on HIV/AIDS during units on disease control and suggests teaching it in grades 5-12.

The state *Course of Study* mandates minimum "student outcomes," or objectives, not a particular curriculum. Local education agencies are free to use the state-prepared *AIDS Unit of Instruction*, or any other curriculum, as long as the state objectives are met.

GOALS

The Preface of the *Unit of Instruction* states, "Education is the most effective preventive measure against the spread of the AIDS virus. The state department of education has an obligation to present Alabama students with current, factual information about what AIDS is, how it is transmitted, and how it can be prevented. Our students must be informed. They must be told, clearly and honestly, what the risks are and how to avoid them."

Objectives, or "student outcomes," for the study of AIDS include:

FIFTH GRADE

Categorize everyday activities as being "safe" or "unsafe" with respect to the spread of the AIDS virus.

* Sources for information: The number of students in public elementary and secondary schools (fall 1984, rounded to the nearest 1,000), the number of public school districts (1986-87), and the racial and ethnic makeup of the public school student body (fall 1986, percents may not add to 100% due to rounding) are from the *Digest of Education Statistics*, 1988, U.S. Department of Education, pages 54, 82, and 84. The incidence of AIDS is from "HIV/AIDS Caseload Summary," Centers for Disease Control, March, 1989.

Enumerate procedures for preventing the spread of the AIDS virus through injuries involving the potential exchange of blood.

SIXTH GRADE

Describe the methods of transmission, symptoms, harmful effects, and recent statistics regarding the AIDS virus.

Discuss safe and unsafe practices as they relate to the transmission of the AIDS virus.

SEVENTH GRADE

Trace the development of the AIDS virus (HIV) within the body, and discuss how to prevent its spread.

Delineate individual responsibilities in preventing STDs and resources available for treatment.

EIGHTH GRADE

Discuss AIDS in relation to statistics on AIDS, economic costs, and impact of AIDS on society.

Analyze and discuss responsible actions relating to the prevention and transmission of STDs.

SENIOR HIGH

Discuss AIDS in relation to symptoms and transmission.

Develop strategies to avoid contracting the AIDS virus.

SPECIFIC FEATURES

Regarding **prevention**, the *AIDS Unit of Instruction* includes:

- a strong "say 'No'" message and tips and role-plays on how to say 'no' to sex and drugs
- decision-making guidelines, including, "Is the decision lawful? Is the decision consistent with all the facts? Does the decision promote health and safety in myself and others?"
- a strong emphasis on not being sexually active "until you are in a monogamous marriage relationship with an uninfected person"
- a discussion of the failure rate of condoms

Regarding **transmission**, the *AIDS Unit* includes the following information:

- AIDS is not spread through casual contact
- The AIDS virus "infects people regardless of age, sex, race, socioeconomic status, or sexual orientation"

- "people get infected with the AIDS virus because of what they do, not because of who they are"
- exit and entrance points for the AIDS virus include "breaks in the skin, penis, vagina, mouth, rectum, and mucous membrane"

Regarding **infection**, the *AIDS Unit* states that:

- "infected women should seriously consider not having babies;" and "infected women should not breast-feed babies"
- "AIDS is a killer!...AIDS is at our back door—in our state and possibly in our home town"
- teens can get confidential AIDS antibody testing

FOR FURTHER INFORMATION

Sue B. Adams
Education Specialist
AIDS Education Project
Alabama State Department of Education
111 Coliseum Boulevard
Montgomery, AL 36193
205/261-2744

MARYLAND PROFILE*

students		676,000
districts		24
racial/ethnic make-up of student body	White	58%
	Black	37%
	Hispanic	2%
	Asian	3%
incidence of AIDS	13.6 per 100,000	

MANDATES AND RECOMMENDATIONS

In 1987, the Maryland legislature enacted an emergency law requiring all schools to teach about HIV/AIDS during the 1987-88 school year. In 1988, the state board of education passed the AIDS Prevention Education Bylaw, mandating that AIDS instruction be taught once in elementary school (grades 3-6), once in middle school (grades 6-9) and once in high school (grades 9-12).

The bylaw required the state department of education to write "Instructional Guidelines" to help local school systems develop appropriate curricula. These "Guidelines" recommend goals and sub-goals for teaching AIDS prevention. Each local school system must develop its own curriculum.

The department of education is presenting a framework for comprehensive health instruction to the state board of education in 1990. Once comprehensive health instruction is in place, AIDS instruction will be integrated into the units on disease prevention.

GOALS

The introduction to the "Instructional Guidelines" states that the goal for local AIDS curricula "should be to educate students in a systematic and consistent manner about the disease, its modes of transmission, prevention, and social ramifications."

Objectives, or "instructional expectancies," for the study of AIDS include:

GRADES 3-6

Discuss the role of the body's immune system against disease.

Identify healthy and unhealthy behavior.

* Sources for information: The number of students in public elementary and secondary schools (fall 1984, rounded to the nearest 1,000), the number of public school districts (1986-87), and the racial and ethnic makeup of the public school student body (fall 1986, percents may not add to 100% due to rounding) are from the *Digest of Education Statistics*, 1988, U.S. Department of Education, pages 54, 82, and 84. The incidence of AIDS is from "HIV/AIDS Caseload Summary," Centers for Disease Control, March, 1989.

Discuss how lack of accurate information can lead to anxiety, uncertainty, and fear.

Describe the influence fear has on how people act toward one another.

Dispel the misconception that AIDS is easily spread through casual contact.

Identify public and private health agencies responsible for the prevention, treatment, and control of disease.

GRADES 6-9

Explain how the AIDS virus is and is not transmitted.

Identify high risk behaviors for contracting AIDS.

Identify sexual abstinence as the most effective means of preventing AIDS.

Describe ways that individuals, families, and society can promote and maintain healthy lifestyles and prevent disease.

Identify reliable school and community sources of information and support regarding AIDS.

GRADES 9-12

Describe the medical history of the HIV infection.

State ways to prevent the spread of AIDS including abstinence from sex and drugs.

Discuss the social, moral, and technical issues surrounding AIDS and the right of individuals to hold differing opinions.

Explain the testing procedure for HIV infection and identify local testing sites.

SPECIFIC FEATURES

Each of Maryland's 24 jurisdictions must develop its own AIDS curriculum.

FOR FURTHER INFORMATION

Janet Pabst
AIDS Prevention Specialist
Division of Instruction
Maryland State Department of Education
200 West Baltimore Street
Baltimore, MD 21201
301/333-2321

NEBRASKA PROFILE*

students		267,000
districts		7
racial/ethnic make-up of student body	White	93%
	Black	4%
	Hispanic	2%
	Other	1%
incidence of AIDS		2.7 per 100,000

MANDATES AND RECOMMENDATIONS

The Nebraska Department of Education recommends that AIDS prevention education be taught as part of comprehensive health instruction. There are no state mandates for comprehensive health instruction or for AIDS instruction.

In 1987, the Nebraska Department of Health and the Nebraska Department of Education published *AIDS: A Resource Guide*, which the Nebraska AIDS Education Task Force recommends for use in grades 5-12.

GOALS

The overview of *AIDS: A Resource Guide* states, "Education about AIDS in Nebraska schools should prepare individuals to protect themselves and others from the infection. Following instruction about AIDS, students should act more responsibly and make decisions that will contribute to their health and well being...No knowledge is more crucial than this knowledge about health. Without it no other life goal can be successfully achieved."

Student objectives for the study of AIDS include:

UPPER ELEMENTARY

Understand the infectious disease cycle, or "chain of infection."

Comprehend why STDs are a serious health problem.

Know how to locate and contact local and state resources where AIDS information can be obtained.

Formulate ways in which individuals and society can assist in the prevention and control of STDs.

MIDDLE SCHOOL/JUNIOR HIGH

Recognize the cause of AIDS and understand that there are various ways of transmitting the disease AIDS.

* Sources for information: The number of students in public elementary and secondary schools (fall 1984, rounded to the nearest 1,000), the number of public school districts (1986-87), and the racial and ethnic makeup of the public school student body (fall 1986, percents may not add to 100% due to rounding) are from the *Digest of Education Statistics*, 1988, U.S. Department of Education, pages 54, 82, and 84. The incidence of AIDS is from "HIV/AIDS Caseload Summary," Centers for Disease Control, March, 1989.

Recognize that there are ways in which a person can reduce his or her risk of contracting AIDS.

SENIOR HIGH

Understand how AIDS-related problems can be solved and rehearse solving specific problems, using the basic steps in decision-making.

Know about models for discussing the use of AIDS prevention strategies with a potential sex partner.

SPECIFIC FEATURES

A teacher's research sheet on "Answers to Common AIDS Questions Asked by Young Adults" includes topics such as:

- "Was AIDS caused by homosexuals?" The answer given is, in part, "Anyone, heterosexual, homosexual or bisexual who engages in risky sexual or IV drug-abusing behaviors can acquire the AIDS virus. It is the risky behaviors, not one's sexual orientation, that places the person at risk."

- "How many women have AIDS?" and "Does AIDS affect all races of people?" Answers indicate that, although a small percentage of AIDS cases are women, the number will increase; and that minorities disproportionately have AIDS.

An activity on "Eliminating Barriers to Individual AIDS Prevention" has high school students:

- suggest how to resist peer pressure to be sexually active;

- understand that many parts of the body other than the genitals can be sensual to touch; and

- discuss ways to create more "comfortable and private atmospheres where condoms are secured."

A curriculum handout for high school students has information on local and national hotlines for more information on AIDS and/or STDs. The handout also states, "Minors can get STD treatment without parental consent in every state. That's the law."

A glossary for students at the upper elementary school level includes these definitions:

- "anal intercourse– sexual union involving the penis in the rectum"

- "oral-anal sex– touching a partner's anus with the mouth"

- "condom– rubber cover used over the penis. Used during sexual activity to prevent the exchange of semen. Offers protection against the AIDS virus and other STDs"

FOR FURTHER INFORMATION

JoAnne Owens-Nauslar
AIDS Project Director
Nebraska Department of Education
301 Centennial Mall South
Lincoln, NE 68509
402/ 471-4334

WASHINGTON PROFILE*

students		761,000
districts		297
racial/ethnic make-up of student body	White	86%
	Black	4%
	Hispanic	4%
	Asian	5%
	Other	2%
incidence of AIDS	8.9 per 100,000	

MANDATES AND RECOMMENDATIONS

In 1988 the state legislature passed the AIDS Omnibus Bill, one section of which mandates AIDS prevention education at least once each school year beginning no later than the fifth grade.

The Office of the Superintendent of Public Instruction developed *KNOW: AIDS Prevention Curriculum*, and published a list of commercially-developed AIDS curricula approved for use in Washington public schools. A local school district may either: 1) use *KNOW: AIDS Prevention Curriculum*; 2) use one of the other state-approved curricula; or 3) develop its own curriculum, which must be reviewed and certified by the health department for medical accuracy.

The state board of education recommends that HIV/AIDS education be integrated into a K-12 comprehensive health instruction program that promotes wellness-oriented beliefs and effective decision-making skills to avoid risky behavior.

GOALS

The *KNOW: AIDS Prevention Curriculum* states that the primary goal for grades K-5 is "to allay children's fears of AIDS and to establish a foundation for more detailed discussion of sexuality and health." The primary goal for grades 6-12 is "to teach students to protect themselves and others from infection with the AIDS virus."

"Student learning objectives" include:

FIFTH GRADE

Recognize HIV infection as one of several STDs.

List behavior that protects against HIV and other STDs.

* Sources for information: The number of students in public elementary and secondary schools (fall 1984, rounded to the nearest 1,000), the number of public school districts (1986-87), and the racial and ethnic makeup of the public school student body (fall 1986, percents may not add to 100% due to rounding) are from the *Digest of Education Statistics*, 1988, U.S. Department of Education, pages 54, 82, and 84. The incidence of AIDS is from "HIV/AIDS Caseload Summary," Centers for Disease Control, March, 1989.

SIXTH GRADE

Examine media messages about sexuality.

Describe how fear and misinformation affect attitudes.

SEVENTH GRADE

Describe the HIV agent of infection and its transmission modes.

Describe methods of preventing the spread of HIV, including abstinence, monogamous sexual relationships, avoidance of substance abuse, and safer sex practices.

EIGHTH GRADE

Personalize information about AIDS by empathizing with persons with AIDS.

Apply communication skills to drug and sexuality situations.

NINTH GRADE

Assess methods of HIV/AIDS control and prevention.

Examine the process of HIV transmission and the relative risk of AIDS associated with various behaviors or situations.

TENTH GRADE

Review the roles of abstinence and the proper use of latex condoms in disease control.

Demonstrate an awareness of the emotional and social aspects of coping with the disease AIDS.

ELEVENTH GRADE

Examine responsibilities and risks related to sexuality and drugs.

Distinguish between fact and opinion by analyzing various sources of information about AIDS/HIV.

TWELFTH GRADE

Demonstrate an understanding of the value and limitations of HIV antibody testing as a public health measure.

Develop a personal directory of locally available resources for information and health services to help prevent AIDS and to support AIDS patients and their families.

SPECIFIC FEATURES

Parents may choose to sign their children out of the AIDS education program *only* after the parents have previewed the AIDS program. The AIDS Omnibus Bill provides that a "parent preview meeting" be held at least one month prior to classroom presentations.

The *KNOW: AIDS Prevention Curriculum* emphasizes abstinence and also discusses "safer sex." The curriculum includes such details as, "Condoms made of 'natural skin' are not as effective as a rubber (latex) condom in protecting against STDs."

Glossaries for students include such definitions as, "Sexual intercourse– sexual union of two people involving the insertion of the penis in the vagina, the penis in the anus (anal intercourse), or the genitals in the mouth (oral intercourse)."

The curriculum includes a lesson about bubonic plague in San Francisco in 1900, where Chinese were blamed for the disease. The board of health did not implement a citywide rat eradication program until the plague spread to a different part of the city and most of the sick were Caucasian. The curriculum urges students to discuss parallels between this situation and the AIDS epidemic.

At the senior high level, a chart indicates where AIDS lessons can be integrated into other subject areas, including English, health, home and family life, science, social studies, math, and psychology.

FOR FURTHER INFORMATION

Pamela M. Ba'dwin
AIDS Education Coordinator
State Department of Public Instruction
Old Capitol Building, Mail Stop FG-11
Olympia, WA 98504
206/ 753-2744

METHODOLOGY

The Equality Center, a nonprofit research and policy organization, conducted this study for the Council of Chief State School Officers in the spring of 1989. With direction from Cynthia G. Brown (Director of the CCSSO Resource Center on Educational Equity) and Jane Kratovil (Director of the HIV/AIDS Prevention Education Project), the study was conducted and the report written by Margaret Nash and Margaret Dunkle.

This study had four major stages: choosing the states, developing the interview schedule, conducting the telephone interviews and gathering additional materials and data, and analyzing the data and drafting the report.

CHOOSING THE STATES

The first stage consisted of preliminary research leading to the selection of the four states for inclusion in the study. Staff of the Council and the Equality Center cooperatively developed criteria for selection of states and chose the states for inclusion. The major criteria were:

- at least one state that integrated HIV/AIDS instruction into comprehensive health instruction;
- some states with mandates and some with recommendations for HIV/AIDS instruction;
- at least one state with a high rate of HIV infection; and
- geographic distribution.

DEVELOPING THE INTERVIEW SCHEDULE

After choosing the four states, the Equality Center drafted an interview format to structure telephone interviews with two to four key players in each state. Questions fit into five broad categories. The first section contained background questions, such as where health instruction staff were located within the state

education department, and how HIV/AIDS instruction is funded in the state.

The second section focused on the development of the policy for HIV/AIDS instruction. Questions included: Where did the idea come from? Who initiated it? What were the key steps in developing the policy? What was public reaction when the HIV/AIDS policy began to be discussed?

The third section focused on curricular content. Questions were geared toward understanding the relationship between HIV/AIDS instruction and the current health curriculum, and similarities and differences in requirements for HIV/AIDS instruction and other content areas. We also asked how the state HIV/AIDS curriculum addresses the special needs of minority and low-income children and youth, and youth whose sexual preference is identified as gay and lesbian youth.

The fourth section concentrated on curricular development. We asked when HIV/AIDS began to be taught and in what grades, and who designed the curriculum.

In the fifth section, we asked about implementation and evaluation. Questions covered mechanisms to ensure that the local school districts are teaching the HIV/AIDS curriculum, as well as training and technical assistance from the state to the local level. Because HIV/AIDS instruction is at a relatively early stage, the information received in response to these questions was quite sparse. Additional research is needed to describe and assess successful processes for implementation and evaluation.

Finally, we asked interviewees what advice they would offer to people in other states who were just starting to work on HIV/AIDS instruction, and what three wishes they might make regarding HIV/AIDS instruction or comprehensive health instruction in their own state. The responses to this question were used to identify the major categories (e.g.,

building a broad base of support, providing strong leadership, etc.) of this report.

At this stage the Equality Center also developed several additional data collection forms, including "Criteria Analysis and Background," which summarized the status of HIV/AIDS instruction and of comprehensive health (mandated or recommended), the incidence of AIDS in the state, the size of the school system, and the racial and ethnic composition of the state. A second form outlined features of each state's HIV/AIDS curriculum, including the year was first used, grade levels covered, and topics included. A "Document" chart listed various relevant documents, and provided a place to record if the document exists for a particular state, from whom it was requested, and who could answer questions about it. Documents on this chart include the HIV/AIDS curriculum, the comprehensive health curriculum, organizational flow charts, task force reports, legislation, and policies on HIV/AIDS. Finally, the Equality Center developed a "State Players" chart, to record names, address, and telephone numbers of possible people to interview, and by whom they were referred.

Interviews and Data Collection

Staff of the Equality Center interviewed two to four people in each state, starting with the AIDS coordinator in the department of education. In some states the Equality Center interviewed people in the legislature, as well as in the state department of education and department of health. While most of the interviews were of state level policymakers and staff, some people on the local level who actually teach HIV/AIDS instruction were interviewed, as well.

Each interview took approximately 45 minutes. The quotations in the margins of the report are from these interviews.

The Equality Center gathered and reviewed the states' curricula for HIV/AIDS instruction, and, where it existed, the curricula for instruction in comprehensive health. In

addition, the Center collected state policies, legislation, and by-laws regarding HIV/AIDS instruction. The Center also received organizational flow charts for the state departments of education, newspaper clippings and speeches on the debate surrounding HIV/AIDS instruction in the state, testimony before legislative bodies, and task force reports recommending actions for policymakers.

Analyzing the Data and Writing the Report

Working closely with CCSSO staff, the Equality Center analyzed the data and wrote this report.

In addition to review by staff of the Council of Chief State School Officers, the draft report was read by David Poehler and Jack T. Jones of the Centers for Disease Control, who offered helpful suggestions for improvement.

Finally, special thanks go to the following state education agency staff who reviewed the draft to ensure that there were no factual errors—Sue B. Adams (Alabama), Janet Fabst (Maryland), JoAnne Owens-Nauslar (Nebraska), and Pamela M. Baldwin (Washington).

In this report, the term "HIV/AIDS" is used (rather than the term "AIDS") to stress that preventing HIV infection is the key to taking control of the epidemic.

Council of Chief State School Officers
Resource Center on Educational Equity
379 Hall of the States
400 North Capitol Street, N.W.
Washington, DC 20001-1511
(202) 393-8159