

# HOW

PREVENTION:

Multiple Challenges,

Multiple Strategies



#### COUNCIL OF CHIEF STATE SCHOOL OFFICERS

The Council of Chief State School Officers (CCSSO) is a nationwide, nonprofit organization comprised of the public officials who head the departments of elementary and secondary education in the states, the District of Columbia, five U.S. extra-state jurisdictions, and the Department of Defense Education Activity.

CCSSO provides leadership, advocacy, and technical assistance services to its members to fulfill the organization's vision that all school systems will ensure high standards of performance for every student and that each child is prepared to succeed as a productive member of a democratic society.

The Council, established in 1927, represents the chief state school officers' view on federal education policy. The organization undertakes projects to help state education agencies understand, devise, and execute policy, adopt initiatives to promote educational reform efforts, and engage in collaborative exchanges to share best practices and model solutions. These endeavors result in the development of many resources, which are widely disseminated to CCSSO's state constituencies, other partner organizations, the education community, related federal agencies, and the U.S. Congress. The Council's work is supported by membership dues, the foundation community, and governmental agencies.

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The School Health Project assists state education agencies in promoting and supporting a coordinated approach to school health. Current activities include producing and disseminating materials that chief state school officers, state health officials, their staff, and other interested colleagues can use to engage the public concerning the importance of taking a coordinated approach to school health. The project assists state education agencies to strengthen their capacity to support school-linked approaches to preventing teen pregnancy and to assure that effective HIV prevention programs are targeted to young people who are disproportionately at risk for contracting HIV. The project also produces the Directory of Coordinated School Health Program Staff. The Council also operates the Comprehensive Health Education Network, a listserv that connects state education agency staff and colleagues around the country who work on school health initiatives.

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# HIV

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# HIV Prevention: MULTIPLE CHALLENGES, MULTIPLE STRATEGIES

Since 1987 the Council of Chief State School Officers (CCSSO) has worked to strengthen the capacity of state education agencies to assist local education agencies and schools to implement effective HIV education within the framework of a coordinated school health program. Starting with the publication in 1990 of *How Four States Put HIV/AIDS into the Classroom* and followed by *Beyond the Health Room* (1990) and *Lessons From the Classroom* (1992), CCSSO has worked to provide specific guidance to state education agencies on issues of HIV education and school health. This publication continues the effort by examining the current face of the HIV epidemic and how state education agencies can help assure that local education agencies, schools, and their partners in the community can offer effective programming and protect the health of young people.

Since the onset of the HIV/AIDS epidemic, there has been a significant demographic change in the populations affected by the disease. What was once thought to be a disease that primarily affected White gay men is now known to be one that shows no discrimination with regard to sexual orientation, race, ethnicity, gender, or age.

Current trends in HIV and AIDS incidence indicate that the disease is disproportionately affecting African Americans, Latinos, and women. For example, although African Americans represent approximately 12% of the U.S. population, in 2000 over 38% of all reported AIDS cases occurred among African Americans (CDC, 2001a). Similarly, Hispanics represent 13% of the American population, however, they represented 19% of the total number of new AIDS cases reported in 2000 (CDC, 2001b). AIDS is now the third leading cause of death in African American women aged 25-44 and the leading cause of death among African American men aged 25-44 (CDC, 2001d).

Young people are being infected with HIV at a staggering rate. One-fourth of all new HIV infections occur in people under the age of 22 (Rosenberg et al., 1994) and one-half in people under the age of 25 (CDC, 2001d). AIDS is the fifth leading cause of death in people between the ages of 25 and 44. Based on current trends, an average of two young people are infected with HIV every day. Research has also shown that both HIV prevalence and risk behaviors continue to remain high among young gay and bisexual

men. Researchers from CDC found that results from a sample of young gay and bisexual men, ages 15-22, in seven urban counties, indicated that overall, 7% were already infected with HIV (CDC, 2001c). These statistics are alarming, indicating the need for a proactive effort to target those most at risk with effective prevention programs (American Association for World Health, 1997).

## A Call to Action

The Surgeon General of the United States has responded to this obvious need for frank discussion on the sexual health of children in the country by releasing *The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior* (Office of the Surgeon General, 2001). Intended to represent an effort to find “common ground” upon which the nation could work to promote sexual health and responsible sexual behavior, the document serves as a catalyst for a nationwide dialogue about sexuality. *Call to Action* was developed through a collaborative process and was based on a scientific review of papers by experts in the field. Recommendations were developed at two national conferences, followed by an extensive review and comment period as the document was prepared.

*Call to Action* acknowledges the need to promote responsible sexual behavior given such negative consequences as sexually transmitted disease (STD) and HIV/AIDS infection, unintended pregnancy, abortion, and sexual violence. Healthy sexual development and responsible sexual behavior begin at an early age and continue throughout the lifespan. *Call to Action* emphasizes the role that parents can play in this process by providing stable environments, positive parenting that promotes healthy social and emotional development, and protection from abuse. In addition, it highlights the link between the role of parents and the role of schools in providing young people with sexuality education that includes values and medically accurate information.





#### A ROLE FOR EDUCATION

*Call to Action* emphasizes the fact that traditionally schools have had a role in ensuring equity of access to information that is perhaps greater than almost all other institutions. This in turn makes schools important players in helping to reduce adolescent sexual risk-taking behaviors. Because many teenagers are in school, including those participating in risky sexual behavior, they can be reached through tailored prevention programs and programs designed to increase their connections to and involvement with schools. Evidence has shown that among youth who are in school, greater involvement with school is related to less sexual risk taking, including later age of initiation of sex and lower frequency of sex, pregnancy, and childbearing (Resnick et al., 1997).

*Call to Action* stresses three fundamental science-based strategies that can help provide a foundation for promoting sexual health and responsible behavior: (1) increasing public awareness of issues relating to sexual health and responsible sexual behavior, (2) providing the health and social interventions necessary to promote and enhance sexual health and responsible behavior, and (3) investing in research related to sexual health and disseminating findings widely. There is a place for the education community in each of these strategies:

# 1

In order to **increase awareness**, the education community can:

- ◆ RECOGNIZE THAT SEXUALITY EDUCATION IS BEING PROVIDED IN A NUMBER OF VENUES—HOMES, SCHOOLS, CHURCHES, OTHER COMMUNITY SETTINGS—BUT MUST ALWAYS BE DEVELOPMENTALLY AND CULTURALLY APPROPRIATE.
- ◆ RECOGNIZE THAT PARENTS ARE THE CHILD’S FIRST EDUCATORS AND MUST HELP GUIDE OTHER SEXUALITY EDUCATION EFFORTS SO THAT THEY ARE CONSISTENT WITH THEIR VALUES AND BELIEFS.
- ◆ RECOGNIZE THAT IN MOVING TOWARD EQUITY OF ACCESS TO INFORMATION FOR PROMOTING SEXUAL HEALTH AND RESPONSIBLE BEHAVIOR, SCHOOL-BASED SEXUALITY EDUCATION IS A VITAL COMPONENT OF COMMUNITY RESPONSIBILITY.

# 2

In order to **implement and strengthen interventions**, the education community can work to:

- ◆ ELIMINATE DISPARITIES IN SEXUAL HEALTH STATUS THAT ARISE FROM SOCIAL AND ECONOMIC DISADVANTAGE, DIMINISHED ACCESS TO INFORMATION AND HEALTH CARE SERVICE, AND STEREOTYPING AND DISCRIMINATION.
- ◆ TARGET INTERVENTIONS TO THE MOST SOCIOECONOMICALLY VULNERABLE COMMUNITIES WHERE COMMUNITY MEMBERS HAVE LESS ACCESS TO HEALTH EDUCATION AND SERVICES AND ARE, THUS, LIKELY TO SUFFER MOST FROM SEXUAL HEALTH PROBLEMS.

# 3

In order to **expand the research base**, the education community can support:

- ◆ RESEARCH, DEVELOPMENT, DISSEMINATION, AND EVALUATION OF EDUCATIONAL MATERIALS AND GUIDELINES FOR SEXUALITY EDUCATION, COVERING THE FULL CONTINUUM OF HUMAN SEXUAL DEVELOPMENT FOR USE BY PARENTS, CLERGY, TEACHERS, AND OTHER COMMUNITY LEADERS (CALL TO ACTION, 2001).

Many state education agencies have provided leadership in assuring that young people receive developmentally and culturally appropriate HIV prevention information. With this publication, CCSSO hopes to assist state education leaders to continue these efforts and to ensure that school-based HIV prevention programs reach the young people most at risk.



# Risk Behaviors



There is wide-scale agreement that abstinence from sexual activity is the most appropriate behavioral choice for young people still in school. However, the failure to confront the reality of today's teenagers is unfortunate for all. Through an examination of the most current data on HIV infection from the Centers for Disease Control and Prevention, CCSSO has identified three groups of young people who may be disproportionately at risk for HIV.

## AFRICAN AMERICAN YOUTH

According to statistics recently released by the Centers for Disease Control and Prevention (CDC), AIDS is the leading cause of death for African American men between the ages of 25 and 44 (CDC, 2001d). Because of the long incubation period (up to 10 years or more), it is clear that many of these young adults were infected as teenagers. CDC estimates that "half of all new HIV infections in the U.S. are among people under 25, and the majority of young people are infected sexually" (CDC, 2001d).

Results from the 1999 Youth Risk Behavior Survey (YRBS) (CDC, 1999) provide a portrait of the behavior of African American youth. When students in grades 9-12 were asked if they had ever had sexual intercourse, 71.2% of African American youth indicated that they had.

African American students in grades 9-12 were also more likely to report that they had engaged in sexual intercourse for the first time before the age of 13 (20.5%) than White students (5.5%). African American students were also more likely to have engaged in sex with four or more people (34.4%) than White students (12.4%). African American students were more likely to have been pregnant or had gotten someone pregnant one or more times (13.4%) than White students (4.3%).

## LATINO YOUTH

The more than 27 million Latinos in the United States represent a blend of cultures and ethnic groups. Approximately two-thirds are of Mexican descent, while the remaining one-third came from Cuba, Puerto Rico, the Dominican Republic,

## Percentage Reporting

# Ever Having Sex

(GRADES 9-12)

(CDC YOUTH RISK BEHAVIOR SURVEY 1999)



Central America, South America, or Europe. Although representing an estimated 13% of the U.S. population, Latinos account for approximately 20% of the AIDS cases reported through December 1998 (CDC, 2001b). It is expected that by the beginning of the next century, Latinos will represent the largest minority group living in the United States. It is also expected, unless the trend is reversed, that by the year 2005 the number of newly reported AIDS cases among Latinos will surpass that of Whites (Maldonado, 1998).

Results from the 1999 Youth Risk Behavior Survey (CDC, 1999) indicate that Latino students (54.1%) were significantly more likely to have engaged in sexual intercourse than White (45.1%) students — a percentage second only to that of African American youth. Latino students were also more likely to report that they had engaged in sexual intercourse for the first time before the age of 13 (9.2%) than White students (5.5%).

### GAY, LESBIAN, AND BISEXUAL YOUTH

The majority of school-based HIV prevention efforts have focused on heterosexual behaviors. However, research tells us that for some young people, adolescent sexual behavior includes both opposite sex and same sex activity. While some of these young people may identify as gay or lesbian, others may identify as bisexual, and some may take on no identification but may experience same sex attractions and behaviors. These gay, lesbian, and bisexual (GLB) youth must deal with problems that are unique to them in addition to the problems common to all teenagers. GLB teenagers may be extremely reluctant to disclose their sexual orientation or behavior for fear of being harassed, ridiculed, and/or physically attacked. And while gay and lesbian teenagers

have the same feelings of infatuation and love as heterosexual teenagers, these feelings can be mixed with fear.

Research supports the understanding that adolescent sexual behavior is not necessarily tied to sexual identity. In 1995, Massachusetts<sup>1</sup> administered an expanded YRBS that included questions about sexual orientation to more than 4,000 children in the ninth through 12th grades. Of all the children who reported **any history of same-sex sexual contact**, only 39.2% identified as gay, lesbian, or bisexual; 43.5% identified as heterosexual; 8.6% said “not sure”; and another 8.6% said “none of the above.”<sup>2</sup> In total, 2.5% of the 4,000 students surveyed self-identified as gay, lesbian, or bisexual.

<sup>1</sup> MASSACHUSETTS WAS THE ONLY STATE TO COLLECT DATA ON SEXUAL ORIENTATION FOR THE YOUTH RISK BEHAVIOR SURVEY IN 1995

<sup>2</sup> AS REPORTED BY THE MASSACHUSETTS DEPARTMENT OF EDUCATION AIDS/HIV PROGRAM

Garofalo (1998) analyzed data from the expanded 1995 Massachusetts YRBS, focusing on students who self-identified as GLB. According to this study, GLB teens were more likely to engage in risky sexual and drug-related behaviors than other adolescents. The study also reports that GLB youth are more likely to have used drugs and alcohol and to have had their first sexual experience before the age of 13. The study reports several other serious trends:

- ◆ GAY, LESBIAN, AND BISEXUAL YOUTH WERE NEARLY FIVE TIMES MORE LIKELY AS OTHER STUDENTS TO SKIP SCHOOL BECAUSE THEY FEARED FOR THEIR SAFETY.
- ◆ ONE-THIRD OF ALL SELF-IDENTIFIED GAY, LESBIAN, AND BISEXUAL YOUTH REPORTED HAVING ATTEMPTED SUICIDE DURING THE PAST 12 MONTHS. THIS IS MORE THAN THREE TIMES THE PERCENTAGE (9.9%) REPORTED BY SELF-IDENTIFIED HETEROSEXUAL TEENAGERS.
- ◆ ONE-THIRD OF ALL GAY, LESBIAN, AND BISEXUAL TEENS REPORTED HAVING SEX AGAINST THEIR WILL, COMPARED WITH 9% OF STRAIGHT TEENS.
- ◆ GAY, LESBIAN, AND BISEXUAL YOUTH WERE MORE LIKELY TO REPORT THREE OR MORE SEX PARTNERS IN THE PREVIOUS THREE MONTHS WHEN COMPARED TO THEIR HETEROSEXUAL PEERS (37.9% VERSUS 7.5%).

A recent study, analyzing data collected from students who participated in the 1987 Minnesota Adolescent Health Survey, suggests that adolescent females who identify as lesbian, bisexual, or unsure of their sexual orientation may be at increased risk of pregnancy and poor contraceptive practice (Saewyc, 1999). The purpose of the study was to compare the sexual and pregnancy histories of adolescents who self-identified as lesbian or bisexual, unsure of their sexual orientation, or heterosexual. The researchers hypothesized that when compared to unsure and heterosexual respondents, lesbian and bisexual adolescents would report an equal or higher likelihood of heterosexual intercourse, a higher prevalence of sexual and physical abuse and running away, and an equal or higher prevalence of pregnancy. It was also expected that among those students who had ever had sexual intercourse, bisexual and lesbian adolescents would report less contraceptive use, less use of effective contraceptive methods, and an equal or higher prevalence of frequent intercourse. The results supported these hypotheses, leading researchers to conclude that providers of reproductive health care and family planning services should not assume that pregnant teenagers are heterosexual or that adolescents who say they are bisexual, lesbian, or unsure of their sexual orientation are not in need of family planning counseling or information on protecting themselves from HIV infection.



# Elements of Promising Programs

As state education agencies and their partners respond to the challenges of supporting schools in delivering effective HIV prevention programs, they should base their efforts on those programs found by evaluation to be effective or to show signs of promise. An extensive review of the prevention literature, including the findings from the Research to the Classroom Project, suggests that the following elements make an HIV/AIDS prevention program more likely to succeed in targeting at-risk populations:

- ◆ THE PROGRAM SHOULD HAVE A **CLEARLY DEFINED TARGET POPULATION** (I.E., RACE/ETHNICITY, SEXUAL ORIENTATION, CULTURE, GENDER, ETC.). PROGRAMS THAT ARE “GENERIC,” “HOMOGENIZED,” OR AIMED AT THE “GENERAL POPULATION” DO NOT WORK (INSTITUTE FOR HEALTH POLICY STUDIES, CA DEPT. OF HEALTH SERVICES, 1991).
- ◆ THE PROGRAM SHOULD BE **CULTURALLY RELEVANT** FOR THE INTENDED RECIPIENTS. A REVIEW OF THE AVAILABLE RESEARCH DEMONSTRATES THAT ONE OF THE MOST CRITICAL FACTORS IS THE CULTURAL APPROPRIATENESS OF THE INTERVENTION. EVIDENCE HAS SHOWN THAT CULTURALLY APPROPRIATE INTERVENTIONS ENHANCE LEARNING AND DECREASE BEHAVIORAL INTENTION TO ENGAGE IN SEXUAL RISK-TAKING BEHAVIORS.
- ◆ THE PROGRAM SHOULD HAVE A **FOUNDATION IN A RESEARCH-BASED BEHAVIOR CHANGE MODEL**. EVERY HIV PREVENTION PROGRAM IS CONCERNED WITH HOW AND WHY PEOPLE CHANGE THEIR BEHAVIORS. THE UNDERLYING PRINCIPLES OR THEORIES FOCUS HIV PREVENTION EFFORTS ON THE ELEMENTS BELIEVED TO BE ESSENTIAL FOR INDIVIDUALS TO ENACT AND SUSTAIN BEHAVIOR CHANGE. FOUR OF THE MAJOR BEHAVIOR CHANGE THEORIES ARE THE HEALTH BELIEF MODEL, THE AIDS RISK REDUCTION MODEL, THE STAGES OF CHANGE, AND THE THEORY OF REASONED ACTION. THESE FOUR MODELS PROVIDE EXAMPLES OF HOW THE BEHAVIOR PROCESS IS BELIEVED TO OCCUR. THEY TEND TO FOCUS ON ATTITUDES, BELIEFS, AND INTENTIONS OF THE INDIVIDUAL. A FULL EXPLANATION OF THESE MODELS IS BEYOND THE SCOPE OF THIS PAPER, BUT A SUCCESSFUL BEHAVIORAL INTERVENTION SHOULD BE GUIDED BY ONE OF THESE THEORIES.<sup>3</sup>

<sup>3</sup>FOR A MORE IN-DEPTH EXPLANATION OF THESE THEORIES SEE “BEHAVIOR CHANGE: A SUMMARY OF FOUR MAJOR THEORIES” AT [HTTP://WWW.FHI.ORG/EN/AIDS/AIDSCAP/AIDSPUBS/BEHRES/BCR4THEO.HTML](http://www.fhi.org/en/aids/aidschap/aidspubs/behres/bcr4theo.html)

◆ **ABSTINENCE AS THE MOST APPROPRIATE CHOICE** SHOULD BE THE PRIMARY MESSAGE, HOWEVER, SUCCESSFUL PROGRAMS MUST ALSO **RECOGNIZE A FOCUS ON LOWERING RISK BEHAVIOR**. AN ABSTINENCE-ONLY INTERVENTION MAY BE APPROPRIATE FOR YOUNGER ADOLESCENTS AND THOSE WHO HAVE NOT ENGAGED IN SEXUAL INTERCOURSE. HOWEVER, RESEARCH HAS NOT SHOWN THIS APPROACH TO BE SUCCESSFUL FOR OLDER TEENAGERS AND/OR THOSE WHO HAVE ENGAGED IN SEXUAL INTERCOURSE. **As ABSTINENCE-ONLY PROGRAMS ARE EVALUATED, THOSE FOUND TO BE EFFECTIVE SHOULD BE CONSIDERED FOR THE TARGETED GROUPS.**

◆ THE INTERVENTION SHOULD PROVIDE **SPECIFIC SKILLS TRAINING** BY MODELING AND PROVIDING OPPORTUNITIES TO PRACTICE REFUSAL, NEGOTIATION, AND OTHER COMMUNICATION SKILLS. IN EFFECTIVE INTERVENTIONS YOUTH ARE GIVEN THE OPPORTUNITY TO USE AND PRACTICE THESE SKILLS. ACTIVE REHEARSAL OF LEARNED SKILLS HELPS TO STRENGTHEN RESISTANCE TO RISK-TAKING BEHAVIORS. THIS ENABLES ADOLESCENTS TO BECOME MORE ASSERTIVE, BETTER ABLE TO EXTRICATE THEMSELVES FROM SEXUALLY COERCIVE SITUATIONS, AND MORE LIKELY TO INITIATE DISCUSSION WITH A PARTNER CONCERNING THE IMPORTANCE OF ABSTINENCE AND SAFER SEX. IN ADDITION TO SPECIFIC REFUSAL, NEGOTIATION, AND COMMUNICATION SKILLS, EFFECTIVE PROGRAMS INVOLVE PARTICIPANTS IN **ACTIVE RATHER THAN PASSIVE LEARNING**. AS IN OTHER CURRICULA AREAS, STUDENTS MAY LEARN MORE EFFECTIVELY IF THEY ARE ENGAGED IN DISCUSSION, COOPERATIVE LEARNING, AND OTHER OPPORTUNITIES TO DISCUSS AND PRACTICE THE COMMUNICATION AND OTHER SKILLS THAT THE PROGRAM ADDRESSES.

◆ THE INTERVENTION SHOULD **ENLIST THE AID OF THE COMMUNITY AND COMMUNITY LEADERS** IN DECIDING WHAT SHOULD BE EMPHASIZED. COMMUNITY INPUT CAN HELP DETERMINE WHAT CULTURAL AND SOCIAL CONTEXT IS IMPORTANT, AND WHETHER THE PROGRAM “RINGS TRUE” TO PEOPLE’S PERSONAL EXPERIENCES. INTERVENTIONS CAN BE IMPLEMENTED IN COMMUNITY CENTERS, PLACES OF WORSHIP, OR WHEREVER YOUNG PEOPLE GATHER.

Different community and school policies exist regarding the specific elements of HIV prevention and sexuality education. Within that context, effective prevention interventions should contain one or more of the following key objectives:

- ◆ INCREASE KNOWLEDGE ABOUT THE NATURE AND CONSEQUENCES OF HIV/AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES.
- ◆ INCREASE BELIEF IN THE VALUE OF ABSTINENCE AND SAFER SEX.
- ◆ PROVIDE PARTICIPANTS WITH CONFIDENCE IN THEIR ABILITY TO NEGOTIATE ABSTINENCE AND SAFER SEX AND TO USE CONDOMS CORRECTLY.
- ◆ AIM FOR A MEASURABLE DECREASE IN RISK BEHAVIORS OR BEHAVIORAL INTENT IF MEASURING THE BEHAVIOR IS NOT POSSIBLE. OUTCOME GOALS SHOULD INCLUDE AT LEAST ONE OF THE FOLLOWING:
  - ◆ A DELAY OF THE INITIATION OF SEXUAL INTERCOURSE
  - ◆ A REDUCTION IN THE NUMBER OF SEXUAL PARTNERS
  - ◆ A REDUCTION IN THE FREQUENCY OF SEXUAL INTERCOURSE
  - ◆ AN INCREASE IN CONDOM USE
  - ◆ A DECREASE IN PREGNANCY RATE
  - ◆ A DECREASE IN NEWLY REPORTED CASES OF AN STD

# Recommendations for States

State education agencies can play a crucial role in providing leadership for schools, especially in the area of school health. The following recommendations are intended to inform state efforts for enhancing HIV education in schools. They are drawn from review of the related literature and longstanding CCSSO policy and recommendations (CCSSO: Lessons from the Classroom, 1992).

## DEMONSTRATE AND ENCOURAGE LEADERSHIP

State education agencies often provide the leverage districts and schools need to initiate quality HIV prevention programs that target those disproportionately at risk. State education agencies can:

- ◆ ADOPT AND PUBLICIZE AN OFFICIAL WRITTEN POLICY RECOMMENDING OR REQUIRING THAT HIV PREVENTION PROGRAMS OCCUR WITHIN A COORDINATED SCHOOL HEALTH PROGRAM.
- ◆ HIGHLIGHT PROMISING HIV PREVENTION PROGRAMS SHOWN TO BE EFFECTIVE WHEN TARGETING THOSE WHO ARE DISPROPORTIONATELY AT RISK FOR HIV INFECTION AND ENCOURAGE LOCAL EDUCATION AGENCIES TO IMPLEMENT SUCH PROGRAMS.
- ◆ PROVIDE THE FUNDING, OR MECHANISM FOR FUNDING, MATERIALS, TIME, AND TECHNICAL ASSISTANCE NEEDED BY LOCAL EDUCATION AGENCIES TO IMPLEMENT AND EVALUATE HIV PREVENTION PROGRAMS.

- ◆ HELP LOCAL EDUCATION AGENCIES SECURE RESOURCES FOR THE IMPLEMENTATION OF INNOVATIVE RESEARCH-BASED PROGRAMS THAT TARGET GROUPS DISPROPORTIONATELY AT RISK.
- ◆ ADVOCATE HIV PREVENTION AND COORDINATED SCHOOL HEALTH PROGRAMS IN STATE EDUCATION AGENCY SPEECHES AND PUBLICATIONS.



## CURRICULAR SUPPORT

High-quality instruction and curricula are essential for the success of any education program. To enhance targeted HIV education programs, state education agencies can:

- ◆ DEVELOP CURRICULUM GUIDELINES OR A MODEL CURRICULUM FOR HIV EDUCATION BASED ON CRITERIA FOUND TO BE EFFECTIVE WHEN TARGETING YOUTH DISPROPORTIONATELY AT RISK, IN A FORM THAT ALLOWS LOCAL EDUCATION AGENCIES TO ADAPT THE MODEL TO MEET THE DIVERSE NEEDS OF THE CHILDREN THEY SERVE. SUCH CURRICULUM OR CURRICULUM GUIDELINES SHOULD FIT WITHIN THE CONTEXT OF COORDINATED SCHOOL HEALTH PROGRAMS AND SHOULD INCLUDE:
  - ◆ RECOMMENDED SCOPE AND SEQUENCE THAT CONSIDER THE AGE AND DEVELOPMENTAL READINESS OF STUDENTS AND THAT PROVIDE STUDENTS WITH HIV EDUCATION PROGRAMS BEFORE THEY ENGAGE IN RISK-RELATED BEHAVIORS.
  - ◆ ACCURATE, RELEVANT INFORMATION ABOUT HIV INFECTION AND OTHER CATEGORICAL HEALTH PROBLEMS, INCLUDING STDs AND SUBSTANCE ABUSE, AND REINFORCEMENT OF THOSE MESSAGES IN OTHER SUBJECT AREAS.
- ◆ ACTIVITIES THAT TEACH AND ALLOW STUDENTS TO PRACTICE USING HEALTH-ENHANCING DECISIONS.
- ◆ SUGGESTIONS FOR INTEGRATING HIV PREVENTION AND OTHER HEALTH TOPICS INTO THE REGULAR CURRICULUM.
- ◆ TAILOR TECHNICAL ASSISTANCE TO LOCAL CIRCUMSTANCE AND NEEDS. THAT ASSISTANCE MIGHT INCLUDE:
  - ◆ ADVICE ABOUT ADAPTING AND TAILORING CURRICULA TO THE TARGET POPULATION.
  - ◆ REVIEW OF PROGRAM PLANS TO ENSURE THAT THE DIVERSITY OF THE LOCAL STUDENT POPULATION IS CONSIDERED AND RESPECTED.
  - ◆ CRITIQUE OF LOCALLY DEVELOPED CURRICULA UPON REQUEST.
- ◆ ENCOURAGE LOCAL EDUCATION AGENCIES TO INVOLVE STUDENTS, PARENTS, BUSINESS AND INDUSTRY, CHILD-SERVING AGENCIES, AND COMMUNITY LEADERS IN THE PROGRAM PLANNING PROCESS, THEREBY BUILDING A BROAD BASE OF SUPPORT FOR THE CURRICULUM AND ESTABLISHING LINKAGES THAT CAN LEAD TO MORE EFFECTIVE PROGRAM DELIVERY.



- ◆ IDENTIFY EXEMPLARY HIV EDUCATION PROGRAMS AND DISSEMINATE INFORMATION ABOUT THE PROGRAMS.
- ◆ PROVIDE SCHOOLS WITH SUMMARIES OF RESEARCH CONCERNING SUCCESSFUL IMPLEMENTATION OF INNOVATIVE INSTRUCTIONAL METHODS.
- ◆ PROVIDE INCENTIVES AND OPPORTUNITIES FOR STATE AND LOCAL EDUCATORS TO OBSERVE EXEMPLARY PROGRAMS AND MAKE INFORMED DECISIONS ABOUT HOW NEW PRACTICES MIGHT FIT INTO THEIR SCHOOLS.

- ◆ HELP LOCAL DISTRICTS USE A VARIETY OF APPROACHES FOR STAFF DEVELOPMENT (E.G., STIPENDS FOR TRAINING CONDUCTED AFTER SCHOOL HOURS OR FUNDS TO OPERATE DISTRICTWIDE TRAINING CENTERS).
- ◆ PROVIDE ON-SITE TRAINING FOR TEACHERS.
- ◆ ENCOURAGE LOCAL DISTRICTS TO COLLABORATE WITH AREA HEALTH DEPARTMENTS ON TRAINING FOR TEACHERS INVOLVED IN HIV EDUCATION.

## STAFF DEVELOPMENT

Staff development should encourage integral, ongoing programs and provide coaching when teachers return to their classrooms. To help ensure high-quality staff development programs, state education agencies can:

- ◆ PROVIDE TECHNICAL AND FINANCIAL SUPPORT FOR LOCAL EDUCATION AGENCY STAFF DEVELOPMENT PROGRAMS DESIGNED TO PROMOTE STUDENTS' INTELLECTUAL, PHYSICAL, SOCIAL, AND EMOTIONAL DEVELOPMENT. SUCH PROGRAMS SHOULD BE FOR ALL TEACHERS, INCLUDING THOSE WHO TEACH HEALTH, AND SHOULD INCLUDE:
  - ◆ INFORMATION ABOUT HIV INFECTION, AIDS, AND OTHER IMPORTANT HEALTH ISSUES AND PROBLEMS.
  - ◆ STRATEGIES FOR RESPONDING TO THE NEEDS OF DISADVANTAGED STUDENTS.
  - ◆ EXPLORATIONS OF TEACHERS' ATTITUDES AND EXPECTATIONS, ESPECIALLY REGARDING STUDENTS' ETHNICITY, GENDER, ECONOMIC STATUS, AND SEXUAL ORIENTATION.
  - ◆ METHODS OF TEACHING HIV PREVENTION, ESPECIALLY TO DIVERSE POPULATIONS.

## ACCOUNTABILITY FOR LEARNING OUTCOMES

As more communities initiate or improve their HIV education, the demand for solid evaluations of the effectiveness of these programs will increase. To assist school districts in evaluating their programs, state education agencies can:

- ◆ IDENTIFY AND DEVELOP TOOLS FOR MEASURING THE EXTENT TO WHICH TARGETED HIV PREVENTION PROGRAMS DECREASE SEXUAL RISK-TAKING BEHAVIORS DURING THE PROGRAM AND A SPECIFIED FOLLOW-UP PERIOD. THESE TOOLS SHOULD MEASURE THE FOLLOWING:
  - ◆ WHETHER YOUTH BEGIN, END, OR CONTINUE SEXUAL ACTIVITY.
  - ◆ WHETHER THERE IS ANY INCREASE OR DECREASE IN THE NUMBER OF SEXUAL PARTNERS.
  - ◆ WHETHER THERE IS ANY CHANGE IN THE FREQUENCY OF INTERCOURSE.
  - ◆ WHETHER THERE IS ANY INCREASE OR DECREASE IN CONDOM USE.
  - ◆ WHETHER THERE IS ANY INCREASE OR DECREASE IN PREGNANCY RATE.
  - ◆ WHETHER THERE IS ANY INCREASE OR DECREASE IN NEWLY REPORTED CASES OF AN STD.

- ◆ PROVIDE TECHNICAL ASSISTANCE TO LOCAL EDUCATORS IN THE USE OF EVALUATION FOR PROGRAM IMPROVEMENT.
- ◆ ADVISE LOCAL EDUCATION AGENCIES ABOUT WAYS OF WORKING WITH THEIR COMMUNITIES TO ADDRESS CONCERNS ABOUT THE COLLECTION OF EVALUATION OR SURVEILLANCE DATA.
- ◆ INCLUDE QUESTIONS ABOUT HIV INFECTION AND TRANSMISSION IN STATEWIDE TESTING PROGRAMS. SUCH QUESTIONS NOT ONLY MEASURE KNOWLEDGE ABOUT HIV INFECTION AND TRANSMISSION BUT ALSO SEND A MESSAGE TO STUDENTS, SCHOOLS, EDUCATORS, AND THE COMMUNITY THAT HIV IS AN IMPORTANT SUBJECT.

## FAMILIES AND COMMUNITIES

The importance of family involvement should not be overlooked. Families model and reinforce positive or negative health behaviors for children. Communities can be thought of as natural extensions of the family and therefore can also play a crucial role in HIV education and prevention. Community involvement can guide program implementation by highlighting prevention messages that have an appropriate cultural and social context. To help districts and schools effectively involve families and communities in HIV prevention programs, state education agencies can:

- ◆ IDENTIFY SCHOOLS AND PROGRAMS IN THE STATE WITH HIGH LEVELS OF FAMILY AND COMMUNITY PARTICIPATION, PARTICULARLY THOSE WHOSE PARTICIPANTS HAVE TRADITIONALLY HAD LIMITED INVOLVEMENT WITH SCHOOLS, AND SHARE THE INFORMATION STATEWIDE.
- ◆ SUPPORT OR PROVIDE STAFF DEVELOPMENT TRAINING THAT INCLUDES SUGGESTIONS FOR PLANNING, IMPLEMENTING, AND EVALUATING FAMILY AND COMMUNITY INVOLVEMENT PROGRAMS.

## STRENGTHENING PARTNERSHIPS

The successful delivery of effective HIV prevention programs that target youth disproportionately at risk depends on the ability of educators at all levels to work collaboratively with a broad cross-section of the community, other agency staff, and advocates for the well-being of children. State education agencies can foster effective partnerships in the following ways:

- ◆ MODEL COLLABORATION AT THE STATE LEVEL BY:
  - ◆ FACILITATING COLLABORATION AMONG ALL STATE EDUCATION AGENCY STAFF RESPONSIBLE FOR HEALTH-RELATED ISSUES, AND BETWEEN THOSE STAFF AND OTHERS WORKING IN SUCH AREAS AS SCHOOL IMPROVEMENT AND RESTRUCTURING, TITLE I PROGRAMS, BILINGUAL EDUCATION, AND SPECIAL EDUCATION.
  - ◆ WORKING WITH OTHER STATE AGENCIES INVOLVED WITH THE HEALTH OF SCHOOL-AGED CHILDREN, INCLUDING HEALTH AND SOCIAL SERVICE AGENCIES, OTHER EDUCATION ORGANIZATIONS, AND CHILD AND YOUTH ADVOCATES, TO SHARE INFORMATION AND DEVELOP COLLECTIVE STRATEGIES FOR IMPLEMENTING EFFECTIVE RESEARCH-BASED PROGRAMS TAILORED TO AT-RISK YOUTH.
- ◆ PROVIDE STAFF DEVELOPMENT TRAINING FOR STATE AND LOCAL SERVICE PROVIDERS TO HELP THEM LEARN HOW OTHER YOUTH-SERVING ORGANIZATIONS WORK AND HOW TO COLLABORATE MORE EFFECTIVELY.
- ◆ OFFER TECHNICAL ASSISTANCE AND INCENTIVES TO DISTRICTS AND SCHOOLS THAT ENGAGE IN JOINT VENTURES THAT TAKE INTO ACCOUNT LOCAL PREFERENCES, NEEDS, AND CIRCUMSTANCES.



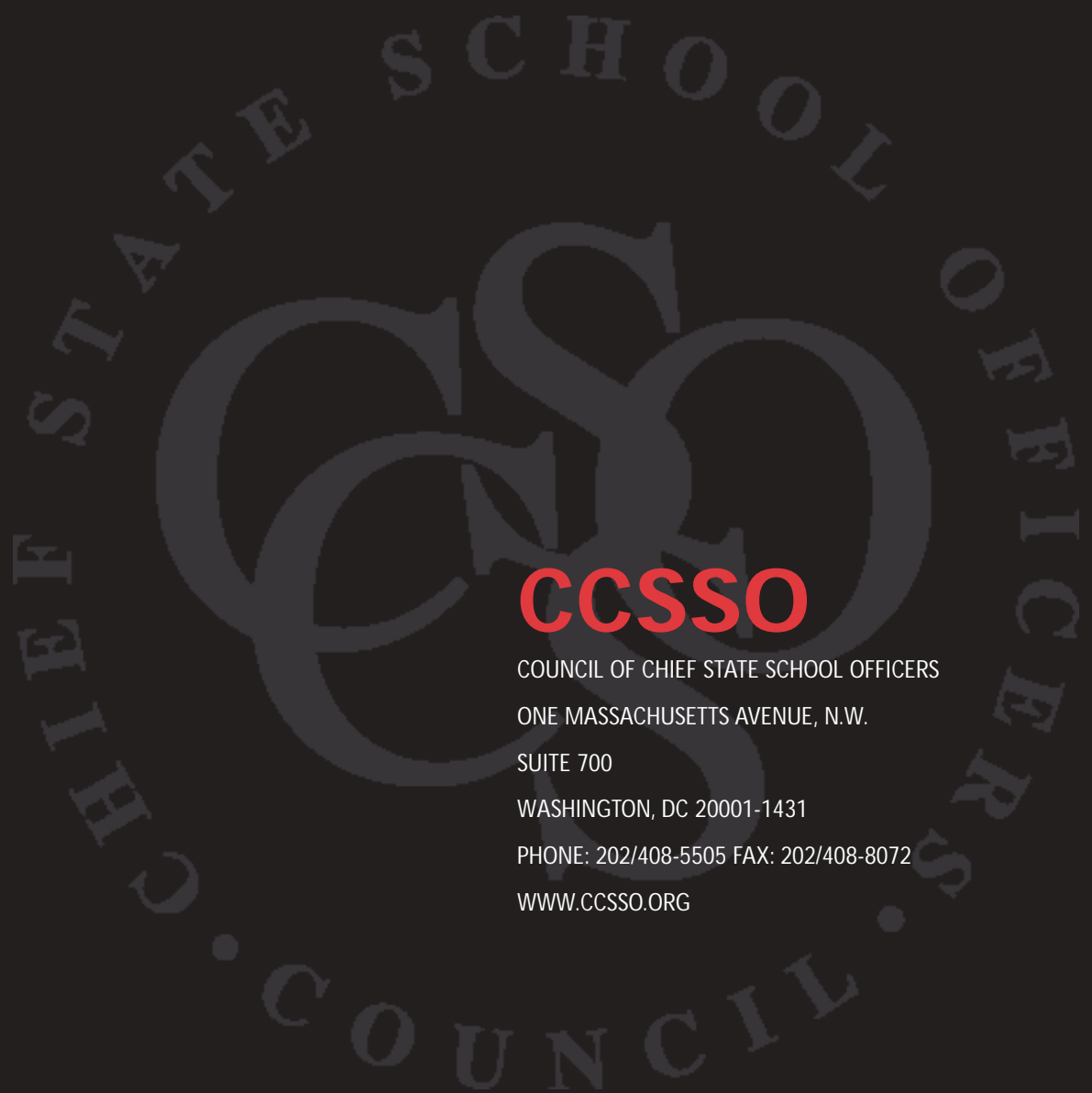
# Conclusion

Schools face unprecedented challenges as we enter the 21st century. Efforts to provide more academically rigorous education for all children sometimes result in competition for student time and lesser attention to other issues such as sound health education. However, HIV is killing children and disproportionately affecting those children who are also most at risk of academic failure. This document is designed to highlight the need for targeted HIV prevention interventions and to put forth suggestions as to what state education agencies can do to help implement targeted programs. In order to effectively provide the prevention services that are needed, state education agencies must recognize the differing needs of the groups identified through research as being disproportionately at risk, and then address these needs. Using the suggested recommendations and adapting those recommendations when necessary, state education agencies can take steps toward providing capable, competent programming that succeeds in reaching emerging “at-risk” populations. By providing leadership that supports effective, culturally specific HIV education, state education agencies can help to assure that these young people live to reap the benefits of an improved education.

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