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Meeting Materials for the Council on Linkages Between Academia and Public Health Practice

July 8, 1993

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KRISTINE M. GEBBIE, R.N., M.N., F.A.A.N.
NATIONAL AIDS POLICY COORDINATOR
DEPARTMENT OF HEALTH & HUMAN SERVICES
Room 729H Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

DAY Thursday DATE July 8, 1993

TIME 8:00 a.m. LOCATION Harrison's Pier 5 - Clarion Inn in Baltimore

SUBJECT Council on Linkages Between Academia and Public Health Practice

PARTICIPANTS:

See Attached Agenda

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The Link

Quarterly Bulletin of
The Council on Linkages
Between Academia and
Public Health Practice

VOL. I FALL, 1992

Focus on Funding...

Using College Work-Study to Get Students Out Into the Community

Deborah Greenberg and Virginia Seyler, M.H.S.

As public health faculty and practitioners consider strategies to develop training opportunities for students in the community, funding presents an immediate problem. The federal College Work-Study (CWS) program offers one potential solution, perhaps the most promising. To date, it remains a largely ignored and untapped source of support for off-campus employment.

The CWS program was established in 1965 as part of the U.S. Higher Education Act to supplement the grants and loans awarded in aid packages for students with demonstrated financial need. It is designed to promote part-time employment and summer internships via a federal matching funds mechanism, whereby federal funds may pay up to 70 percent of an eligible students' wages. Jobs may be located in any sector, without preference toward academic institutions. The federal regulations do stipulate, however, that work in public and non-profit organizations must be academically relevant. The program is administered by the financial aid office within each university, which retains discretion as to how funds are allocated.

CWS is intended to give students experiences relevant to their career pursuits, as well as service opportunities to benefit local communities. To encourage this activity the regulations include a provision to create "community services learning programs," by which the federal government pays up to 90 percent of wages. In practice, however, less than 1 percent of work-study funds are spent on these programs, according to a recent General Accounting Office report (February 1992). Ninety-five percent of CWS funds go to on-campus jobs — sometimes for meaningful research, sometimes for clerical or low-skilled support services.

Through reauthorization legislation, Congress has repeatedly tried to ensure that students have the opportunity to work in community service rather than in more typical work-study jobs. Senator Harris Wofford (D-PA), a former college president, has sponsored a series of community service amendments to the Higher Education Reauthor-ization Act. The amendments, which have passed the Senate (S.1150), would ensure that at least 10 percent of each university's CWS allocation go to the students engaged in community service on or off campus. They also limit the contribution of the community service agencies to no more than 10 percent of wages,

...see **Focus on Funding** page 3

Sixteen Years at the Crossroads of Academia and Public Health Practice in Ohio

C. William Keck, M.D., M.P.H.

In August 1973, the Ohio General Assembly passed legislation creating the Northeastern Ohio Universities College of Medicine (NEOUCOM). This community based medical College is made up of a unique consortium of three state supported universities in northeastern Ohio: the University of Akron, Kent State University, and Youngstown State University. The College offers a six-year, combined BS/MD program intended to graduate well-qualified Doctors of Medicine who will be able to excel in any field of specialization, but who have had significant orientation to the principles and practices of primary care in the community setting. Clinical training is accomplished in community hospitals (no university hospital was constructed). In 1975, the College decided to include community health science teaching and research as one of its components and began to search for a faculty member with community health expertise.

In January 1976, I was appointed Director of Health for the City of Akron, and Associate Professor of Community Health at the College of Medicine. I was expected to spend four ten-hour days at the Health Department and one full day a week at

...see **Crossroads** page 3

The Council on Linkages Between Academia and Public Health Practice

The Council on Linkages Between Academia and Public Health Practice is comprised of leaders from national organizations representing state and local health departments and academic institutions. The Council grew out of the Public Health Faculty/Agency Forum, which developed recommendations for improving the relevance of public health education to demands of public health in the public sector. The need for this improvement, for public health professionals to place a higher value on practice-specific training, was documented by the Institute of Medicine report, The Future of Public Health.

Mission: To improve public health practice and education by refining and implementing recommendations of the Public Health Faculty/Agency Forum, establishing links between academia and the agencies of the public health community, and creating a process for continuing public health education throughout one's career.

Members: John Arradondo, MD, MPH, (Chair), U.S. Conference of Local Health Officers; Roy DeHart, MD, American College of Preventive Medicine; C. William Keck, MD, MPH, American Public Health Association; Lloyd Novick, MD, MPH, Association of State and Territorial Health Officials; Michel Ibrahim, MD, Association of Schools of Public Health; Neil Sampson, Health Resources and Services Administration; Carl Tyler, MD, Centers for Disease Control; Martin Wasserman, MD, JD, National Association of County Health Officials; and William Wiese, MD, MPH, Association of Teachers of Preventive Medicine.

Staff: Ronald Bialek, MPP (Project Director); Virginia Seyler, MHS and Lois Banks.

Funded by the Health Resources and Services Administration through a Public Health Special Projects Grant to the Johns Hopkins University, School of Hygiene and Public Health, Health Program Alliance.

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MEETING OF THE

Council on Linkages Between Academia and Public Health Practice

AGENDA

Harrison's Pier 5 - Clarion Inn
711 Eastern Avenue
Baltimore, Maryland

Turlock Room

Thursday, July 8, 1993
8:00 a.m. - 4:00 p.m.

7:30 - 8:00	"Healthy" Breakfast
8:00 - 8:05	Approval of Minutes
8:05 - 10:00	Discussion with Kristine Gebbie Office of the Assistant Secretary of Health U.S. Department of Health and Human Services
10:00 - 10:10	Update on <u>The Link</u>
10:10 - 10:20	Report on the Joint Council of Official Public Health Agencies Work Group on Human Resources Development
10:20 - 10:30	Request from ASTHO regarding Confirmation of M. Jocelyn Elders, M.D. as U.S. Surgeon General
10:30 - 10:45	Break
10:45 - 12:00	Presentation of Prevention Effectiveness Research and Community Health Practice Guidelines Steven M. Teutsch, Chief Prevention Effectiveness Activity Centers for Disease Control and Prevention

12:00 - 1:00	Lunch
1:00 - 1:10	Schedule Next Meeting
1:10 - 1:25	A Role for the Model Standards Project in Community Health Practice Guidelines Development Claude Hall, Director Model Standards Project American Public Health Association
1:25 - 2:10	Development of Organization Practice Guidelines Bernard Turnock, Acting Dean University of Illinois School of Public Health
2:10 - 3:00	Methodology for Developing Guidelines for Clinical Preventive Services Steven Woolf, Scientific Advisor U.S. Preventive Services Task Force Office of Disease Prevention and Health Promotion
3:00 - 4:00	Next Steps in the Development of Community Health Practice Guidelines
4:00	Adjourn

COUNCIL ON LINKAGES BETWEEN ACADEMIA AND PUBLIC HEALTH PRACTICE

ANTICIPATED ATTENDEES
Friday, July 8, 1993

Barbara Aliza
John Arradondo
Lois Banks
Ron Bialek
Amy Boyer
Patrick Chaulk
Roy DeHart
Kay Doggett
Kristine Gebbie
Mike Gemmell
Claude Hall
Bill Keck
Doug Lloyd
Debbie Maiese
Lloyd Novick
Jim Papai
Mike Parkinson
Richard Riegelman
Neil Sampson
Ginny Seyler
Steven Teutsch
Bernard Turnock
Carl Tyler
Sasikumar Vishawanath
Bob Venezia
Marty Wasserman
Steven Woolf

COUNCIL ON LINKAGES BETWEEN ACADEMIA AND PUBLIC HEALTH PRACTICE

Conference Call Meeting Minutes

June 1, 1993

Members Present - John Arradondo (Chair), Lloyd Novick, Roy L. DeHart, Michel A. Ibrahim, Neil Sampson, William H. Wiese, C. William Keck

Staff Present - Ronald Bialek, Virginia B. Seyler, Sasikumar Vishwanath

Participants - Claude Hall, Mike Parkinson, Peggy Millson, Tom Bruce, Alex Ross, Robert Venenzia

I. Approval of Minutes

The meeting was called to order at 1:00 p.m. Minutes of the Council's last meeting held on February 8, 1993 were approved.

II. Nominations of Chair

Following this, Dr. Arradondo announced that as of November, he will no longer be Chair. He asked for nominations for a new Chair. Neil Sampson nominated Dr. Lloyd Novick. Dr. Roy L. DeHart proposed Dr. William H. Wiese. Dr. Wiese yielded to Dr. Novick. A motion was made to elect Dr. Novick as the new Chair of the Council on Linkages. His selection was approved by acclimation. Dr. Novick will assume the Chairmanship in November 1993.

III. Community Health Practice Guidelines Development

Ron Bialek briefed members on activities since the last meeting regarding this topic. Follow-up conversations have taken place with AHCPR and a meeting, sponsored by APHA, was held during Prevention '93. In addition, there have been two conference call meetings with some Council members to discuss specific practice guidelines that should be developed and a plan for the Council to pursue.

Staff developed a concept paper for the Council's involvement in community health practice guidelines development. The paper developed a protocol for the Council to pursue that would stimulate interest in guidelines development. The Council, assisted by CDC, HRSA, and others, would attempt to demonstrate the efficacy of community health practice guidelines development.

Neil Sampson pointed out that this guidelines development effort could be similar to the development of guidelines for clinical preventive services. Other agencies within the federal government, such as ODPHP, NIH, and AHCPR, would also become involved, i.e., ODPHP could serve an advisory role, while NIH would help with the research aspects.

Several members expressed concern that the Council does not possess the scientific expertise necessary for guidelines development. Dr. Arradondo stressed that our aim was to stimulate activity and to get "the ball rolling." While the Council could provide insight into topic areas to pursue and issues to consider, others would need to provide the scientific and methodological expertise.

Bill Wiese agreed that the Council should move forward in this effort. He suggested that a meeting be set up to discuss identifying the resources, and gaining a formal commitment from at least one federal agency.

Peggy Millson, a representative from the Canadian guidelines development project, was asked to explain how the Canadian project got started. She said that the initial project was funded out of the Deputy Secretary's office and was a joint effort of federal and provincial health agencies. Through the initial project, a generic protocol has been developed. However, now, the initiators have been replaced, and it is unclear whether the government will continue to support the project.

Tom Bruce raised a question about the scope of community health guidelines development. Mike Parkinson said that he envisioned guidelines of nine or ten activities that all local health departments do. The purpose of the guidelines development would be to find out if these functions hold up scientifically. Dr. Novick raised the point that we could cut the topics two different ways -- by functions (restaurant inspections, outbreak control) or issues (teen pregnancy prevention, child health). He feels that the issue topics, such as those laid out in the staff issue paper, are more exciting. Neil Sampson made the point that population-based public health services, such as restaurant inspections, are what need to be reviewed. Bill Wiese said that the Linkages Council should first concern itself with development of a sound methodology. Then the Council could lay out specific issues for guidelines development, potentially with the input of others.

John Arradondo said we should proceed with the agreed upon mission of the Council to act as a catalyst to set up the structure for guidelines development. He suggested the Council contact organizations and agencies beyond its membership. Once the appropriate players are brought to the table, the Council can shape

the discussion. Alex Ross suggested including Assistant Secretary Lee and Surgeon General Elders. The members were unanimous in agreeing to pursue Step 1 outlined in the protocol paper during the July 8, 1993 meeting from 10:00 a.m. to 4:00 p.m. in Baltimore.

Other Business

Ron Bialek brought up the subject of a fax to all Council members requesting names of consultants in the area of substance abuse prevention. A private group, NOVA, approached him about involving the Council in guidelines development if the group won a grant award for from the National Center for Substance Abuse Prevention. Ron explained that NOVA wanted advice in specific areas but no formal commitment. Bill Wiese raised the point that these activities may be beyond the scope of the Council's mission. Roy DeHart agrees that this activity may distract the Council from its main goal. Ron Bialek said this would be an opportunity for the Council to be involved with development of a model which could build in academic-practitioner partnerships. Michel Ibrahim said that if it fits in with the Council's general approach, and does not draw from the energy base, the Council should pursue it. We should consider being involved in the components of the project consistent with practice guidelines development. There was general agreement with this statement.

Ron Bialek said that he will get back to NOVA with the names of potential consultants that were provided by Council members. These people will be contacted before they are written into any proposal.

The meeting ended at 3:30 p.m.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
415 Second Street, N.E., Suite 200, Washington, D.C. 20002
(202) 546-5400

PRIORITY

To: Friends of Public Health
From: George Degnon, Executive Vice President
Date: July 1, 1993
RE: Confirmation of M. Joycelyn Elders, M.D. As U.S. Surgeon General

On behalf of the Association of State and Territorial Health Officials (ASTHO), I am requesting the active assistance of your organization in securing the confirmation of M. Joycelyn Elders, M.D. As U.S. Surgeon General.

Dr. Elders' nomination will be submitted by the White House to the Senate by July 2, 1993. The hearing to confirm her will be held the week of July 12, 1993 before the Senate Committee on Labor and Human Resources.

Dr. Elders, currently Director of the Arkansas State Health Department and President of ASTHO, has a strong stance on public health, prevention, and access for the underserved. Yet certain groups are organizing substantial opposition to her nomination and have a plan of attack to derail her confirmation.

ASTHO urges you to act now to mobilize support for Dr. Elders' confirmation. Please assist support efforts by:

1. Immediately communicating with your membership, professional colleagues and other organizations the need to write letters to the members of the Senate Labor Committee as well as call their individual Senators' offices in support of Dr. Elders;

2. Sending a letter of support from your organization to all Senators...as well as a personal letter to your senators yourself;

3. Making phone calls and office visits to Senate members and their staff;

4. Calling the ASTHO office (202)546-5400 to indicate your organization's support of Dr. Elders no later than July 12 -- ASTHO is compiling a master list to be used in Hill Visits; and

5. Participating in other activities including writing op-ed letters to newspapers, writing press releases, etc.

Attached is a sample letter which can guide your efforts in writing to the Senate. Also attached is a list of members of the Committee on Labor and Human Resources, who should be heavily targeted.

We will be happy to provide you with additional information on Dr. Elders and her record. If you need additional assistance or if you wish to be more proactive in this effort, please contact Jennifer Tuteur at the ASTHO office.

DRAFT Response from the Council of Graduate Programs in Public Health/Preventive Medicine to the Final Report of the Public Health Faculty/Agency Forum

The Council of Graduate Programs in Public Health/Preventive Medicine, hereinafter referred to as the Council, has reviewed the Final Report of the Public Health Faculty/Agency Forum and heartily endorses its underlying purpose of making public health education more relevant to practice. The Council supports, as well, the Report's recommendation that "community-based organizations and educational programs in public health and preventive medicine outside of schools of public health be heavily involved in the activities to improve the relevance of academic public health to practice."

In addition to these general statements of support, the Council offers the following recommendations for broadening the scope not only of this report but future considerations of roles/relationships between public health education and practice. The recommendations are organized under the headings Scope of the Public Health Community, Universal Competencies and Recommendations, and Other Comments.

SCOPE OF THE PUBLIC HEALTH COMMUNITY

The Report clearly indicates that its scope was limited by the Federal Government to examining the relationship between schools of public health and public health agencies (page 3). The Council recommends that future studies and analyses include from the outset representation from community health education programs and public health education programs in departments of preventive medicine/schools of medicine. These programs may be the ONLY public health education and training programs within sizable geographic areas, and they represent not only important academic resources but also critical linkages to a broad spectrum of public health agencies.

UNIVERSAL COMPETENCIES AND RECOMMENDATIONS

Because the graduate programs in public health/preventive medicine may vary in their emphases on the four disciplinary areas (public health administration, epidemiology and biostatistics, behavioral sciences, and environmental public health) described by the Report, the Council focused on the over-arching Universal Competencies and Recommendations: practica, collaboration and communication, professional and student education and teaching methods, and human and fiscal resources. Our comments are as follows:

PRACTICA: The concept of a practicum is essential to making public health education more relevant to practice. The practicum for preventive medicine residents as a potential model for other graduate students, is, as the Report indicates (page 13), worthy of further examination. For graduate students who do not attend full time, and/or who may already have considerable public health experience, other approaches may need to be explored. Public health practica experiences other than in public health departments should be explored as well.

COLLABORATION AND COMMUNICATION: Whether another National Commission, such as the proposed National Steering Committee on Cooperation and Collaboration, is the best approach to ensuring collaboration and communication between public health education and practice may be debated. More important is to encourage funding agencies, accrediting bodies, professional associations, and others to emphasize the importance of such linkages among a broadly defined array of public health agencies and educational programs. Perhaps the proposed Commission could assist in this regard.

PROFESSIONAL AND STUDENT EDUCATION AND TEACHING METHODS: We had no additional comments on this topic.

HUMAN AND FISCAL RESOURCES: Implementing the Report's recommendations, albeit on a smaller scale for programs, perhaps, than for schools of public health, will nevertheless require additional programmatic expenditures. The Council underscores the importance of expanding federal and other funding sources to ALL graduate programs in public health, including those outside schools of public health, in order to universally make public health education more relevant to practice.

OTHER COMMENTS:

Draft 3/16/93 Barton and Rhoads

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

April 9, 1993

Mr. Ronald Bialek, M.P.P.
Project Director
Council on Linkages Between Academia
and Public Health Practice
624 North Broadway, Hampton House 584
Baltimore, Maryland 21205

Dear Mr. Bialek:

I have reviewed your letter of February 24 with members of my staff. All grant and cooperative agreement programs administered by the National Center for Prevention Services include training and development for health department staff as integral components. In response to your specific questions:

1) **Do the mentioned grant programs (immunizations, tuberculosis, and sexually transmitted diseases) permit states to use federal funds for public health or preventive medicine education and training purposes? If yes, please explain how states may access these funds.**

Immunization grant recipients (all state and territorial health departments and some large city health departments) are required to develop a plan to inform health professionals of the most recent immunization recommendations, policies, and procedures. In addition, grantees are required to provide camera-ready copies of Vaccine Information Pamphlets to all providers in their jurisdiction administering immunizations and to instruct these providers about how the materials are to be used. Grantees must also supply to users of publicly purchased vaccines not covered by the National Vaccine Injury Compensation Act (i.e., hepatitis B and Haemophilus Influenza B vaccines) copies of the corresponding Important Information Statements as well as instructions on their appropriate use. Finally, the grant guidance requires grantees to instruct health care providers of their obligations to appropriately record and maintain certain information on each vaccine recipient's medical file and to report adverse events associated with administration of vaccine. Immunization Action Plans, a component of this grant program, address provider education and training, particularly on implementation of the Standards for Pediatric Immunization Practices.

Grants for STD prevention are made under two parts of Section 318 of the Public Health Service Act. Under Section 318(b), grants are authorized for research, demonstration, public education, and professional education. Grants under 318(b) may be made to public entities, including states and cities, and private non-profit organizations

Under Section 318(c), grants are authorized to support activities to interrupt STD transmission through selective screening, surveillance, partner notification, and the interstate containment of disease spread. CDC's pending program announcement of 318(c) funding for STD Accelerated Prevention Campaigns in fiscal year 1994 includes a requirement that grantees describe plans for professional education about STDs. Grants will be awarded to health departments of the states, the District of Columbia, some large cities, and United States territories.

The tuberculosis cooperative agreement program supports surveillance, prevention, and control/elimination; multidrug-resistant TB outbreak control; HIV-related TB prevention projects; and laboratory upgrade and applied research. A model TB center program will provide support to establish state of the art TB screening and treatment. The eligible state and large city health department applicants will be required to collaborate with a school of public health or a medical university to provide training of health care providers.

2) **Do these grant programs actively promote the use of federal funds for education and training purposes? If yes, please explain.**

The Immunization Grant Guidance requires grantees to inform and educate providers about the issues described in item 1. Beyond that, grantees are free to request funds for specific professional education and training needs. However, since the amount of grant funding available for operations is fixed in each annual budget, and since operational demands at the grantee level usually exceed available funding, extensive professional education and training may be low on the list of an individual grantee's priorities.

Under the Section 318(b) authority CDC supports the national network of STD Prevention/Training (P/T) Centers in 11 health departments. Grantees are required to collaborate with a local university school of medicine to provide STD clinical training opportunities for public and private health practitioners.

As noted above, 318(c) grants to be made in fiscal year 1994 will actively promote a level of professional training in support of community-wide STD prevention efforts. In reality, this will formally document, structure, and

standardize an activity that most STD programs have maintained to some degree as an ongoing operational necessity, and which CDC has always supported through these grants.

The Tuberculosis Program Guidance directly addresses education and training in its model TB center.

3) **What are the current restrictions on the use of federal funds by states for education and training purposes? Are these restrictions required by legislation, regulation, or agency policy?**

Limits on the amount of funds available for operational purposes usually determine the level and extent of professional education and training in each grantee area. Grantees that can contribute funds to assist in the operation of their immunization grant programs are likely to have more discretionary resources with which to conduct such education and training.

Including funds awarded for the support of the STD P/T Centers, between 10-15 percent of appropriated funds for 318(b) are expended for specified activities, mainly relating to STD educational efforts. The balance of CDC STD funds are mainly for outreach and education efforts to rapidly refer, diagnose, and treat at risk persons to avert and abort disease outbreaks. There are no other restrictions either by regulation or agency policy.

Other than the limits imposed by availability of funds, there are no restrictions on the use of federal tuberculosis funds by states for education and training purposes.

4) **How much flexibility do states have once grants are issued to fill vacant slots with student interns or preventive medicine residents?**

States are free to make their own selections for positions paid by immunization grant funds. The issue is not who should fill a particular position but whether that position is making a direct contribution toward the achievement of immunization program objectives. Most immunization program operational needs do not require the direct services of a physician.

Under STD grants, states have considerable flexibility in filling positions, but as noted above, the CDC funds are mainly for outreach activities. Positions associated with them do not usually attract either student interns or preventive medicine residents. The P/T Center grantees under Section 318(b) work closely with medical training institutions. Many P/T Centers support a fellow, typically in preventive medicine or infectious disease, who provides liaison with the
medical school faculty. This fellow may teach and also proctor P/T Center students in their STD clinical practicum.

Under tuberculosis cooperative agreements, health departments have flexibility in filling funded positions. CDC recommends only that positions be filled with qualified, experienced individuals in order to effectively and efficiently carry out program activities and achieve stated objectives. Depending on availability of funds, CDC would consider requests for innovative, cost-effective uses of student interns or preventive medicine residents.

5) **Do any of the federal grant funds go directly to local health departments? If yes, can they use the funds for education and training purposes?**

Of the 63 current Federal immunization grantees, five are local health departments: Washington, D.C., Chicago, Houston, New York City, and San Antonio. These five grantees are obligated to use Federal immunization funds in the same way as all other recipients. Many states have contracts or other funding arrangements with local health departments through which they pass basic immunization grant and IAP funds. These recipients must specify how they propose to use the funds. States will not agree to proposals unless they are directly linked to achieving immunization program objectives.

Grants under Section 318(b) go directly to five local health departments for the operation of STD P/T Centers. These are Baltimore, Birmingham, Chicago, Long Beach, and San Francisco. Grants under Section 318(c) go directly to seven local health departments, Baltimore, Chicago, Washington, D.C., Los Angeles, New York City, Philadelphia, and San Francisco. Provisions and restrictions on their use of funds with respect to education and training are identical to those for states.

In addition to funding state health departments, tuberculosis cooperative agreements support nine major city health departments. As with awards to the states, there are no explicit promotion or restriction of funds for education or training purposes.

Thank you for your interest in public health and in fostering greater cooperation between public health and academia.

Sincerely,

Alan R. Hinman, M.D.

Alan R. Hinman, M.D., M.P.H.
Assistant Surgeon General
Director
National Center for Prevention Services

EXECUTIVE SUMMARY

LONGITUDINAL STUDY OF GRADUATES, SCHOOLS OF PUBLIC HEALTH 1956-1985

Nicholas Parlette, MPH

Copies of the complete report may be obtained from A.S.P.H.
Call (202) 842-4668 for price.

This study was supported by PHS/HRSA contracts 89-488(P) and 240-90-0062, and by a grant from the Henry J. Kaiser Family Foundation 90-8102.

EXECUTIVE SUMMARY

There is considerable information about the number and nature of applicants to schools of public health and about the enrollments in these schools. Data has also been collected from the schools on their graduates, which tends to be demographic in nature. In addition, there have been a number of studies of graduates from these schools which have focused on their employment at a given point in time (the time of the study). To our knowledge, there have not been any studies which have documented the entire employment history, the careers, of these graduates.

The purpose of this study was to document the career patterns of graduates from all U.S. schools of public health and to determine how relevant their education was to their careers. Subsidiary questions were: What level of salaries do graduates earn, and have their salaries kept pace with inflation? What are the current continuing education activities of respondents, and what are their suggestions for continuing education courses? The study was designed so that statistically valid comparisons could be made of graduates of five areas of specialization in public health (health service administration, biostatistics, epidemiology, environmental health sciences, and health education/behavioral sciences) over a three-decade period (1956-1985). Furthermore, the study was designed so that the results, when compiled by specialization and decade, could be projected onto the entire population of graduates in the specific specializations and decades.

The U.S. schools of public health provided the study team with their alumni lists from which a random sample, stratified by specialization and decade, was drawn. The information necessary for the study was gathered through the use of a mailed questionnaire to 5,015 graduates. The study achieved a 55 percent response rate, after adjustments for bad addresses, yielding 2,429 completed career histories which were in sufficient numbers in each of the 15 study strata so that extrapolations to all

graduates from these schools in these strata could be made with reasonable margins of error.

The primary research questions were:

1. What are the career patterns of graduates of U.S. schools of public health?

2. Are these patterns different for graduates from different specializations and different periods of time?

3. How do graduates evaluate their public health education in relation to their careers?

Persistence in Public Health

Sixty-four (64.4) percent of the respondents have remained for their entire career in public health. Ten (10.8) percent never entered public health. Twenty-one (21.7) percent of the respondents made at least one transition out of public health and either remained out (14.9 percent) or re-entered at a later time (7.0 percent). This latter group contained some individuals who have made several transitions out of public health and have re-entered. Two (2.6) percent of graduates never worked.

Looking at each area of specialization, we see that for graduates in each area of specialization, persistence in public health has declined from decade to decade. The only exception to this trend is in biostatistics in which graduates from the second decade under study (1966-1975) have a higher percentage (80 percent) of graduates still in public health than for the earlier cohort of graduates. Graduates in environmental health sciences for all three decades have the highest percentage of persistence in the field. Statisticians have the next best persistence record, followed by epidemiology, health administration, and health education/behavioral sciences.

Health education/behavioral sciences has less than 60 percent of its graduates in each decade still in the field of public health.

Where are graduates employed? Just under 50 percent (49.2 percent) of respondents were employed in their current or last job in public organizations; 25.2 percent were employed in non-profit organizations; 16.2 percent were employed in for-profit; and 9.4 percent were self-employed. When the graduates first and current or last position are compared, we see there is a strong trend out of the public and non-profit sectors into the for-profit or self-employment sectors. There is also a decided trend for more recent graduates not to enter the field through the public sector. Just 44.9 percent of the 1976-1985 graduates found their first employment in public sector jobs compared to 71.6 percent of graduates during the 1956-1965 decade.

As can be see in the following abbreviated table, there are major generational shifts in the place of employment of graduates. Organizations are classified by their major mission.

Type of Employing Agency*
By First Job and Current/Last Job
(percentages)

	1956-1965		1966-1975		1976-1985	
Organization	Current	First	Current	First	Current	First
Health Department	28.1	41.6	17.8	18.6	17.1	17.0
Medical Care	17.2	10.7	18.6	16.5	23.3	26.0
Education	27.2	23.0	25.5	28.9	16.8	20.0
Industry	12.9	5.4	17.0	6.8	21.7	15.1

* Only organizations employing at least 10 percent of graduates are included.

The type of employing agency varies by area of specialization. The top three in each specialization are:

- for administration: 33.9 percent are employed in medical care organizations (hospitals), 23.4 percent in health departments, and 13.7 percent in industry;

- for biostatisticians: 36 percent are working in educational institutions (mostly universities), 26.1 percent are in industry, and 18.3% in health departments;

- for environmental health: 33.5 percent work in industry, 19.4 percent in health departments, and 14.9 percent in educational institutions;

- for epidemiologists: 29.4 percent are employ in education, 27.8 percent in health departments, and 18.1 percent in medical care;

- for health education/behavioral sciences: 28.8 percent in education, 21.8 percent in health departments, and 16.2 percent in medical care.

We were interested in determining what happens to individuals who leave the field. The most frequent transition out of public health was to (or return to) the practice of medicine. Twenty-seven (27) percent of total transitions out of public health were for this reason. Next was to non-public health professions (21.8 percent). Transition to the practice of another health-related profession (dentists, veterinarians, nurses, etc.) accounted for 17.1 percent of the transitions. To enter industry and/or start one's own business, a non-public health related business, accounted for a combined 20 percent of these transitions from the field of public health.

For each job change, we asked respondents to give the reason. A better position and promotion accounted for over 50 percent of the aggregate reasons for changing jobs. The next most often mentioned reason was that the job ended,

primarily the funding ended, following by personal reasons, career change, dissatisfaction with the job, and, finally, low pay.

Salaries

Respondents were asked to give their initial salary and their present or final salary. They were also asked to indicate whether the salary represented part-time work and, if so, to give the percentage. All salaries were converted to full-time (92.8 percent reported full-time salaries). The median salary for all respondents was **$58,000**. The mean salary was **$67,690**. Thirty-six (36.3) percent of the respondents were earning less than $50,000; 48 percent were earning between $50,000 and $100,000; 11.5 percent were earning between $100,000 and $150,000; 3.0 percent were earning between $150,000 and $200,000; 2.1 percent were earning more than $200,000. Men's salaries outpaced women's by a considerable margin. Twenty-three (23) percent of men are paid more than $100,000, while just 1.7 percent of women are in this salary bracket.

We were interested in whether or not salaries have kept pace with inflation. All salaries were adjusted to 1983 dollars using the Consumer Price Index (CPI). The general pattern of a rise and fall in "real purchasing power" in initial salary as indicated by the use of the CPI-adjusted salary level is fairly consistent across the six specializations and by gender. Beginning salaries rose for all specializations through the early 1970s when they reached their peak and since then all salaries have fallen, and appear to still be on a downward trend. The median CPI-adjusted current or final salaries have declined for all specializations. In other words, salaries have not kept pace with inflation.

Graduates in administration have commanded the highest initial salaries of the five specializations studied. Health education/behavioral sciences have received the lowest beginning salaries.

Current or last median salaries have been the highest for graduates in administration followed by biostatistics, epidemiology, environmental health and, finally, health education/behavioral sciences.

Respondents' Evaluation of Their Education

The objective of this study was to determine how well the schools did the job of preparing graduates for their professional careers. Five statements were prepared. Respondents were asked to indicate their agreement (+3 equals complete agreement; -3 equals complete disagreement) with the statement by circling the appropriate number. The first statement was: "My school of public health education prepared me broadly and intellectually to address my job requirements throughout my career." The second statement probed for the graduates' evaluation of acquisition of skills for their first job and for subsequent jobs. The third statement asked for their judgment on how well the schools provided base knowledge; again, for the first job and subsequent jobs. There is overwhelming evidence that the schools have done their job and quite well. Over 90 percent of the respondents agreed with the statement that they had been prepared broadly and intellectually to address their job requirements. There are slight variations by discipline, but the overall judgments are quite similar. Although the provision of specific skills was rated somewhat less favorably than the provision of a broad intellectual base, more than 80 percent agreed that they had received the skills necessary for their first job. The level of satisfaction for skill acquisition increased when subsequent jobs was the factor being rated. And this is true for each specialization and each decade.

When the provision of a necessary knowledge base for the practice is the factor under consideration, the percent of favorable responses is once again over 90 percent. And, in fact, the trend for more recent graduates to be more critical is less pronounced for all of the specializations.

Space was provided so respondents could comment if they wished. Favorable comments outnumbered negative comments by a 2 to 1 margin.

The final section of the questionnaire asked if graduates were taking course work or continuing education. Just over half of the respondents still in the work force were enrolled in some form of continuing education. Twenty-five percent of retirees were also taking courses, generally for personal interest.

Respondents were asked if the course work was to improve their specialization skills or management skills. The majority of respondents indicated that the purpose of the course work was to improve specialty skills followed by management skills.

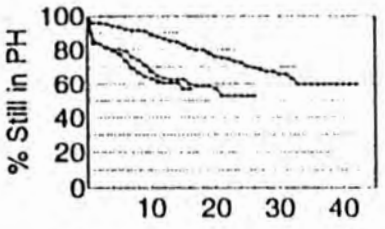
The final question on continuing education was: are you taking course work to prepare for another profession? Twenty percent indicates this was their purpose (this represents nine (9) percent of all respondents).

In sum, the job market for graduates of schools of public health has changed considerably during the last 30 years. Furthermore, the scope of employment opportunities has broadened accordingly. As the field changes so has the job market. The schools of public health have continued to provide an exceptionally high quality professional education preparing their graduates intellectually and providing them with the skills necessary for their careers.

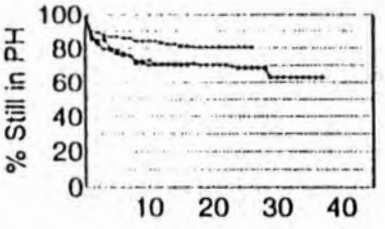
Figure 15

Males and Females Combined,
By Decade of First PH Degree

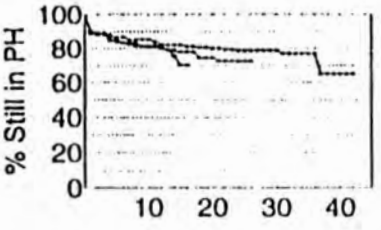
Administration (n=169,153,243)



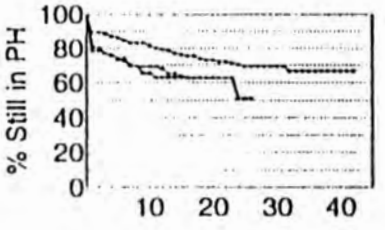
Biostatistics (n=106,114,111)



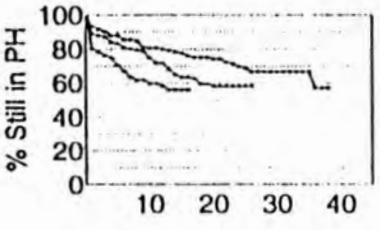
Environmental Health Science (n=150,105,125)



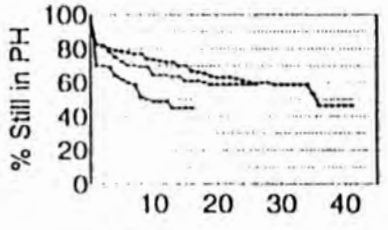
Epidemiology (n=128,78,113)



Health Ed./Beh. Science (n=125,132,157)



Other (n=143,123,100)



The longest line represents the decade 1956-65
The intermediate line rrpresents the decade 1966-75
The shortest line represents the decade 1976-85

Percent of Graduates Still In Public Health (PH)
Depending on the Time Since the First PH Degree

TABLE 30

RESPONDENTS' CURRENT/FINAL REPORTED SALARY BY DECADE OF FIRST PUBLIC HEALTH DEGREE

DECADE / SALARY	1956-1965 N = 736		1966-1975 N = 654		1976-1985 N = 771	
less than 20,000	3.5		1.1		1.0	
20,000-29,999	5.7		4.3		6.4	
30,000-39,999	11.3	32.6	8.7	26.6	18.9	48.3
40,000-49,999	12.1		12.5		22.0	
50,000-59,999	13.0		15.6		16.0	
60,000-69,999	14.0		15.6		12.5	
70,000-79,999	10.2	48.7	8.4	52.4	6.0	43.2
80,000-89,999	6.5		7.8		5.3	
90,000-99,999	5.0		5.0		3.4	
100,000-109,999	6.3		8.7		2.3	
110,000-119,999	1.8		1.1		1.4	
120,000-129,999	2.2	12.4	2.8	14.6	0.9	5.5
130,000-139,999	1.1		1.2		0.4	
140,000-149,999	1.0		0.8		0.5	
150,000-159,999	2.2		2.6		1.2	
160,000-169,999	0.4		0.5		0.1	
170,000-179,999	0.4	3.6	0.0	3.5	0.3	2.0
180,000-189,999	0.5		0.2		0.3	
190,000-199,999	0.1		0.2		0.1	
200,000-249,999	1.5		1.7		0.5	
250,000-299,999	0.4		0.9		0.3	
300,000-399,999	0.4	2.7	0.3	3.1	0.1	1.0
400,000 or more	0.4		0.2		0.1	

TABLE 33

COMPARISON OF RESPONDENTS' EVALUATION OF PUBLIC HEALTH EDUCATION BY TRANSITION OUT OF PUBLIC HEALTH OR RE-ENTRY CURRENT/FINAL JOB*

Statement	Out (705)	Still In (1,557)	Re-entry (86)
My School of Public Health education prepared me broadly and intellectually to address my job requirements throughout my career.	2.17	1.82	1.81
My School of Public Health education provided me with the specific skills I needed			
...for my first job	2.51	2.15	2.62
...in subsequent jobs	2.56	2.09	2.20
My School of Public health education gave me a base knowledge that served me well in			
...in my first job	2.18	1.86	2.11
...in subsequent jobs	2.24	1.82	1.81

* Means were calculated for the six (6) point agree-disagree scale.
1.00 = complete agreement with the statement; 6.00 = complete disagreement.

TABLE 13

REPORTED DEGREES
LISTED IN SEQUENCE RECEIVED

Prior to First Public Health Degree

Degree	1st Degree	2nd	3rd	4th	Total	%
MD	374	21	2	-	397	39.7
Ph.D.	21	32	3	-	56	5.6
Other Doct.	88	19	-	-	107	10.7
MBA	14	3	-	-	17	1.7
Other Masters	405	17	1	-	423	42.3
Totals	902	92	6		1,000	100.0

First Public Health Degree

Degree	1st Degree	2nd	3rd	4th	Total	%
BA/BS*	75	1	-	-	76	3.0
MPH/MSPH	988	669	70	5	1,732	69.8
Other PH Mast.	53	14	3	-	70	2.8
MA/MS	351	82	7	-	440	17.7
Ph.D.	31	57	2	1	91	3.6
Dr.PH	2	12	4	-	18	0.7
Other Doct.	23	31	-	-	54	2.2
Totals	1,523	866	86	6	2,481	99.8

* Only Bachelor degrees in Public Health counted. If respondent reported advanced public health degree, these were also counted.

Post Public Health Degree

Degree	1st Degree	2nd	3rd	4th	Total	%
MD	-	54	8	2	64	8.4
MBA	-	27	4	2	33	4.3
LLB/D	-	15	11	-	26	3.4
Ph.D.	-	35	11	3	49	6.4
Ph.D. (P.H.)		145	65	3	213	27.9
Dr.PH	-	48	44	16	108	14.2
Other Masters	-	55	25	7	87	11.4
Other Doct.	-	67	49	6	122	16.0
MPH/MSPH	-	17	9	1	27	3.5
Other PH Mast.	-	25	7	-	32	4.2
Totals		488	233	40	761	99.7

CORE PUBLIC HEALTH FUNCTIONS

- Health-related data, surveillance, and outcomes monitoring
- Investigation and control of diseases and injuries
- Protection of environment, housing, food, and water
- Laboratory services
- Public information and education
- Targeted outreach and linkage to personal services
- Quality assurance
- Training
- Research, demonstration, and evaluation
- Leadership, policy development, and administration

MEETING OF THE

Council on Linkages Between Academia and Public Health Practice

AGENDA

Harrison's Pier 5 - Clarion Inn
711 Eastern Avenue
Baltimore, Maryland

Turlock Room

Thursday, July 8, 1993
8:00 a.m. - 4:00 p.m.

7:30 - 8:00 "Healthy" Breakfast

8:00 - 8:05 Approval of Minutes

8:05 - 10:00 Discussion with Kristine Gebbie
Office of the Assistant Secretary of Health
U.S. Department of Health and Human Services

10:00 - 10:10 Update on The Link

10:10 - 10:20 Report on the Joint Council of Official Public Health Agencies Work Group on Human Resources Development

10:20 - 10:30 Request from ASTHO regarding Confirmation of M. Jocelyn Elders, M.D. as U.S. Surgeon General

10:30 - 10:45 Break

10:45 - 12:00 Presentation of Prevention Effectiveness Research and Community Health Practice Guidelines

Steven M. Teutsch, Chief
Prevention Effectiveness Activity
Centers for Disease Control and Prevention

12:00 - 1:00	Lunch
1:00 - 1:10	Schedule Next Meeting
1:10 - 1:25	A Role for the Model Standards Project in Community Health Practice Guidelines Development Claude Hall, Director Model Standards Project American Public Health Association
1:25 - 2:10	Development of Organization Practice Guidelines Bernard Turnock, Acting Dean University of Illinois School of Public Health
2:10 - 3:00	Methodology for Developing Guidelines for Clinical Preventive Services Steven Woolf, Scientific Advisor U.S. Preventive Services Task Force Office of Disease Prevention and Health Promotion
3:00 - 4:00	Next Steps in the Development of Community Health Practice Guidelines
4:00	Adjourn

COMMUNITY HEALTH PRACTICE GUIDELINES DEVELOPMENT: A Proposed Protocol

Draft - 5/17/93

Introduction: Over the past year, there have been several meetings with a variety of interested organizations and individuals concerning the development of guidelines to facilitate and enhance the practice of public health in our nation's communities. There has been some expression of need for the development of systematic, scientifically-based community practice guidelines for use by state and local public health agencies.

Local and state public health agencies possess only a limited understanding of the extent of correlation between their specific program efforts and impacts on health status. While there is no doubt, for example, that providing an individual immunization according to an established schedule protects that person against unnecessary illness, it is much less certain how many cases of foodborne disease are prevented by a particular schedule of food service inspections. This relative lack of knowledge undermines efforts to improve management and optimize resource use.

Since early in 1992, the American Public Health Association (APHA) has been communicating with the Canadian Public Health Association's Community Health Practice Guidelines Working Group (CHPGWG) about the possibility of transnational cooperation in the systematic evaluation of community health practices. At the 1992 Annual Meeting of APHA, several national organizations and federal agencies were invited to discuss this issue further. Significant interest in this area has been expressed by the Council on Linkages Between Academia and Public Health Practice and the Model Standards Project. Federal agencies involved in early discussions have included: the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and the Agency for Health Care Policy and Research (AHCPR). Other federal players that might be included in future efforts would be: the National Institutes of Health (NIH), the Environmental Protection Agency, the Food and Drug Administration, and the Substance Abuse and Mental Health Services Administration. In addition, some activities to develop guidelines might parallel efforts of CDC's Prevention Effectiveness Research, making involvement of this branch of CDC essential.

To move this whole area ahead, it is being proposed that the Council on Linkages Between Academia and Public Health Practice take responsibility for initiating the first phases of community health practice guidelines development.

An Approach to Developing Community Health Practice Guidelines: The development of community health practice guidelines is similar conceptually to the efforts of the U.S. Preventive Services Task Force. There is a need to demonstrate whether individual preventive treatments are effective and appropriate, and to develop guidelines based upon the evidence. Following is a modest approach to the initial development of guidelines taking into consideration existing resource limitations. Even with limited resources, it is imperative to begin an effort to develop community health practice guidelines to complement current and future health care reform efforts.

STEP 1: Convene a Meeting of the Council on Linkages Between Academia and Public Health Practice and Federal Agencies

A specific model for the development of community health practice guidelines does not exist. As a first step, this meeting would serve to bring together various federal players to discuss potential methodological approaches to guidelines development. The Office of Disease Prevention and Health Promotion (ODPHP) would be asked to present an overview of the approach used for development of the Guide to Clinical Preventive Services. Presentations on methodologies, guidelines development, and scientific rating of evidence, also could be made by CDC, NIH, AHCPR, the CHPGWG, and others.

STEP 2: Develop and/or Adapt Methodology for Development of Community Health Practice Guidelines

Following the discussions under Step 1, the federal government would take the initiative to finalize a methodology. Continued input from the Linkages Council and others would be solicited. It is likely that CDC and HRSA would need to have substantial involvement in this effort. While AHCPR has expressed some interest in public health practice guidelines development, the Agency's main focus is in development of clinical guidelines.

STEP 3: Select Two to Three Topic Areas for Evaluation and Development of Practice Guidelines

On March 10, 1993, a subcommittee of the Linkages Council held a conference call meeting for the purpose of selecting topic areas where public health practice guidelines are needed. Areas discussed included: 1) tobacco prevention for children; 2) sex education to reduce teen pregnancy and sexually transmitted diseases; 3) infection control in high risk populations (by settings and illness categories); 4) interventions to prevent childhood injuries; and 5) community interventions for lead poisoning prevention. These areas, as well as others, should be discussed in greater detail to determine two to three areas to demonstrate the efficacy of community health practice guidelines development.

STEP 4: Develop Systematic Literature Review

Similar to how ODPHP utilized Preventive Medicine Residents (PMRs) and staff to conduct literature reviews for the Preventive Services Task Force, the CDC PMRs could be utilized for the community health practices guidelines activity, under the direction of CDC staff. There is a tremendous educational value to this activity for the residents. Having residents in one place under the direction of the same staff will ensure that the literature reviews are conducted consistently and under the protocol developed for this activity.

STEP 5: Draft Papers on the Scientific Evidence

Following the literature reviews, papers would be developed for presentation to the Linkages Council. The papers would summarize the quality of the scientific evidence of effectiveness pertainint to particular community health practices. The evidence would be discussed. In addition, the papers would be disseminated to other interested parties, including state and local public health agencies, academic institutions, and other federal agencies. Based on the quality of the evidence, the Council would determine whether or not to proceed with development of guidelines.

STEP 6: Develop Community Health Practice Guidelines

CDC and the CDC PMRs could be called upon to develop practice guidelines based on the scientific evidence and the input of the Linkages Council. Once guidelines are drafted, they would be presented to the Council for discussion and potential revision. The draft guidelines would be disseminated to other players (health departments, academic institutions, federal agencies, etc.) for comment. After reviewing comments, revisions would be made and a final review would take place before the Linkages Council. The final guidelines would be disseminated to all state and local public health agencies and other interested parties.

COUNCIL ON LINKAGES BETWEEN ACADEMIA AND PUBLIC HEALTH PRACTICE

Conference Call Meeting Minutes

June 1, 1993

Members Present - John Arradondo (Chair), Lloyd Novick, Roy L. DeHart, Michel A. Ibrahim, Neil Sampson, William H. Wiese, C. William Keck

Staff Present - Ronald Bialek, Virginia B. Seyler, Sasikumar Vishwanath

Participants - Claude Hall, Mike Parkinson, Peggy Millson, Tom Bruce, Alex Ross, Robert Venenzia

I. Approval of Minutes

The meeting was called to order at 1:00 p.m. Minutes of the Council's last meeting held on February 8, 1993 were approved.

II. Nominations of Chair

Following this, Dr. Arradondo announced that as of November, he will no longer be Chair. He asked for nominations for a new Chair. Neil Sampson nominated Dr. Lloyd Novick. Dr. Roy L. DeHart proposed Dr. William H. Wiese. Dr. Wiese yielded to Dr. Novick. A motion was made to elect Dr. Novick as the new Chair of the Council on Linkages. His selection was approved by acclimation. Dr. Novick will assume the Chairmanship in November 1993.

III. Community Health Practice Guidelines Development

Ron Bialek briefed members on activities since the last meeting regarding this topic. Follow-up conversations have taken place with AHCPR and a meeting, sponsored by APHA, was held during Prevention '93. In addition, there have been two conference call meetings with some Council members to discuss specific practice guidelines that should be developed and a plan for the Council to pursue.

Staff developed a concept paper for the Council's involvement in community health practice guidelines development. The paper developed a protocol for the Council to pursue that would stimulate interest in guidelines development. The Council, assisted by CDC, HRSA, and others, would attempt to demonstrate the efficacy of community health practice guidelines development.

Neil Sampson pointed out that this guidelines development effort could be similar to the development of guidelines for clinical preventive services. Other agencies within the federal government, such as ODPHP, NIH, and AHCPR, would also become involved, i.e., ODPHP could serve an advisory role, while NIH would help with the research aspects.

Several members expressed concern that the Council does not possess the scientific expertise necessary for guidelines development. Dr. Arradondo stressed that our aim was to stimulate activity and to get "the ball rolling." While the Council could provide insight into topic areas to pursue and issues to consider, others would need to provide the scientific and methodological expertise.

Bill Wiese agreed that the Council should move forward in this effort. He suggested that a meeting be set up to discuss identifying the resources, and gaining a formal commitment from at least one federal agency.

Peggy Millson, a representative from the Canadian guidelines development project, was asked to explain how the Canadian project got started. She said that the initial project was funded out of the Deputy Secretary's office and was a joint effort of federal and provincial health agencies. Through the initial project, a generic protocol has been developed. However, now, the initiators have been replaced, and it is unclear whether the government will continue to support the project.

Tom Bruce raised a question about the scope of community health guidelines development. Mike Parkinson said that he envisioned guidelines of nine or ten activities that all local health departments do. The purpose of the guidelines development would be to find out if these functions hold up scientifically. Dr. Novick raised the point that we could cut the topics two different ways -- by functions (restaurant inspections, outbreak control) or issues (teen pregnancy prevention, child health). He feels that the issue topics, such as those laid out in the staff issue paper, are more exciting. Neil Sampson made the point that population-based public health services, such as restaurant inspections, are what need to be reviewed. Bill Wiese said that the Linkages Council should first concern itself with development of a sound methodology. Then the Council could lay out specific issues for guidelines development, potentially with the input of others.

John Arradondo said we should proceed with the agreed upon mission of the Council to act as a catalyst to set up the structure for guidelines development. He suggested the Council contact organizations and agencies beyond its membership. Once the appropriate players are brought to the table, the Council can shape

the discussion. Alex Ross suggested including Assistant Secretary Lee and Surgeon General Elders. The members were unanimous in agreeing to pursue Step 1 outlined in the protocol paper during the July 8, 1993 meeting from 10:00 a.m. to 4:00 p.m. in Baltimore.

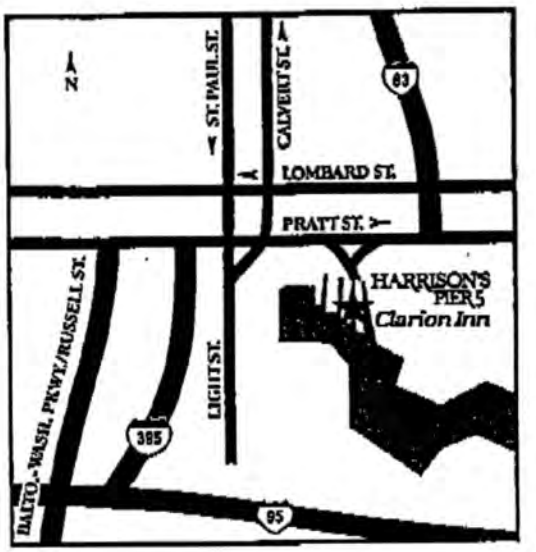
Other Business

Ron Bialek brought up the subject of a fax to all Council members requesting names of consultants in the area of substance abuse prevention. A private group, NOVA, approached him about involving the Council in guidelines development if the group won a grant award for from the National Center for Substance Abuse Prevention. Ron explained that NOVA wanted advice in specific areas but no formal commitment. Bill Wiese raised the point that these activities may be beyond the scope of the Council's mission. Roy DeHart agrees that this activity may distract the Council from its main goal. Ron Bialek said this would be an opportunity for the Council to be involved with development of a model which could build in academic-practitioner partnerships. Michel Ibrahim said that if it fits in with the Council's general approach, and does not draw from the energy base, the Council should pursue it. We should consider being involved in the components of the project consistent with practice guidelines development. There was general agreement with this statement.

Ron Bialek said that he will get back to NOVA with the names of potential consultants that were provided by Council members. These people will be contacted before they are written into any proposal.

The meeting ended at 3:30 p.m.

B A L T I M O R E, M D



HARRISON'S PIER 5
Clarion Inn
Clarion

711 Eastern Avenue
Baltimore, Maryland 21202
410-783-5553

Directions from Washington:

Take Baltimore-Washington Parkway (295N) into downtown Baltimore. Make a right turn onto Pratt Street. Keep straight. After passing the Aquarium (located on the right hand side of the street), make a right at President Street and another right at Eastern Avenue. Keep straight and make a left into the parking lot which is located next to the Hotel.

Table 18. HIV objective status

Objective	1989 baseline		1990	1991	Target 2000
	Original	Revised			
18.1 AIDS (number of diagnosed cases per year)	44,000-50,000	[1]48,400	52,900	[2]59,000	98,000
a. Gay and bisexual males	26,000–28,000	[1]27,800	27,900	[2]33,000	48,000
b. Blacks	14,000–15,000	[1]14,500	16,600	[2]19,000	37,000
c. Hispanics	7,000–8,000	[1]8,200	9,600	[2]11,000	18,000
18.2 HIV infection (per 100,000)	400		400	---	800
a. Homosexual males	2,000–42,000		---	---	20,000
b. Intravenous drug abusers	30,000–40,000		---	---	40,000
c. Females giving birth to live-born infants	150		150	---	100
18.3 Adolescents who ever had sexual intercourse					
Adolescents 15 years					
Females	[3]27%		[4]43%	---	15%
Males	[3]33%		[4]53%	---	15%
Adolescents 17 years					
Females	[3]50%		[5]67%	---	40%
Males	[3]66%		[5]76%	---	40%
18.4 Condom use at last sexual intercourse					
Sexually active unmarried females 15–44 years	[3]19%		---	---	50%
a. Sexually active females 15–19 years	[3]26%		[6]40%	---	60%
b. Sexually active males 15–19 years	[3]57%		[6]49%	---	75%
c. Intravenous drug abusers	---		---	---	60%
18.5 IV-drug abusers in treatment	11%		---	---	50%
18.6 IV-drug abusers using uncontaminated drug paraphernalia	[7]25–30%	[1,8]30.8%	---	---	50%
18.7 Risk of transfusion-transmitted HIV infection (units of blood)	1 per 40,000–150,000		---	1 per 225,000	1 per 250,000
18.8 Testing for HIV infection (HIV infected people)	15%		---	---	80%
18.9 Clinician counseling to prevent HIV and other sexually transmitted disease	[9]10%		---	---	75%
a. Providers practicing in high incidence areas	---		---	---	90%
18.10 HIV education in schools					
Students in grades 4th–12th	66%		---	---	95%
18.11 HIV education in colleges and universities	---		---	---	90%
18.12 Outreach programs for drug abusers (cities with populations greater than 100,000)	[8]35%		---	---	90%
18.13 Clinic services for HIV and other sexually transmitted diseases					
Family planning clinics	40%		---	---	50%
18.14 Occupational exposure to HIV	---		---	---	100%

[1]Data have been revised. Original data were estimated based on preliminary analysis; see Introduction.
[2]Estimated from first half of 1991.
[3]1988 data.
[4]10th grade students.
[5]12th grade students.
[6]9th–12th grade students.
[7]1989 data.
[8]1991 data.
[9]1987 data.

NOTE: Data sources are in table C.

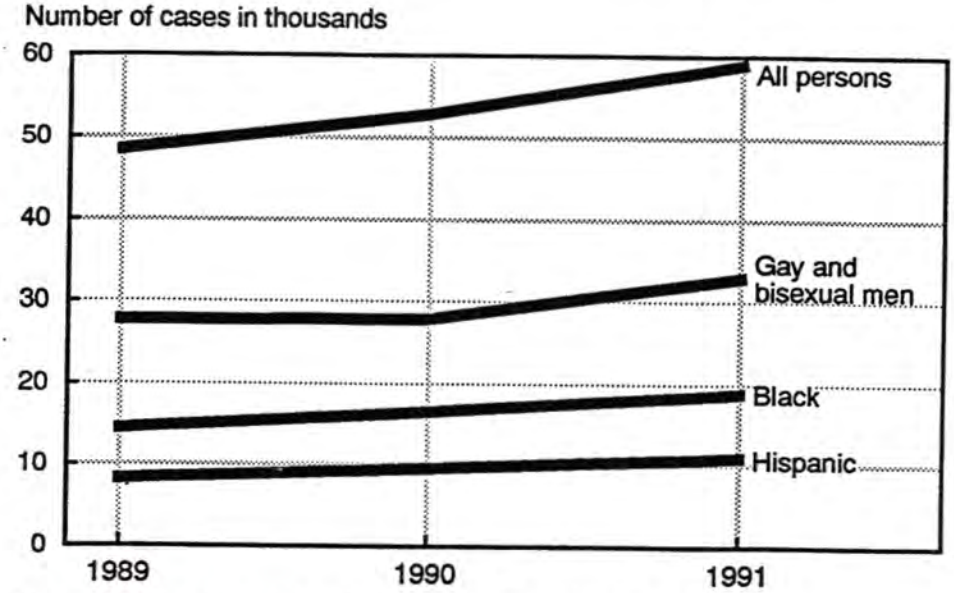
Priority Area 18
HIV Infection

Background and Data Summary

An estimated 1 million people in the United States are infected with the human immunodeficiency virus (HIV) (1). By the end of 1993, a projected total of 390,000 to 480,000 cases of AIDS will have been reported (1). This projection is based on the case definition in effect before January 1993. Although antimicrobial treatment extends survival, no treatment is yet available to prevent death among people with acquired immunodeficiency syndrome (AIDS). HIV and AIDS are a growing threat to the health of the nation and will continue to make major demands on health and social services systems for decades.

Data beyond baseline are available for 5 of the 14 objectives in this priority area. The first two objectives (18.1 and 18.2) aim to slow the rise in the number of AIDS cases and the prevalence of HIV infection. In 1991 the number of new AIDS cases reported was about 10 percent higher than the 1989 baseline figure (18.1). This pattern was similar for special population subgroups. At the current rate of increase, the number of cases for the total and special populations will exceed the year 2000 targets. The prevalence of HIV infection among the total population is still estimated at 400 per 100,000 people, showing no change from the baseline in 1989 (18.2). National data are not available regarding seroprevalence among men who have sex with men or among intravenous drug users. Data from the 1990 Youth Risk Behavior Survey on the history of sexual intercourse among adolescents show a worsening situation (18.3). The same survey shows the proportion of sexually active, teenage females whose partners used condoms at the last sexual intercourse (18.4a) increased since 1988, but a decrease in the proportion of sexually active, teenage males who use condoms (18.4b). Data for objective 18.7 on the risk of transfusion-transmitted HIV infection show an improvement toward the year 2000 goal. Recent data are available to establish a baseline for objective 18.12 on the proportion of cities with outreach programs to contact drug abusers and deliver HIV risk reduction messages.

Figure 23. Annual incidence of diagnosed AIDS cases: United States, 1989–91



NOTE: Related detailed tables in *Health, United States, 1992*, are 53–58.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Center for Infectious Diseases.

Data Issues

Definition

In January 1993 a new AIDS case definition was implemented for the AIDS Surveillance System (2). The new definition adds pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer to the list of diseases that indicate that AIDS has fully developed among HIV-infected people. In addition, the new definition includes HIV-infected people with a CD4 cell count below 200 cells per microliter of blood, regardless of whether those persons have opportunistic infections, neoplasms, or any other symptoms of HIV infection. This is expected to add 160,000 to the total number of diagnosed AIDS cases.

Data Source Description

Data on the annual number of diagnosed AIDS cases are available from the AIDS Surveillance System of the Centers for Disease Control. Completeness of reporting varies by geographic region and patient population. Recent research shows that the completeness of reporting was 92 percent for hospitalized patients diagnosed with AIDS through 1988 (3). The data for monitoring the objective are adjusted for delayed and incomplete reporting (1).

Data Availability

No national data are available that directly measure HIV seroprevalence among the general population or that provide nationally representative estimates for high risk groups such as men who have sex with men and intravenous drug users. Estimates of the prevalence of HIV infection in the U.S. population as a whole are based on mathematical

models using back calculation, a statistical method that estimates the number of prior HIV infections that would account for the number of AIDS cases that have subsequently occurred (1).

Information on the proportion infected among various high risk groups has been obtained from seroprevalence studies conducted in clinical settings as part of a sentinel surveillance system conducted by CDC in collaboration with State and local health departments (4). The surveillance system covers various clinical settings in selected metropolitan areas. Seroprevalence estimates for men who have sex with men are based on anonymous surveys conducted in sexually transmitted disease (STD) clinics. For intravenous drug users, estimates are based on surveys among drug users entering treatment programs. Clients attending STD clinics and drug treatment programs are not representative of all persons with these high risk behaviors. In addition, there is considerable geographic variation in seroprevalence in both groups. For these reasons, data are not presented here on HIV seroprevalence levels in high risk groups.

National estimates of the total number of intravenous drug users are needed to properly measure progress towards meeting objective 18.5, which addresses the proportion of intravenous drug users in treatment. Enumeration of intravenous drug users is difficult because of the illegality of the behavior. In addition, surveys such as the National Household Survey on Drug Abuse will miss an unknown proportion of intravenous drug users who are homeless, institutionalized, or difficult to locate. The 1991 National Household Survey on Drug Abuse estimated there were approximately one million people who had used needles to inject illicit drugs in the past year (5).

Comparability of Data Sources

The 1990 Youth Risk Behavior Survey (YRBS) provides the most recent information on the proportion of sexually active teenagers who used condoms during last sexual intercourse (18.4a and 18.4b). The YRBS is a school-based survey and so does not include teenagers who are

not in school and at higher risk. The data presented are for students in the 9th–12th grades; for most students, ages ranged from 14–17 years. These data are not directly comparable to the baseline, which shows condom use among young men and women aged 15–19 years.

Objective 18.3 (adolescent postponement of sexual intercourse) is discussed in priority area 5.

References

1. Centers for Disease Control. Estimates of HIV prevalence and projected AIDS cases: Summary of a workshop, October 31–November 1, 1989. MMWR 39: 110–19. 1990.

2. Centers for Disease Control. MMWR 40: 787. 1991.

3. Rosenblum L, Buehler JW, Morgan MW, et al. The completeness of AIDS case reporting, 1988: A multisite collaborative surveillance project. Am J Public Health 82: 1495–9. 1992.

4. Centers for Disease Control and Prevention. National HIV serosurveillance summary, vol 2. Results through 1990. No HIV/NCID/11–91/011. Atlanta, Georgia: U.S. Department of Health and Human Services. 1991.

5. National Institute on Drug Abuse. National Household Survey on Drug Abuse: Population estimates 1991. No (ADM)92–1887. Washington: U.S. Department of Health and Human Services. 1992.

HIV Infection Objectives

18.01: Confine annual incidence of diagnosed AIDS cases to no more than 98,000 cases.

NOTE: Targets for this objective are equal to upper bound estimates of the incidence of diagnosed AIDS cases projected for 1993.

18.01a: Confine annual incidence of diagnosed AIDS cases among gay and bisexual men to no more than 48,000 cases.

18.01b: Confine annual incidence of diagnosed AIDS cases among blacks to no more than 37,000 cases.

18.01c: Confine annual incidence of diagnosed AIDS cases among Hispanics to no more than 18,000 cases.

18.02: Confine the prevalence of HIV infection to no more than 800 per 100,000 people.

18.02a: Confine the prevalence of HIV infection among homosexual men to no more than 20,000 per 100,000 homosexual men.

18.02b: Confine the prevalence of HIV infection among intravenous drug abusers to no more than 40,000 per 100,000 intravenous drug abusers.

18.02c: Confine the prevalence of HIV infection among women giving birth to live-born infants to no more than 100 per 100,000.

18.03*: Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17.

Duplicate objectives: 05.04 and 19.09

18.04*: Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse.

NOTE: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.

Duplicate objective: 19.10

18.04a*: Increase to at least 60 percent the proportion of sexually active, unmarried young women aged 15–19 whose partners used a condom at last sexual intercourse.

Duplicate objective: 19.10a

18.04b*: Increase to at least 75 percent the proportion of sexually active, unmarried young men aged 15–19 who used a condom at last sexual intercourse.

Duplicate objective: 19.10b

18.04c*: Increase to at least 60 percent the proportion of intravenous drug abusers who used a condom at last sexual intercourse.

Duplicate objective: 19.10c

18.05: Increase to at least 50 percent the estimated proportion of all intravenous drug abusers who are in drug abuse treatment programs.

18.06: Increase to at least 50 percent the estimated proportion of intravenous drug abusers not in treatment who use only uncontaminated drug paraphernalia ("works").

18.07: Reduce to no more than 1 per 250,000 units of blood and blood components the risk of transfusion-transmitted HIV infection.

18.08: Increase to at least 80 percent the proportion of HIV-infected people who have been tested for HIV infection.

18.09*: Increase to at least 75 percent the proportion of primary care and mental health care providers who provide age-appropriate counseling on the prevention of HIV and other sexually transmitted diseases.

NOTE: Primary care providers include physicians, nurses, nurse practitioners, and physician assistants. Areas of high AIDS and sexually transmitted disease incidence are cities and States with incidence rates of AIDS cases, HIV seroprevalence, gonorrhea, or syphilis that are at least 25 percent above the national average.

Duplicate objective: 19.14

18.09a*: Increase to at least 90 percent the proportion of primary care and mental health care providers who practice in areas of high AIDS and sexually transmitted disease incidence, who provide age appropriate counseling on the prevention of HIV and other sexually transmitted diseases.

Duplicate objective: 19.14a

18.10: Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th–12th grade, preferably as part of quality school health education.

18.11: Provide HIV education for students and staff in at least 90 percent of colleges and universities.

18.12: Increase to at least 90 percent the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly intravenous drug abusers) to deliver HIV risk reduction messages.

NOTE: HIV risk reduction messages include messages about reducing or eliminating drug use, entering drug treatment, disinfection of injection equipment if still injecting drugs, and safer sex practices.

18.13*: Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia).

Duplicate objectives: 19.11 and 05.11

18.14: Extend to all facilities where workers are at risk for occupational transmission of HIV regulations to protect workers from exposure to blood borne infections, including HIV infection.

NOTE: The Occupational Safety and Health Administration (OSHA) is expected to issue regulations requiring worker protection from exposure to blood borne infections, including HIV, during 1991. Implementation of the OSHA regulations would satisfy this objective.

Attachment 2

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

Memorandum

Date MAR 18 1992

From Assistant Secretary for Health

Subject Follow-up to HIV Progress Review

To William L. Roper, M.D., M.P.H.
Director
Centers for Disease Control

Robert L. Trachtenberg
Acting Administrator
Alcohol, Drug Abuse, and Mental Health Administration

I wanted to take the opportunity presented by the HIV Progress Review to clarify the nature of Lead Agency responsibilities for HIV Infection, to ask that graphics making our intentions clear in the HIV Infection area be created and disseminated, and to ask that your staffs prepare an analysis of State budget cuts in essential HIV-prevention services (e.g., drug abuse prevention and treatment and sexually transmitted disease programs).

Lead Agency Responsibility

In the HIV Infection area it is important to clarify that the National AIDS Program Office (NAPO) is responsible for coordinating PHS efforts to halt the spread of HIV infection. Work to achieve the objectives should (and must) occur in the PHS agencies themselves. The agencies are responsible for PHS contributions to progress in achieving the *Healthy People 2000* HIV Infection objectives. Dr. Allen, through NAPO, is responsible for assuring that we have a coordinated, PHS-wide approach to achieving the objectives.

HIV Target/Graphics Issues

Due to the nature of the HIV and AIDS objectives (e.g., restraining growth in prevalence and incidence, rather than reducing prevalence and incidence from current levels), our Healthy People 2000 HIV Infection objectives give the impression that it is the goal of PHS to increase the occurrence of the disease. I would like graphics prepared that compare projected rates with our targets and illustrate our commitment to containing HIV infection.

These graphics should be disseminated to the agencies, organizations, and individuals who use the objectives in their work to prevent HIV.

Analysis of the Effect of State Budget Cuts

The Progress Review made it abundantly clear that reductions in State resources for HIV-related programs have serious implications for our ability to achieve the HIV Infection objectives. I would like to know the nature and extent of State budget cuts in this area. I would also like an analysis of the implications of these cuts. For example, can we quantify--even in rough terms--the relationship between drug treatment slots and risk reduction? Can we quantify the relationship between investments in STD programs and risk of HIV infection?

I would like this information as soon as reasonably possible, but certainly within two months.

Thank you for your attention to these matters. Thanks also for a constructive and productive Progress Review; the review helped to clarify our challenges and opportunities in preventing the spread of HIV infection.

James O. Mason

James O. Mason, M.D., Dr.P.H.

cc: Dr. James Allen

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

APR - 6 1993

TO: Debbie Maiese
Office of Disease Prevention and Health Promotion

THROUGH: Valerie P. Setlow, Ph.D.

SUBJECT: *Healthy People 2000* Status Report

Per Dr. Manley's note of March 19, please find attached the information requested.

Robert D. Moran
CDC Desk Officer
National AIDS Program Office

Attachment

Healthy People 2000 Status Report

PRIORITY AREA: HIV
LEAD AGENCY: National AIDS Program Office (NAPO)
CO-LEAD AGENCY: Not applicable

Who are your workgroup members (by name and organization)?

Public Health Service

Brownell, David F.	Office of the Associate Director, HIV/AIDS, Centers for Disease Control and Prevention (CDC)
Craft, Edwin	Office of Treatment Improvement, Substance Abuse and Mental Health Services Administration (SAMHSA)
Girasek, Deborah	Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health (OASH)
Klein, Richard	National Center for Health Statistics, CDC
Kotomori, Richard T.	Special Initiatives Branch, Indian Health Service (IHS)
Maccannon, Gerrie	Cross Cutting Initiatives, OMH
Messore, Johanne G.	National AIDS Program Office, OASH
Moran, Robert D.	National AIDS Program Office, OASH
Maise, Deborah	Office of Disease Prevention and Health Promotion, OASH
Pohl, Donald W.	Office of AIDS Coordinator, Food and Drug Administration (FDA)
Reck, Linda	Office of AIDS Research, National Institutes of Health (NIH)
Ross, Alex	Office of Health Planning and Evaluation, OASH
Schneider, Donald	Center for General Health Services and Extramural Research, Agency for Health Care Programs and Research (AHCPR)
Scholle, Robert	Office of Population Affairs, OASH
Weisman, Gloria	Bureau of Health Professions, Health Resources and Services Administration (HRSA)
Wilson, Ron W.	National Center for Health Statistics, CDC

Walker, John III Office of Minority Health, OASH

Other Department of Health and Human Services

Pine, Penny Office of Research and Demonstrations, Health Care Financing Administration (HCFA)

Smith, Elmer Medicaid Bureau, HCFA

Other Federal Governmental Departments

Handelman, Elise M. Directorate of Technical Support, Occupational Safety and Health Administration (OSHA)

What meetings have been held since January 1, 1992?

Month, Year	Group Meeting
1992	
January	NAPO Internal
	Presentation to PHS Executive Task Force
	Presentation to the Assistant Secretary for Health
February - June	NAPO Internal
July	Presentation to PHS Executive Task Force
	Full workgroup meeting
August	Presentation to PHS Executive Task Force
September	School-based prevention education subgroup meeting
	Individual behavior change subgroup meeting
October	Health care provider education subgroup meeting
November	Objective-specific (18.9) subgroup meeting
	Objective-specific (18.9) subgroup meeting
	Objective-specific (18.5 and 18.12) subgroup meeting
	Objective-specific (18.5 and 18.12) subgroup meeting

December Objective-specific (18.13) subgroup meeting

Health care provider education subgroup meeting

1993

January Health care provider education subgroup meeting

NAPO Internal

Presentation to PHS Executive Task Force

February Full workgroup meeting

Safety of the blood supply subgroup report

When is the next meeting scheduled?

No meetings are currently scheduled.

Is there a strategic plan?

Yes.

a. Is there a person/agency assigned to each objective?

Yes.

b. What barriers have been identified?

Barriers to attaining the *Healthy People 2000* objectives regarding the HIV epidemic are formidable. Below are listed, by objective, some of the barriers that have been identified by the workgroup and subgroups.

18.1 Confine annual incidence of diagnosed AIDS cases to no more than 98,000 cases.

a. Gay and bisexual men	No more than 48,000
b. Blacks	No more than 37,000
c. Hispanics	No more than 18,000

This is a disease indicator objective. Discussion of programmatic barriers and strategies is not relevant. Please see the discussion under objectives 18.3 through 18.14.

18.2 Confine the prevalence of HIV infection to no more than 800 per 100,000 people.

a. Homosexual men	No more than 20,000
b. Intravenous drug users	No more than 40,000
c. Women giving birth to	No more than 100

live-born infants

This is a disease indicator objective. Discussion of programmatic barriers and strategies is not relevant. Please see the discussion under objective 18.3 through 18.14.

18.3 Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17.

Because behaviors that result in HIV infection are often interrelated with other risk behaviors, and numerous cultural, social factors, they may require long-term intervention to change.

Clearance of explicit materials and materials targeting specific risk behaviors may be offensive to the community, local review panels, and policy makers.

18.4 Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse.

a.	Sexually active young women aged 15-19 (by their partners)	Increase to at least 60%
b.	Sexually active young men aged 15-19	Increase to at least 75%
c.	Intravenous drug abusers	Increase to at least 60%

An action, such as the use of a condom during the last sexual experience, is not an accurate measure of behavioral change.

Reduction in the risk for HIV transmission requires a long-term commitment to safe behavior. This may be difficult to maintain without continual reinforcement of the prevention message.

Some local and network television media are reluctant to air commercial advertising or public service announcements about condom use.

Opposition by some religious groups to the use of condoms or the promotion of their use contributes to the reluctance to advertise their use.

Governmental clearance procedures have produced phraseology that negates the promotional aspects of informational material and confuses the message.

Information and data about the effectiveness of condoms to prevent HIV transmission is often understated.

18.5 Increase to at least 50 percent the estimated proportion of all intravenous drug abusers who are in drug abuse treatment programs.

In communities with high HIV prevalence, there is often a shortage of drug treatment slots in general and a shortage of slots targeting women, pregnant women, and adolescents.

Drug treatment slots often lack ancillary services such as child care, transportation, and HIV education.

Inadequate training of drug abuse treatment staff.

High turnover of drug abuse treatment staff.

Lack of scientific knowledge to match clients with specific drug abuse treatment strategies.

Waiting lists for drug abuse treatment.

Limited reimbursement for drug abuse treatment.

Community outreach to drug users is a developing technology which often must be implemented in difficult or dangerous circumstances.

18.6 Increase to at least 50 percent the estimated proportion of intravenous drug abusers not in treatment who use only uncontaminated drug paraphernalia ("works").

The effectiveness of bleach as a disinfectant, especially in the circumstances of actual use, has been brought into question by recent reports in the literature and the media.

In many communities there is a strong belief that drug use cannot be tolerated and that providing the means to inject illegal drugs more safely will increase drug use.

There is a belief among many people that providing the means to inject illegal drugs more safely will send conflicting messages about the acceptability such practices, particularly to children.

Policy makers at local, state, and national levels have been reluctant to champion the cause of safe injection.

Rigorous data to answer the basic question--does the provision of mechanisms to make illegal injection safer--are not available.

It is illegal in many communities to purchase or possess injection equipment.

18.7 Reduce to no more than 1 per 250,000 units of blood and blood components the risk of transfusion-transmitted HIV infection.

Blood donation during the HIV "window period" which is after infection and prior to the ability of current technology to detect.

18.8 Increase to at least 80 percent the proportion of HIV-infected people who have been tested for HIV infection.

There are no mechanisms to directly measure the proportion of HIV seropositive people who know their antibody status.

Current estimates are that less than 50 percent of the people infected with HIV know their status.

18.9 Increase to at least 75 percent the proportion of primary care and mental health care providers who provide age-appropriate counseling on the prevention of HIV and other sexually transmitted diseases.

Inadequate coordination within and among Federal and State agencies and lack of coordination with the private sector.

Costs to modify data collection forms and difficulty of obtaining approval from the Office of Management and Budget for data collection.

Inadequate reimbursement for counseling services.

Limits funds and other resources for evaluation and travel.

18.10 Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education.

Availability and provision of education regarding HIV prevention and risk reduction, prevalent in the middle school years, falls off in grades 10, 11, and 12.

Data about HIV education in the schools may only pertain to public schools.

Federal government assistance to schools and other agencies serving youth may be hindered by concerns for maintaining the distinction between governmental and parental responsibilities.

Barriers listed under objective 18.3 also impede efforts to attain this objective.

18.11 Provide HIV education for students and staff in at least 90 percent of colleges and universities.

Surveys to collect data about HIV education in colleges and universities will not provide information about staff in these institutions as is required by the current wording of the relevant objective.

18.12 Increase to at least 90 percent the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers (particularly intravenous drug abusers) to deliver HIV risk reduction messages.

Inadequate information about effective outreach models.

Discrimination against or discomfort with injection drug users and outreach to them by traditional HIV prevention organizations.

Needs of specials populations; for example, women, adolescents, gay and bisexual men, racial and ethnic minority populations (such as Caribbean within "black"), are not adequately addressed.

Conflict between outreach to illegal users to discourage risky behavior and outreach to encourage drug abuse treatment.

Community reluctance--the not-in-my-backyard syndrome.

Several of the barriers listed under objective 18.5 also impede efforts to attain this objective.

18.13 Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia).

Inconsistency in Federal and State laws regarding HIV and STD infection reporting.

Categorical funding discourages collaboration and coordination.

Categorical funding streams are a disincentive to comprehensive health care.

Inadequate resources.

Inadequate and ineffective referral and follow-up systems, particularly among minority populations.

Fragmented health care planning leading to fragmented health care delivery.

Fragmented health delivery system results in some services being unavailable or inaccessible and inhibits effective referral.

Inability of some health care providers and substance abuse providers to comfortably address issues of sexuality.

Culture differences lead to ineffective STD and HIV risk assessment and risk reduction counseling.

Clients or patients exhibit poor attitudes toward risk reduction and have inadequate education regarding STD and HIV risk factors.

Inadequate community and provider support for offering STD and HIV services in drug treatment centers and tuberculosis, family planning, maternal and child health, and primary care clinics.

Attitudinal problems regarding sex education, sexual orientation, HIV, and STD among staff in drug treatment centers and tuberculosis, family planning, maternal and child health, and primary care clinics.

Drug treatment providers perceive other providers not to be receptive to their referrals.

STD clinics are often overcrowded and understaffed.

Historically, STD clinic staff have not had a continuing relationship with their clients and have not been trained in HIV-related issues such as crisis intervention and counseling.

18.14 Extend to all facilities where workers are at risk for occupational transmission of HIV regulations to protect workers from exposure to bloodborne infections, including HIV infection.

There are no identified barriers to the attainment of this objective. According to accompanying text in the original publication that established this objective for the year 2000, "The [OSHA] is expected to issue regulations requiring worker protection from exposure to bloodborne infections, including HIV, during 1991. Implementation of the OSHA regulations would

satisfy this objective." Those regulations have been issued and OSHA is monitoring compliance.

c. What successful programs models have been identified?

Expenditures in response to the epidemic by the PHS are in excess of $2 billion. Programs to achieve *Healthy People 2000* objectives are implemented throughout PHS, in conjunction with State and local governments and by a variety of community, regional, and national organizations. There are also many programmatic and individual efforts at the community level that are independent of PHS resources.

At the progress review presented to the Assistant Secretary for Health in January 1992, the HIV workgroup choose to highlight three models. These highlighted models included programs conducted under the auspices of the Association of State and Territorial Health Officials and the National Association of State Alcohol and Drug Abuse Directors, as well as PHS collaborations with the National Community AIDS Partnership.

The workgroup has not yet identified the programmatic models it would suggest be highlighted at a future progress review. Nonetheless, the workgroup has identified programmatic strategies that are making a contribution to all the *Healthy People 2000* objectives in the HIV arena. For the most part, the strategies that have been identified address the barriers that were described above.

Below are listed, by objective, the strategies identified by the workgroup that are being implemented or developed to attain the objectives. It is important to note that the information presented below represents workgroup deliberations. This information has not been officially cleared through the PHS agencies. (For the sake of brevity, the objectives listed above are not repeated below. They are simply referenced by their number.)

18.3

Develop, implement, and evaluate a social marketing program to prevent the sexual transmission of HIV and other STD among young people.

Support prevention research to develop, implement, and evaluate interventions designed to change risky behaviors.

Train peer educators to motivate behavioral changes.

Collaborate with *Healthy People 2000* workgroups charged with attainment of chapter 5 objectives (family planning objectives) and, particularly, chapter 19 objectives (sexually transmitted disease objectives--objective 18.3 is identical to objective 19.9.)

Attainment of *Healthy People 2000* objective 18.10 will significantly contribute to the attainment of this objective.

18.4

Develop, implement, and evaluate a national strategy to promote condom use in populations at greatest risk of HIV infection. Target program activities to young people.

Assist and support community efforts to distribute condoms and to provide counseling about condom use.

Assist and support community leadership and infrastructure for community based health education and risk reduction services.

Build effective partnership with the media.

Train peer educators to motivate behavioral change.

Train health care professionals, State officials, community leaders, and drug counselors in effective prevention strategies.

18.5

Expand treatment slots, particularly for women and adolescents.

Increase public knowledge about the requirements and effectiveness of drug abuse treatment.

Develop treatment programs more sensitive to the needs of clients.

Target populations most in need.

Increase research in the areas of medications development, cost effectiveness, client matching, and psychological therapies.

Expand and improve outreach to injecting drug users and include weekend or so-called "white collar" users in the target.

Educate service providers, particularly those in primary care, about how to identify substance abusers and provide care to them or refer them to care.

Improve coordination among outreach workers, the drug abuse treatment community, and primary care providers.

Improve mechanisms for disseminating research findings and the lessons learned from demonstration efforts.

Improve reimbursement for drug abuse treatment.

Improve the Federal government's efforts to provide or facilitate training and technical assistance to States and localities.

Evaluate community supported interventions; such as, needle exchange coupled with outreach, that are designed to reduce drug use and HIV transmission.

Improve coordination and collaboration among Federal agencies.

Attainment of *Healthy People 2000* objective 18.12 will significantly contribute to the attainment of this objective.

18.6

Increase the availability of "uncontaminated" drug injection equipment.

Increase effective decontamination of drug injection paraphernalia that has been used.

Continue and improve outreach programs to injecting drug users.

Build partnerships with State and local legislative bodies and law enforcement agencies.

Conduct and support research to identify the most effective methods for disinfecting drug paraphernalia.

Conduct and support research projects to develop, implement, and evaluate behavioral strategies to increase the use of uncontaminated equipment.

Disseminate critical information regarding the effectiveness of prevention strategies to communities, States, and national organizations.

Train health care professionals, state officials, community leaders, and drug counselors in effective prevention strategies to increase the use of uncontaminated drug paraphernalia.

Assess the effectiveness and side effects of strategies--such as, needle and syringe exchange--to make sterile equipment available to injecting drug users.

18.7

Continue to monitor seroprevalence rates in blood centers.

Continue partnerships with the American Red Cross.

Define and address issues related to pressure on employees to donate blood.

Reduce through information and education the number of people coming into blood centers for the primary purpose of being tested for HIV.

Ensure the availability of alternatives--such as, anonymous testing sites--for those who might be tempted to use blood centers for HIV testing.

Develop new processes for donor screening that address the distinct needs of first time donors and repeat donors.

Develop new processes for training blood center staff.

Develop and implement quality assurance guidance for blood establishments to decrease the number of errors and accidents.

Improve donor perception and understanding of high risk categories

18.8

Fund State and local health agencies to provide HIV counseling and testing services.

Provide guidance and encourage HIV testing in health care facilities, particularly hospitals, where the community or facility prevalence of HIV or AIDS indicates the likelihood of a significant yield.

Ensure that HIV testing includes pretest and post test counseling and that the testing services are linked with care services.

Ensure the availability of confidential and anonymous testing services.

Improve public education about counseling and testing services.

Train health care workers to evaluate client and patient risk and to provide counseling.

18.9

Continue provider education programs on HIV counseling with the AIDS Education and Training Centers, STD centers, family planning centers, pediatric AIDS programs, community and migrant health centers, mental health training program, IHS programs, and the organizations supported by the Ryan White CARE Act.

Collaborate with the Department of Defense, managed care groups, professional associations, and State and territorial health agencies to provide and improve HIV education provided by primary care and mental health care providers.

Identify and inventory existing training curricula and resources and disseminate this information to governmental and non-governmental providers.

Include questions on the National Ambulatory Medical Care Survey about the provision of HIV risk reduction counseling.

Implement demonstrations to test models and incentives for encouraging various health care providers to include HIV counseling services among the services they provide.

Ensure that Federal agencies that fund health service organizations include requirements that recipients provide age appropriate counseling about HIV and STD.

Build partnerships with health professional organizations and associations.

Collaborate with the *Healthy People 2000* workgroup charged with attainment of chapter 19 objectives (the sexually transmitted disease objectives--objective 18.9 is identical to objective 19.14).

18.10

Continue cooperative agreements with all States and several large cities to support a variety of HIV educational activities in the schools.

Improve HIV prevention education in the 10th, 11th, and 12th grades with specific objectives for these grades for States and cities receiving support for HIV educational activities in the schools.

Improve, as a part of a comprehensive health education strategy, age appropriate HIV education in each grade, kindergarten through the 12th grade.

Support and assist national organizations, State agencies, and communities (including parents) to develop locally acceptable HIV prevention and education approaches.

Conduct and support research projects to develop, implement, and evaluate educational strategies for HIV prevention.

Attainment of *Healthy People 2000* objective 18.3 will significantly contribute to the attainment of this objective.

18.11

Work with specified universities under contract to collect surrogate data relevant to this objective.

Work with specified universities under contract to form consortia to educate college students about HIV in the States with contracted universities.

Train school administrators and teachers to help implement effective HIV education programs.

Work with national associations to track the progress in attaining this objective.

18.12

Disseminate information on successful outreach programs.

Include a track on outreach in training activities; such as, the national minority conference to be sponsored by the Office of Minority Health.

Use assemblies of PHS grantees--such as regional and national conferences and consults--to train them and to elicit their advice on PHS programs and recipient needs.

Encourage more active involvement from single State drug agencies in outreach activities.

Expand and enhance outreach activities in rural and low prevalence areas.

Collaborate with national HIV organizations to include injecting drug use and outreach to drug users on their meeting and conference agenda.

Collaborate with the Ryan White CARE Act planning councils to encourage them to consider outreach in the continuum of care.

Coordinate the funding activities of the PHS agencies to produce a single funding stream into the communities implementing HIV prevention activities.

Assess program models that combine needle and syringe exchange with outreach as a mechanism to increase and improve outreach efforts.

Collaborate or contract to assess the quality and coverage of outreach programs.

Disseminate critical information regarding effective prevention strategies to communities, States, and national organizations.

Train health care professionals, State officials, community leaders, and drug counselors in effective prevention strategies for drug users.

Attainment of *Healthy People 2000* objective 18.5 will significantly contribute to the attainment of this objective.

18.13

Develop and implement programs designed to teach new and existing public health clinic staff about HIV and STD infection related areas.

Develop community-wide coalitions to integrate STD and HIV infection related services into all health care sites where people at high risk are likely to be seen.

Develop, implement, and improve client case management, referral, and follow-up systems using approaches such as peer support.

Train health care providers regarding human sexuality awareness and cultural sensitivity.

Foster and improve collaboration among Federal, State, and local agencies that fund health promotion, disease prevention, and treatment services.

Train health care providers in STD and HIV risk assessment and risk reduction counseling.

Foster community-wide planning, coordination, and collaboration to maximize the availability, accessibility, and use of STD and HIV infection related services.

Promote the establishment of formal and informal linkages between specialty clinics and STD, HIV services.

Expand the capacity of primary care providers to respond to STD and HIV infection related health care needs.

Develop standards of care in family planning, maternal and child health, and primary care clinics that include provisions to screen, diagnose, treat, counsel, and provide or refer to partner notification services for HIV and STD infected clients.

Train family planning, maternal and child health, and primary care providers to provide or successfully refer clients to HIV and STD services.

Provide incentives to family planning, maternal and child health, and primary care clinics to build or expand their current capacity to include STD and HIV services.

Foster collaboration between State and local health departments in developing systems of care that include STD and HIV services at public and not-for-profit family planning, maternal and child health, and primary care clinics.

Fund demonstration pilot projects that link family planning, maternal and child health, and primary care services to HIV and STD services.

Incorporate this *Healthy People 2000* objective into the program guidance for family planning, maternal and child health, and primary care clinics.

Gather and disseminate data and findings (lessons learned) from pilot demonstration projects that link HIV, STD services to family planning, maternal and child health, and primary care services.

Provide training and assistance to family planning, maternal and child health, and primary care clinics for the development and implementation of HIV and STD services.

Coordinate family planning, maternal and child health, and primary care funding streams to provide comprehensive health care that includes HIV and STD services.

Improve the ability of private sector family planning, maternal and child health, and primary care clinics to obtain public and private funding to provide HIV and STD services.

Form collaborative relationships with agencies and institutions in planning for community service to facilitate systems development for family planning, maternal and child health, primary care, and STD, HIV services at the community level.

Implement case management at family planning, maternal and child health, and primary care clinics to facilitate referral and tracking of patients to specialty clinics.

Implement a data system to link records between STD, HIV clinics and family planning, maternal and child health, and primary care clinics without compromising confidentiality.

Foster the linkage among TB clinics, drug abuse treatment centers, and clinics offering STD and HIV services.

Expand the capacity of primary care clinics to diagnose and screen for substance abuse and expand the capacity of substance abuse treatment clinics to provide primary care.

Incorporate this *Healthy People 2000* objective into program guidance for substance abuse block grants.

Expand the capacity of STD clinics to provide long term care for HIV-infected people.

Expand the capacity of STD clinics to provide case management, referral, and follow-up services to people dually infected with HIV and STD.

Link the efforts of STD clinics to primary care facilities providing HIV services.

Expand the capacity of STD clinics to offer partner notification services confidentially to all people tested for HIV and for the full range of STD.

Collaborate with the *Healthy People 2000* workgroup charged with attainment of chapter 5 objectives (the family planning objectives--objective 18.13 is identical to objective 5.11).

18.14

The OSHA will continue to monitor compliance with its regulations.

d. Is there a defined PHS-wide strategy? Please describe.

It is unclear, if the information desired is a description of the strategy implemented to monitor attainment of the objectives or

the strategy used to attain the objective. The strategy to monitor the objectives is as follows:

The *Healthy People 2000* workgroup for the HIV objectives is a subgroup to the *PHS Executive Task Force on AIDS*. Task Force membership includes AIDS coordinators from all PHS agencies as well as all PHS operational staff offices. In addition, many of the Department components with an HIV mission are represented on the Task Force.

The *Healthy People 2000* workgroup has created six subgroups to address clusters of related objectives. These subgroups address the following areas, individual behavior change, health care provider education, school based prevention education, surveillance, and the safety of the blood supply. One of those subgroups, the health care provider education group, has further divided into three additional subgroups. Therefore, for the 14 HIV *Healthy People 2000* objectives there are nine subgroups.

These nine subgroups are chaired by the PHS agency or office that has been designated to be the lead for the specific objective or objectives addressed by the subgroup. Membership on these subgroups is determined by the respective chairs. This membership includes people who serve on the overall workgroup when their agency or office has a mission in the specific objectives. Membership also includes people who are not members of the overall workgroup, including people from the consortia. The PHS Office of Disease Prevention and Health Promotion and the National AIDS Program Office participate on all the subgroups.

The strategies to attain each of the objectives are described in response to subpart "c" of this question. In addition to the specific strategies described in subpart "c," NAPO has developed, *The Public Health Service Strategic Plan to Combat HIV & AIDS in the United States*. This plan, however, is not limited to the objectives described in the *Healthy People 2000* project. It addresses the broad spectrum of activities implemented and facilitated by PHS in response to the epidemic. Throughout the plan, *Healthy People 2000* objectives are cross referenced whenever it is appropriate. This is particularly apparent in the chapter on Risk Assessment and Prevention.

The agencies of the Public Health Service have also developed strategic plans for their mission in the epidemic. Most relevant to the goals of the *Healthy People 2000* project are the plans developed by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration. The SAMHSA plan is currently under development.

e. Are minority health issues addressed for each objective as appropriate?

The short answer is, yes. However, this is an issue the workgroup and NAPO have recently begun to look at in more depth.

Almost without exception, the strategies described above target those who are infected or who are at elevated risk for infection. Because the epidemic disproportionally impacts upon minorities, the PHS response includes many minority initiatives. It is not clear, however, that the workgroup has the information to monitor the minority population cited in the *Healthy People 2000* objectives. At its meeting in February 1993, the workgroup determined that it must and will look at this issue and make recommendations.

Recent reports from the National Commission on AIDS (*The Challenge of HIV/AIDS in Communities of Color*, January 1993) and the National Research Council (*The Social Impact of AIDS in the United States*, February 1993) have added considerable visibility and urgency to the issue HIV in minority communities. The NAPO is in the process of examining all the PHS, HIV efforts directed toward minorities in the light of these reports and in the light of the recommendations made by the National Commission it its report. This effort should be concluded this spring.

Have data sources been identified for all objectives?

No. Also, data that are available are not always completed, or they may not fit the rigors of the stated objective.

Objective 18.4 is an example of incompleteness. The objective targets condom use among sexually active, unmarried people. Data that are available describe unmarried women 15 to 44 years of age. One of the subobjectives to 18.4 targets intravenous drug users. Those data are not available at all.

Objective 18.10 is an example of an improper fit. The objective is to ensure the provision of HIV education in a <u>proportion of schools</u>, but data regarding HIV education are available only by <u>school district</u>.

a. Have baseline data been identified for all objectives?

No. For objective 18.11 (HIV education for students and staff in colleges and universities) data will not be available until 1995. There are no data about the use of condoms among injecting drug users (objective 18.4c), clinicians in high risk areas who provide counseling for HIV and STD (objective 18.9a), HIV education in colleges and universities (objective 18.11),

outreach programs for drug abusers in the majority of cities with populations greater than 100,000 (objective 18.12), and occupational exposure to HIV (objective 18.14).

c. What special efforts will be required to assure our ability to track progress?

The status of data for the HIV *Healthy People 2000* objectives is as follows:

18.1

A surveillance system for AIDS cases exists. Its findings are published quarterly.

18.2

Infection with HIV is not reportable in more than half the States. States where it is reportable, are relatively low prevalence States. Discussion and evolution of policy on HIV reporting is ongoing.

In the meantime, annual surveys are conducted in designated subgroups of the population. These surveys provide information on the levels and trends of HIV infection in various local populations at potential risk, including the populations targeted by the *Healthy People 2000* objectives. Dissemination of the findings from these surveys is often delayed. Currently information is available through 1990.

18.3

Data for this objective are available from a variety of sources. These include a survey conducted by the National Center for Health Statistics (NCHS), the National Survey of Family Growth, which collects data only from females. It also includes a survey conducted by NIH, the Survey of Adolescent Males, which may not be repeated.

NCHS is exploring the possibility of including questions about sexual behavior on the National Health Interview Survey beginning in 1994.

Relevant data are obtained from the Youth Risk Behavior Survey. This is a biennial telephone survey conducted by CDC on a national sample.

18.4

Data for the overall objective are from the National Survey of Family Growth.

Data for subobjective "a" are also from the National Survey of Family Growth; but the update information for this subobjective will come from the Youth Risk Behavior Survey.

Baseline data for subobjective "b" are from the National Survey of Adolescent Males; and update information will come from the Youth Risk Behavior Survey.

No source of data for subobjective "c" has been identified.

18.5

The 1991 National Household Survey estimates 1.83 million injection drug users in the United States in 1990; 12.4 percent received drug abuse treatment in a drug treatment facility or in a mental health facility. A survey by the National Association of State Alcohol and Drug Abuse Directors estimates 1.14 million injecting drug uses with 13.6 percent admitted to treatment.

Data for updates is expected to come from SAMHSA.

18.6

Data will come from the National AIDS Demonstration Research Program conducted under the auspices of NIH.

18.7

Studies estimate the risk of becoming infected with HIV from a blood transfusion screened as negative for HIV antibody have been conducted. Estimates range from one in 38,000 to one in 300,000.

Data for updates will come from CDC and the American Red Cross.

18.8

Data will come from the HIV Counseling and Testing Data Sites System maintained by CDC. These data are from public sites, while the objective targets all HIV infected people.

18.9

Baseline data were taken from the Primary Care Physician Survey of Sexual History-Taking and Counseling Practices that was published in the Western Journal of Medicine in 1987.

Updates will come from national surveys that include questions on provider practices on counseling about HIV and STD. Although there are several surveys which will be used to measure progress, two are of particular interest to the subgroup. The first is the Primary Care Providers Survey conducted by the Office of Disease Prevention and Health Promotion. This survey has just recently concluded, and it will be repeated about midway through the decade and again at the end of the period. Data from this survey will also be used to measure subobjective "a."

The second survey of particular interest is the periodic *National Medical Care Survey* conducted by the National Center for Health Statistics.

Data are also available from program sources. The subgroup is currently in the process of obtaining reports about information that can be gleaned from these sources.

18.10

There is a biennial survey conducted with the nation's 16,000 school districts to survey them for HIV prevention education conducted in grades kindergarten through 12. The subgroup suggests that the *Healthy People 2000* objective be rewritten so that this data source can be used for tracking.

18.11

The National Youth Risk Behavior Survey to be conducted by CDC in 1995 and repeated in 1999 can be used to measure HIV education for students, but not for staff. The subgroup suggests that word "staff" be dropped from this objective.

The American College Health Association is planning to conduct a survey which may be useful in updating attainment levels.

18.12

There are 195 cities targeted by this objective. Data are available from 63 (or 32%) of them. The sources of these data are PHS agencies.

18.13

The Office of Population Affairs will implement a national questionnaire on the provision of STD and HIV services by family planning clinics.

There are no identified sources for data about other clinics targeted by this objective.

18.14

Although data are not currently available for this objective, it is essentially achieved. With regulations in place, OSHA has begun to monitor compliance as a part of its inspection procedures.

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HIV Objectives by Agency Responsibility

Number	Objective	Lead Agency	Contributing Agency
18.1	Confine annual incidence of diagnosed AIDS cases to no more than 98,000 cases.	Centers for Disease Control	
18.2	Confine the prevalence of HIV infection to no more than 800 per 100,000 people.	Centers for Disease Control	
18.3	Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15% by age 15 and nor more than 40% by age 17.	Office of Population Affairs	Centers for Disease Control
18.4	Increase to at least 50% the proportion of sexually active, unmarried people who used a condom at last sexual intercourse.	Office of Population Affairs	Alcohol, Drug Abuse and Mental Health Administration; Centers for Disease Control; Food and Drug Administration
18.5	Increase to at lease 50% the estimated proportion of all IVDUs who are in drug abuse treatment programs.	Alcohol, Drug Abuse and Mental Health Administration	Centers for Disease Control
18.6	Increase to at least 50% the estimated proportion of IVDUs not in treatment who only use uncontaminated "works."	Alcohol, Drug Abuse and Mental Health Administration	Centers for Disease Control
18.7	Reduce to no more than 1 per 250,000 units of blood and blood components the risk of transfusion-transmitted HIV infection.	Food and Drug Administration	National Institutes of Health
18.8	Increase to at least 80% the proportion of HIV infected people who have been tested for HIV infection.	Centers for Disease Control	Health Resources and Services Administration

18.9	Increase to at least 75% the proportion of primary care and mental health care providers who provide age appropriate counseling on the prevention of HIV and other STDs.	Health Resources and Services Administration	Alcohol, Drug Abuse and Mental Health Administration; Centers for Disease Control
18.10	Increase to at least 95% of the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education.	Centers for Disease Control	
18.11	Provide HIV education for students and staff in at least 90% of colleges and universities.	Centers for Disease Control	
18.12	Increase to at least 90% the proportion of cities with populations over 100,000 that have outreach programs to contact drug abusers to deliver HIV risk reduction messages.	Centers for Disease Control	Alcohol, Drug Abuse dna Mental Health Administration; Health Resources and Services Administration
18.13	Increase to at least 50% the proportion of family planning clinics, maternal and child health clinics, STD clinics, TB clinics, drug treatment centers, and primary care clinics that screen, diagnose, treat, counsel, and provide partner notification services for HIV and bacterial STDs.	Centers for Disease Control	Alcohol, Drug Abuse dna Mental Health Administration; Health Resources and Services Administration; Office of Population Affairs
18.14	Extend to all facilities where workers are at risk for occupational transmission of HIV regulations to protect workers from exposure to bloodborne infections, including HIV infection.	Occupational Safety and Health Administration	National Institutes of Health; Centers for Disease Control

INTERGOVERNMENTAL
AIDS REPORTS

STATE FUNDING, FY 1992: SPENDING IS UP NATIONWIDE, BUT EFFORTS FAIL TO KEEP PACE WITH GROWING CASELOAD

Results of the annual survey of state HIV/AIDS expenditures, released by IHPP's AIDS Policy Center (APC) in early May, indicate that spending to combat the disease continues to rise: $401.9 million in state funds (excluding Medicaid) were allocated in FY 1992, up 22 percent over the FY 1991 level of $330.7 million. The increase comes, moreover, at a time when the slow economy has forced severe budget cutbacks for many other state-supported programs.

Nonetheless, state spending has not kept pace with the rapidly escalating number of AIDS cases. In FY 1992 alone, caseload growth was estimated at 26 percent. Statistics from the federal Centers for Disease Control and Prevention (CDC) reveal that at least 111 Americans are infected with HIV each day, and agency officials project that by the end of 1994, the cumulative caseload in the U.S. will total between 415,000 and 535,000.

GETTING THE NUMBERS

Each year since 1986, the AIDS Policy Center has conducted a survey of state funds devoted to HIV/AIDS programs and services. The information allows the Center to maintain a database to identify and analyze trends in the use of state funds to combat the disease.

Again in 1992, APC collected non-Medicaid expenditure information from all 50 states and the **District of Columbia** across six program areas: 1) Education, Information and Prevention; 2) Testing and Counseling; 3) Research; 4) Surveillance; 5) Health Care and Support Services; and 6) Administrative Activities. This year, however, a seventh reporting category—*Federal Funding*—was added to measure the states' use of federal dollars under the Ryan White CARE Act.

Though APC's survey collects similar information each year, occasional improvements are made in the tool used to gather the data. >>>

The most recent survey of the 50 states and the District of Columbia, covering FY 1992, was made possible by a grant from the George Gund Foundation. The National AIDS Program Office provided additional support for initial phases of the survey.

SPECIAL ISSUE

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The FY 1992 questionnaire is a case in point. In addition to simplifying the format and clarifying the wording of some questions, APC researchers requested more detailed information on how state spending targets specific populations (e.g., adolescents or women). Only a few of the returned surveys, however, were able to respond on such a detailed level.

Respondents were also asked to report the level of federal funds used by their state for each of the six program areas.

Finally, two reporting categories were broadened somewhat: Category 1, *Education and Information*, now includes a sub-area on prevention initiatives, including needle exchange and condom distribution programs. Category 5, *Health Care and Support Services*, introduces a sub-area on financial assistance with private health insurance premiums.

CAVEATS

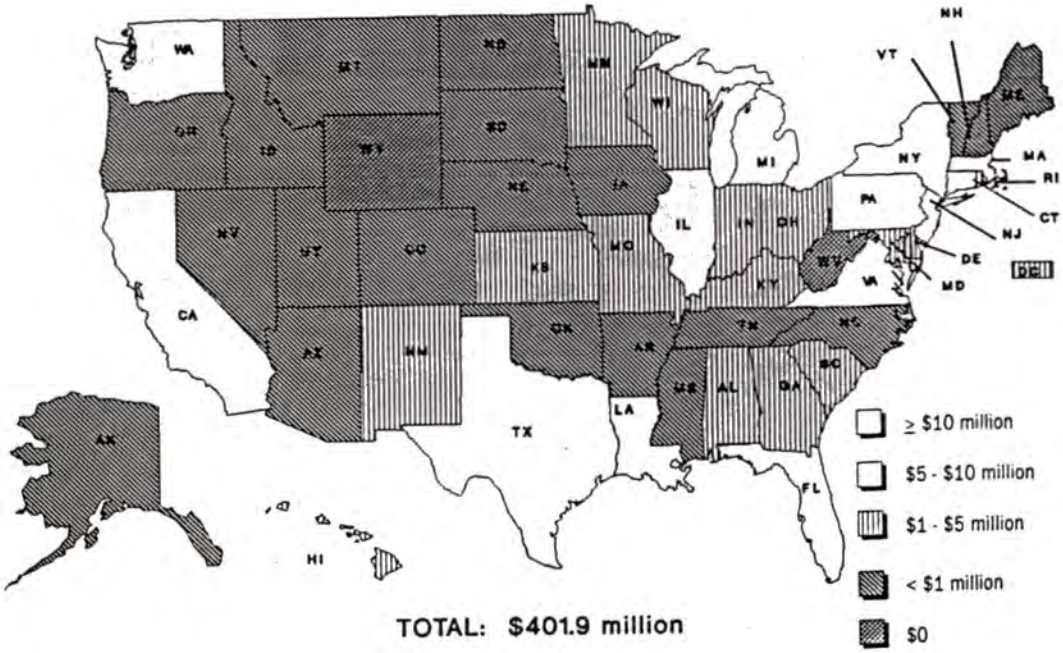
Obtaining accurate data on state HIV/AIDS expenditures is difficult for the following reasons:

- HIV/AIDS services are often integrated with existing programs for substance abuse, sexually transmitted diseases, family planning and child health;
- In most cases, funds for special projects such as those conducted at state and private universities have not been reported by the states;
- Variations in both the structure and administration of state HIV/AIDS programs make it difficult to isolate dollar amounts within the survey's different program categories; and
- Fiscal years vary across the states, despite the FY 1992 label on the data.

EXHIBIT 1
STATE HIV/AIDS FUNDS BY STATE FY 1992

On average, states spent $7.9 million on HIV/AIDS programs during FY 1992. The average is skewed upwards by a few states with high AIDS caseloads such as **California** and **New York,** which by themselves account for 48 percent of total spending. Each of nine states—**California, Florida, Illinois, Louisiana, Massachusetts, New Jersey, New York, Texas, Washington**—reported spending $10 million or more on HIV/AIDS programs. In addition to providing high levels of funds, those states also share the top spots for highest cumulative AIDS caseloads. *(See Exhibit 10.)*

In FY 1991, six states reported that they had spent none of their own funds on HIV/AIDS. This year, only two—**West Virginia** and **Wyoming**—fell into that category, most likely a reflection of their very low caseloads (297 and 58 respectively as of December 1992). Both rely exclusively on federal appropriations to support their HIV/AIDS programs and services.



TOTAL: $401.9 million

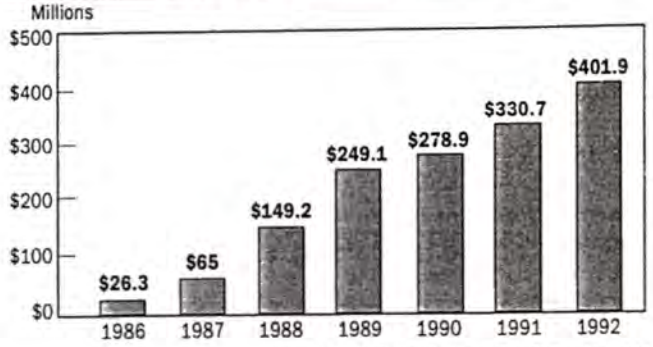
Source: AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, May 1993

WHERE THE DOLLARS HAVE GONE: TRENDS, 1986 - 1992

Collectively, the states reported total HIV/AIDS funds for FY 1992 of $401.9 million, up roughly 20 percent over the FY 1991 total of $330.7 million. (*See Exhibit 1, at left.*) Over the seven-year period covered by the Center's database, the state treasuries have appropriated a total of $1.5 billion for HIV/AIDS programs and services. That figure demonstrates a concerted and continually intensifying effort to fight the epidemic.

EXHIBIT 2
TOTAL STATE-ONLY SPENDING, FY 1986-1992

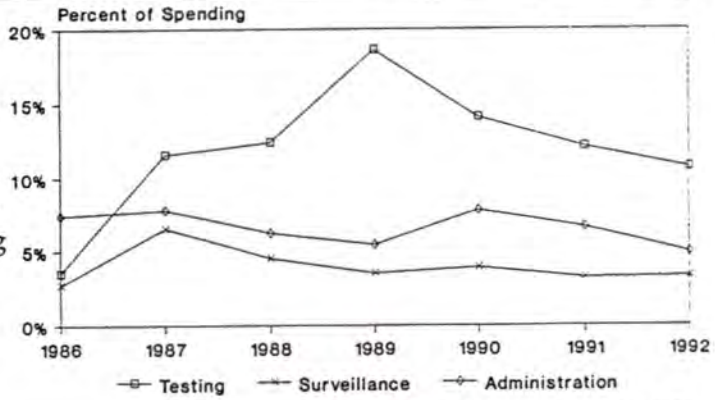
State funds for HIV/AIDS programs have increased steadily throughout the years as cases of AIDS have increased. The largest annual jump, of 67 percent, occurred between FY 1988 and FY 1989, coinciding with increasing public awareness of the growing health threat.



Source: AIDS Policy Center, IHPP, GWU, May 1993

EXHIBIT 3
SHARE OF STATE-ONLY SPENDING FOR TESTING, ADMINISTRATION & SURVEILLANCE, ('86-'92)

State funds in the testing and counseling category peaked in 1989 and have dropped steadily since, as the CDC assumed greater financial responsibility for testing through its HIV Prevention Cooperative Agreement grants to the states.



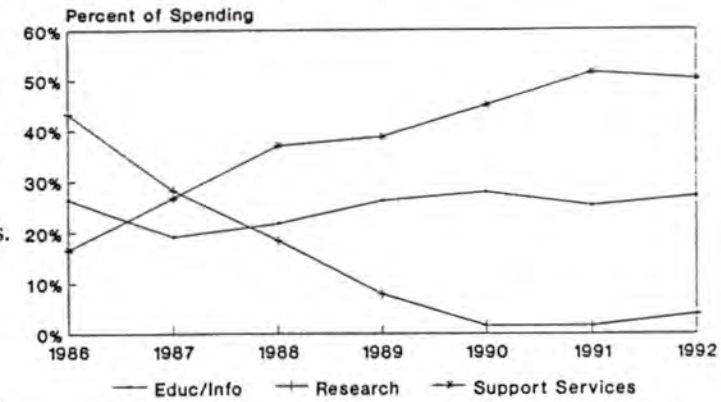
Source: AIDS Policy Center, IHPP, GWU, May 1993

EXHIBIT 4
SHARE OF STATE-ONLY SPENDING FOR EDUCATION, RESEARCH & SUPPORT ('86-'92)

Although research dollars were at a high in 1986, state funds in that category have fallen sharply—the result of the more prominent federal role in appropriating and coordinating research efforts nationally. The funds leveled off between 1990 and 1991; the slight increase in 1992 reflects a large project in **California**, where nearly $12.5 million supported a variety of research studies.

In contrast, state dollars for health care/support services have increased, in response to the escalating numbers of people with HIV disease in need of such services. Improved availability of early intervention drug therapies such as Pentamidine, AZT and ddI that prolong the lives of HIV-positive individuals has also had a major impact on demands for health care services.

Compared to the categories of research and health care/support services, state dollars for education/information have remained fairly constant as the CDC administered prevention grant funding to the states. There could be a change in the pattern of state funds in this category in future years, however. In November 1992, the CDC notified state officials of a 7 percent reduction in HIV Prevention Cooperative Agreements over FY 1992 levels and said that almost all states will receive fewer funds again in FY 93. The decrease stems from congressional mandates that diverted $5 million from state and local HIV prevention programs to similar efforts by minority organizations. Whether states raise their outlays in FY 1993 to compensate for the decrease in federal dollars is an area to watch in the future.

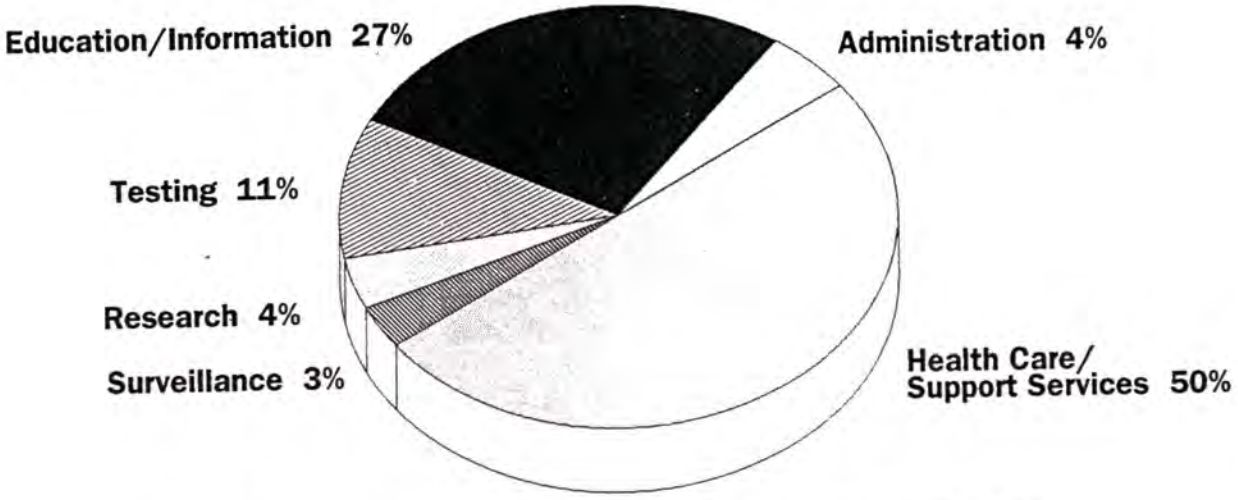


Source: AIDS Policy Center, IHPP, GWU, May 1993

EXHIBIT 5
STATE AIDS SPENDING BY CATEGORY, FY 1992

Though FY 1992 total spending represents an increase over the previous year, the distribution of dollars across six program categories remained roughly the same as in FY 1991. Exhibit 1 indicates that, by and large, a majority of state funds go to treatment and direct services. For example, Health Care/Support Services, the single largest category, still commands about half of all state HIV/AIDS expenditures. Education/Information commands another quarter of the available state dollars. Though down substantially from the 1989 peak of 19 percent, Testing/Counseling rounds out the top three at 10 percent of total spending. Surveillance funds remained most constant over the seven-year period at slightly below 4 percent. Research has become almost exclusively a federal effort. Only 4.9 percent of state only funds went to Administrative Activities—evidence that states concentrate their dollars on programs and services rather than overhead.

Overall, the results of the FY 1992 survey reveal that states are balancing their HIV/AIDS expenditures almost evenly between prevention efforts—included in Education, Testing/Counseling and Surveillance—and treatment services.



Source: AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, May 1993

EXHIBIT 6
SPENDING BREAKDOWN OF HEALTH CARE/SUPPORT SERVICES CATEGORY

Health care/support services account for the lion's share of state spending—a full 50 percent. This follows the trend established during FY 1990 and 1991. And, as might be expected, the largest slice (39 percent) of the category of health care/support service funds went to outpatient and home care programs.

Surprisingly, one of the largest portions of funds (27 percent) went to institutional care such as in juvenile, correctional, and mental health facilities. The fact is particularly significant because only 18 states were able to identify such expenditures, suggesting that HIV/AIDS health care, particularly in prisons, has become a major component of state budgets. Another major expenditure category was HIV/AIDS drug assistance programs, which received 14 percent of states' funds. Some states have found that advances in drug therapies, although prolonging life, have increased total HIV-related health care costs.

In the April 1993 issue of *The AIDS Reference Guide*, for example, Cornelis Reitmeijer, M.D. of the Denver Department of Health and Hospitals, reported that 40 percent of total HIV health care charges were incurred by both inpatient and outpatient care for people with asymptomatic and symptomatic HIV infection who do not meet the definition of full blow AIDS. Reitmeijer said he expects that total costs will continue to soar as new HIV/AIDS treatments become available and more people with HIV require treatment.

Insurance Premiums	1%
Mental Health	1%
Hospitals	2%
Consortia	5%
Pediatric Care	5%
Living Support	8%
Drug Assistance	11%
Case Mgmt.	11%
Institutions	27%
Outpatient Care	29%

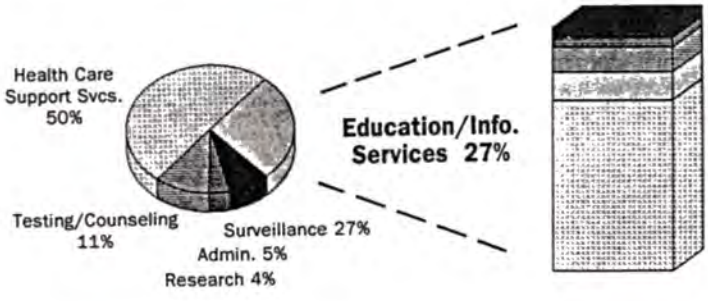
EXHIBIT 6A
THE TEN STATES THAT SPEND THE MOST ON HEALTH CARE/ SUPPORT SERVICES

	State	Amount	% of Total State $$
1	New York	$54.5M	54%
2	California	$24.0M	26%
3	New Jersey	$20.4M	74%
4	Louisiana	$19.4M	97%
5	Florida	$18.3M	79%
6	Illinois	$10.2M	73%
7	Texas	$9.5M	76%
8	Pennsylvania	$5.1M	55%
9	Washington	$4.6M	43%
10	Connecticut	$4.2M	48%

Source: AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, May 1993

EXHIBIT 7
SPENDING BREAKDOWN OF EDUCATION/INFORMATION CATEGORY

Programs for Education/Information receive the second largest portion of total state funds. More than 70 percent of funds in that category were expended for education programs targeting minorities, gay and bisexual men, injection drug users, women of child bearing age, adolescents and prisoners. The percentage represents a slight increase over the 66 percent reported in FY 1991.



Prevention Programs	2%
Public Employees	2%
Public Schools	4%
Health Care Workers	10%
General Public	12%
Targeted	70%

EXHIBIT 7A
THE TEN STATES THAT SPEND THE MOST ON EDUCATION/ INFORMATION PROGRAMS

	State	Amount	% of Total State $$
1	California	$30.8M	33%
2	New York	$28.7M	28%
3	Massachusetts	$9.8M	52%
4	Washington	$4.2M	40%
5	Florida	$3.2M	14%
6	Connecticut	$2.7M	31%
7	Dist. of Columbia	$2.6M	63%
8	Pennsylvania	$2.5M	27%
9	Hawaii	$2.4M	38%
10	New Jersey	$2.3M	8%

Source: AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, May 1993

EXHIBIT 8
DISTRIBUTION OF STATE FUNDING FOR HIV/AIDS BY PROGRAM CATEGORY

States	Education Information	Testing Counseling	Research	Surveillance	Health Care/ Support Svcs.	Adminis-tration	TOTAL State Funds	Cumulative Cases 1992
Alabama	$270,500	$1,200,000	N/A	$55,000	$355,000	$106,000	$1,986,500	1,489
Alaska	$230,000	$223,800	$0	$0	$87,000	$18,400	$559,200	126
Arizona	$118,388	$0	$30,000	$155,292	$110,600	$0	$414,280	1,771
Arkansas	$2,800	$114,302	$0	$0	$0	$0	$117,102	749
California	$30,775,098	$13,840,000	$12,391,000	$5,085,000	$23,999,000	$6,594,000	$92,684,098	42,755
Colorado	$0	$0	$0	$48,000	$400,000	$20,000	$468,000	2,260
Connecticut	$2,662,891	$932,675	$0	$0	$4,185,952	$1,054,584	$8,836,102	2,628
Delaware	$0	$47,520	$0	$10,000	$1,218,795	$80,000	$1,356,315	463
D.C.	$2,579,237	$100,000	$0	$0	$1,090,162	$371,000	$4,140,399	3,819
Florida	$3,162,349	$1,230,378	$0	$287,660	$18,336,519	$262,906	$23,279,812	22,097
Georgia	$869,711	$482,827	$0	$0	$2,072,735	$87,500	$3,512,773	6,476
Hawaii	$2,403,559	$358,740	$0	$233,740	$2,798,678	$488,569	$6,283,286	896
Idaho	$0	$18,000	$0	$0	$0	$0	$18,000	127
Illinois	$1,964,847	$1,559,831	$0	$40,952	$10,174,629	$278,800	$14,019,059	7,153
Indiana	$197,497	$0	$0	$124,573	$1,100,000	$677,236	$2,099,306	1,563
Iowa	$0	$0	$0	$0	$60,000	$0	$60,000	362
Kansas *	$1,630,336	$131,854	$0	$756	$181,789	$58,520	$2,003,255	666
Kentucky	$453,000	$0	$4,000	$57,900	$600,000	$23,700	$1,138,600	775
Louisiana **	$386,465	$0	$0	$0	$19,385,700	$317,993	$20,090,159	3,460
Maine	$274,200	$0	$0	$0	$299,309	$129,000	$702,509	296
Maryland ***	$1,259,961	$0	$0	$323,011	$2,233,050	$373,827	$4,189,849	4,675
Mass.	$9,803,500	$186,972	$445,700	$169,777	$6,139,843	$1,968,654	$18,714,446	4,736
Michigan	$1,772,000	$1,609,00	$9,500	$0	$4,162,000	$510,000	$8,062,500	3,064
Minnesota	$1,273,323	$204,000	$0	$205,433	$727,500	$177,500	$2,587,756	1,151
Mississippi	$0	$174,069	$0	$0	$0	$0	$174,069	991
Missouri	$70,585	$88,907	$0	$93,765	$958,413	$109,381	$1,321,051	2,831
Montana	$19,749	$28,226	$0	$0	$30,600	$0	$78,575	96
Nebr. ****	$117,000	$0	$0	$0	$0	$20,000	$137,000	277
Nevada	$61,000	$30,000	$0	$36,000	$0	$0	$127,000	999
New Hamp.	$146,877	$0	$0	$13,463	$2,043	$56,208	$218,591	264
New Jersey	$2,312,000	$2,492,507	$222,327	$792,500	$20,389,122	$1,356,000	$27,564,456	13,786
New Mexico	$825,400	$5,800	$0	$91,250	$617,666	$211,366	$1,751,482	510
New York	$28,703,630	$10,639,802	$2,217,000	$3,002,640	$54,502,200	$2,163,828	$101,229,100	46,608
N. Carolina	$277,250	$120,750	$0	$219,000	$0	$0	$617,000	2,582
North Dakota	$0	$0	$0	$0	$20,000	$0	$20,000	25
Ohio	$1,823,000	$655,000	$0	$79,000	$1,267,000	$0	$3,824,000	3,296
Oklahoma	$79,925	$0	$0	$0	$326,000	$125,000	$530,925	1,050
Oregon	$633,737	$0	$0	$0	$0	$0	$633,737	1,423
Pennsylvania	$2,516,142	$1,062,000	$102,000	$70,891	$5,060,199	$450,000	$9,261,232	6,351
Rhode Island	$23,285	$406,925	$0	$32,193	$484,000	$75,794	$1,022,197	535
S. Carolina	$605,120	$1,541,431	$0	$503,636	$34,175	$0	$2,684,362	1,551
South Dakota	$250	$0	$0	$0	$0	$11,607	$11,857	34
Tennessee	$0	$0	$0	$0	$0	$175,000	$175,000	1,670
Texas	$1,250,000	$685,000	$0	$250,000	$9,545,643	$747,431	$12,478,074	15,929
Utah	$0	$49,040	$0	$64,504	$155,110	$117,530	$386,184	528
Vermont	$153,500	$0	$0	$12,056	$69,785	$0	$235,341	106
Virginia	$2,210,607	$1,225,988	$0	$1,013,422	$2,424,015	$74,415	$6,948,447	3,061
Washington	$4,152,666	$1,185,372	$189,746	$82,987	$4,558,345	$430,672	$10,599,788	3,080
West Virginia	$0	$0	$0	$0	$0	$0	$0	272
Wisconsin	$328,750	$475,000	$50,000	$145,000	$1,532,200	$11,250	$2,542,200	952
Wyoming	$0	$0	$0	$0	$0	$0	$0	55
TOTAL	$108,400,135	$43,105,716	$15,661,273	$13,299,401	$201,694,777	$19,733,671	$401,894,973	222,419

See key, next page, for notations. Source:AIDS Policy Center, Intergovernmental Health Policy Center, The George Washington University, May 1993

EXHIBIT 9
PER CAPITA SPENDING FOR PREVENTION MEASURES

A measure of preventive efforts is the combined expenditures for Education, Testing and Counseling and Surveillance. In FY 1992, average per capita spending for prevention was $0.65, a significant increase over the FY 1991 level of $0.51. The increase is somewhat misleading, however, because high per capita spending levels in a number of jurisdictions, including **D.C., Hawaii, California, New York** and **Massachusetts**, tend to skew the national average. Generally, per capita spending in the majority of the states is much lower than the national average.

While most of the states with high spending levels for prevention also have high reported AIDS caseloads, one state—**Hawaii**—does not. Thus, it will be important in years to come to track whether prevention initiatives there lead to significantly lower increases in HIV infection rates compared to states that spend less on prevention.

States	Total Prevention Spending	Per Capita
Alabama	$1,525,500	$0.37
Alaska	$453,800	$0.80
Arizona	$273,680	$0.07
Arkansas	$117,102	$0.05
California	$49,700,098	$1.64
Colorado	$48,000	$0.01
Connecticut	$3,595,566	$1.09
Delaware	$57,520	$0.08
D.C.	$2,679,237	$4.48
Florida	$4,680,387	$0.35
Georgia	$1,352,538	$0.20
Hawaii	$2,996,039	$2.64
Idaho	$18,000	$0.02
Illinois	$3,565,630	$0.31
Indiana	$322,070	$0.06
Iowa	$0	$0.00
Kansas *	$1,762,946	$0.71
Kentucky	$510,900	$0.14
Louisiana **	$386,465	$0.09
Maine	$274,200	$0.22
Maryland ***	$1,582,972	$0.33
Massachusetts	$10,160,249	$1.69
Michigan	$3,381,000	$0.36
Minnesota	$1,682,756	$0.38
Mississippi	$174,069	$0.07
Missouri	$253,257	$0.05
Montana	$47,975	$0.06
Nebraska ****	$117,000	$0.07
Nevada	$127,000	$0.10
New Hampshire	$160,340	$0.15
New Jersey	$5,597,007	$0.72
New Mexico	$922,450	$0.60
New York	$42,346,072	$2.35
North Carolina	$617,000	$0.09
North Dakota	$0	$0.00
Ohio	$2,557,000	$0.23
Oklahoma	$79,925	$0.03
Oregon	$633,737	$0.22
Pennsylvania	$3,649,033	$0.31
Rhode Island	$462,403	$0.46
South Carolina	$2,650,187	$0.74
South Dakota	$250	$0.00
Tennessee	$0	$0.00
Texas	$2,185,000	$0.13
Utah	$113,544	$0.06
Vermont	$165,556	$0.29
Virginia	$4,450,017	$0.71
Washington	$5,421,025	$1.08
West Virginia	$0	$0.00
Wisconsin	$948,750	$0.19
Wyoming	$0	$0.0
TOTAL/AVG.	**$164,805,252**	**$0.65**

KEY (Exhibits 8 and 9):

* Kansas did not complete the FY 1992 Survey questionnaire; figures reported in the FY 1991 Survey were confirmed for FY 1992.

** Louisiana reported figures for the fiscal year beginning 7/1/92 and ending 6/30/93.

*** For Maryland, figures reported by sub-area do not equal total confirmed by the state.

**** Nebraska reported category total expenditures only; no figures were reported in most sub-areas.

Exhibit 8 Cumulative Cases: Centers for Disease Control, Div. of HIV/AIDS, HIV/AIDS Surveillance, U.S. AIDS Reported Through June 1992, July 1992, p. 5.

Exhibit 9 Population by state: U.S. Bureau of Census, Resident Population in 1991, Estimates as of July 1991.

Source: AIDS Policy Center, Intergovernmental Health Policy Project, The George Washington University, May 1993

Research Papers

HIV Education and Health Education in the United States: A National Survey of Local School District Policies and Practices

Deborah Holtzman, Brenda Z. Greene, Gwendolen C. Ingraham,
Lisa A. Daily, David G. Demchuk, Lloyd J. Kolbe

ABSTRACT: *To determine the extent to which HIV education and health education policies and practices are required by school districts in the United States, a national probability sample of public school districts was surveyed by mail in 1990. Of 2,150 districts selected, 78.1% responded. HIV education was required by 66.9% of districts. Of these, the percentage requiring HIV education increased by grade level from 29.7% in kindergarten to 82.3% in 7th grade, then declined to 37.3% by 12th grade. Districts that required HIV education most often addressed HIV-related prevention skills in the upper grade levels. Similar to requirements for HIV education, health education requirements also declined from 7th to 12th grade, reaching even lower levels than HIV education by the last two years of high school. These declines are of particular concern given that students are most likely to engage in risk behaviors when HIV and health education is least likely to be required. Other practices and policies that support HIV and health education also were lacking in many districts.* (J Sch Health. 1992;62(9):421-427)

In the wake of the acquired immunodeficiency syndrome (AIDS) epidemic and recommendations[1,2] that schools play an active role in preventing human immunodeficiency virus (HIV) infection, many U.S. states and cities initiated policies and programs to educate students about HIV. Reported rates of sexual activity[3,4] and illicit drug injection[5] among adolescents — two primary modes of HIV transmission — indicate young people are at risk for HIV infection. Furthermore, the number of young adults with AIDS, many of whom were likely infected with the virus in adolescence, has increased over time.[6] Promoting healthy behavior and decreasing risky behavior among adolescents may be achieved, in part, by school health education programs. But what is the status of HIV education in U.S. schools?

This paper reports the extent to which U.S. school districts require HIV education. The type of education American students receive in school, including health education, is influenced not only by district policies, but by educational policies of their states. Further, the way in which schools and teachers interpret and implement state and district education policies may vary. How these different levels interact determines the process by which school-based HIV education is established.

To date, few studies have explored the extent to which HIV education is required and provided in the U.S., and these estimates vary. In 1987, a survey of state education agencies found 17 states had requirements for HIV/AIDS education.[7] By 1990, 31 states and the District of Columbia reported these requirements.[8] However, state requirements do not always indicate district requirements.

In 1988, a survey of sampled school districts found 96% of districts supported AIDS education, and 80% required AIDS education.[9] The survey, however, included only large school districts and covered only grades 7-12. In 1989, another survey found 79% of school districts required HIV prevention education, and 87% required comprehensive health education.[10] However, only affiliates of one national educational organization were surveyed in this study; of these, only 59% responded.

In 1989, a third survey of school districts found 66% of districts required that students receive HIV education as part of their formal curriculum during the 1988-1989 school year.[11] A total of 232 school districts were randomly selected in this study; of these, 93% responded. However, this survey also was limited to grades 7-12.

Another study reported results from a sample of public schools surveyed during the 1987-1988 school year.[12] Approximately 46% of schools (with any grades prekindergarten through 12) reported having an AIDS education program. In a survey of public school teachers who taught in grades 7-12, respondents were asked whether students were offered instruction in sexuality education and AIDS education.[13] Ninety-three per-

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cent reported sexuality education or AIDS education was offered in their schools in one or more grades; and 77% reported both were provided. However, only 45% of teachers surveyed responded.

National surveys of students also have determined the extent to which they receive HIV education in school. In 1987, a survey of eighth and 10th grade students found 35% had received instruction on AIDS in school.[14] In 1989, a national survey of ninth to 12th grade students found 53.7% had received HIV instruction,[15] and in 1990, another national survey of high school students found 74.0% had received such instruction.[5]

A number of characteristics are evident in these studies. First, considerable variation was found in the estimates (even within the same analytic unit) of HIV education. Second, samples were not always representative of populations from which they were drawn. Third, samples did not always include all grade levels. Representative, broad-based information at each level of analysis can help determine the status of HIV education.

To assess HIV education policy and practices that support HIV education at the district level, the National School Boards Assocation (NSBA) and the American Association of School Administrators (AASA), in collaboration with the Centers for Disease Control (CDC), conducted a survey among a national probability sample of school districts in 1990. The survey was designed to determine the extent to which districts required HIV education in grades K-12, to assess the extent to which selected HIV curriculum topics are addressed for different grades, and to examine district policies and practices that support HIV education.

The survey also explored the extent to which comprehensive health education is required by school districts. According to the CDC Interim Operational Definition of Comprehensive School Health Education,[16] elements of a comprehensive school health education program include:

1) A documented, planned, and sequential program of health education for students in grades kindergarten through 12;

2) A curriculum that addresses and integrates education about a range of categorical health problems and issues at developmentally appropriate ages;

3) Activities to help young people develop skills they will need to avoid: a) behaviors that result in unintentional and intentional injuries; b) drug and alcohol abuse; c) tobacco use; d) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; e) imprudent dietary patterns; and, f) inadequate physical activity;

4) Instruction provided for a prescribed amount of time at each grade level;

5) Management and coordination in each school by an education professional trained to implement the program;

6) Instruction from teachers who have been trained to teach the subject;

7) Involvement of parents, health professionals, and other concerned community members; and

8) Periodic evaluation, updating, and improvement.

METHODS

Sample

The sampling frame was obtained from the National Center for Educational Statistics, U.S. Dept. of Education's Common Core of Data. It consisted of all regular public school districts (excluding special education and vocational education) with any of grades K-12 in the 50 states and the District of Columbia. The sampling frame of approximately 15,500 districts was stratified by enrollment size; seven size categories were defined for this purpose. The total sample was allocated to these size categories in proportion to the aggregate square root of enrollment of the districts in the size category. This allocation resulted in highly variable sampling rates ranging from about 1 in 40 of the smallest districts to 1 in 1 of the largest districts. Such an allocation was expected to be efficient for estimating the number of students in districts with HIV education requirements, as well as providing reasonably precise estimates of district-level characteristics.

Standard errors for each estimate were calculated using SESUDAAN procedures,[17] which take into account the complex sample design. Sample estimates of the proportion of districts with selected policies and practices were found to be accurate to within 5.4 percentage points with 95% confidence. Prior to sampling, districts in each size category were further stratified by census region and metropolitan status (level of urbanicity), to introduce implicit stratification along these variables. Finally, within stratification categories, a sample of districts was randomly selected. In total, 2,150 districts were selected for participation.

Data Collection

With technical assistance from CDC, NSBA and AASA developed a self-administered questionnaire that was mailed to the superintendent of each sampled district in April and May 1990. School district personnel completed the questionnaire and returned it to NSBA in an enclosed, stamped, self-addressed envelope. As questionnaires were received by NSBA, they were checked for completeness and consistency of responses. Two weeks after the questionnaires were mailed, NSBA staff began to telephone districts that did not respond to determine if they had received the questionnaire, to answer questions, and to request that the questionnaire be completed and returned. Within a month of the mailing, through September 15, 1990, NSBA staff called responding districts to obtain missing information or to clarify inconsistent responses as necessary.

Variables and Data Analysis

The questionnaire consisted of 23 items. Participants were asked whether HIV education was required for students in their districts. Districts that responded "yes" were asked in which grades (K-12) it was required, in which subject or in what manner it was provided at each grade level, how many class hours of HIV education students were required to receive per year at each grade level, and whether the HIV education curriculum addressed certain topics across four grade ranges (K-3, 4-6, 7-8, 9-12). Further, if HIV education was required, information about HIV-related teacher

training, education of special education students, community involvement, funding, and policy was requested. Additional HIV-related policy and staff training information was requested from all participants regardless of HIV education requirements.

Participants also were asked whether they had a comprehensive health education program; whether, and in which grades, health education was required; total number of hours of annual instruction at each grade level; and whether the health education curriculum addressed certain topics across the four grade ranges. Lastly, districts were asked about administrative support for health education and whether the school district collaborated with outside agencies to foster the health and welfare of students. The proportion of respondents who selected each response option was weighted to account for the sample design.

RESULTS

The results are representative of all regular public school districts in the U.S. Of the 2,150 districts sampled, 1,679 (78.1%) responded. Response rates by region and metropolitan status were comparable and did not differ substantially from the overall response rate (Table 1). A comparison of participating and nonparticipating school districts showed minimal differences by census region, suburban areas, and areas with moderate enrollments (Table 2). Urban districts and districts with enrollments of 10,000 or more were somewhat more likely to participate than were rural districts and those with smaller enrollment sizes. However, the sample was weighted for nonresponse within these cate-

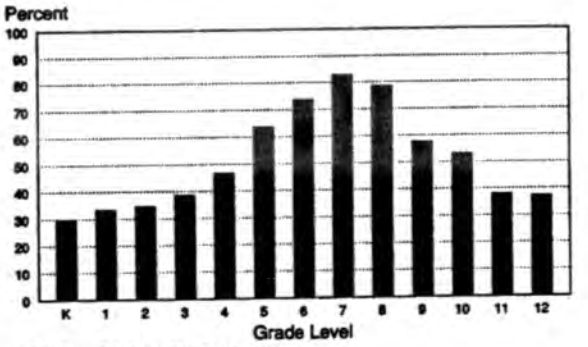
Table 1
Response Rates by Region and Metropolitan Status

	Participating School Districts	Selected School Districts	Response Rate (%)
Region			
Midwest	477	624	76.4
Northeast	310	382	81.2
South	544	693	78.5
West	348	451	77.2
Metropolitan Status			
Urban	293	334	87.7
Suburban	814	1,039	78.3
Rural	572	777	73.6
Total	1,679	2,150	78.1

Table 2
Percentage of Participating and Nonparticipating School Districts by Region, Metropolitan Status, and District Enrollment Size

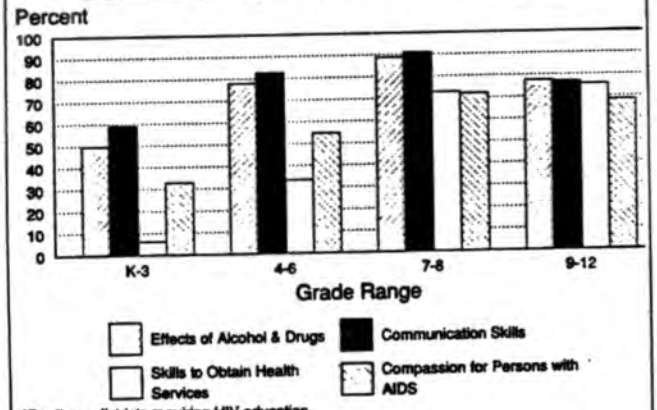
	Participating School Districts	Nonparticipating School Districts
Region		
Midwest	28.4	31.2
Northeast	18.5	15.3
South	32.4	31.6
West	20.7	21.9
Metropolitan Status		
Urban	17.5	8.7
Suburban	48.5	47.8
Rural	34.1	43.5
Enrollment Size		
Less than 300	3.1	11.0
300-599	4.6	7.9
600-999	4.6	9.1
1,000-2,499	15.2	21.2
2,500-4,999	17.9	16.8
5,000-9,999	22.2	17.6
10,000-24,999	23.4	13.2
25,000 or more	9.1	3.2

Figure 1
Percentage of Districts That Require HIV Education by Grade Level*



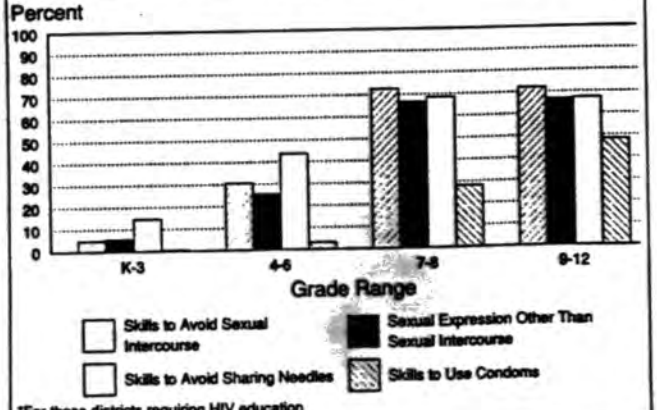
*For those districts requiring HIV education

Figure 2
Percentage of Districts That Address Selected Topics in HIV Curricula by Grade Range*



*For those districts requiring HIV education

Figure 3
Percentage of Districts That Address Selected Topics in HIV Curricula by Grade Range*



*For those districts requiring HIV education

gories to adjust for any effect these differences might have had on the results.

HIV Education

HIV education was required by 66.9% (95% CI = 62.1-71.7) of districts. Of these, the percentage that required HIV education by grade level increased from 29.7% in kindergarten to 82.3% in seventh grade. By 12th grade the percentage progressively declined to 37.3% (Figure 1). At each grade level, most school districts reported HIV education was provided under the subject of health, rather than other subjects or other methods of presentation.

Concerning specific topics addressed as part of the HIV education curriculum at each of four grade ranges (Figures 2 and 3), school districts were most likely to address two topics: communication skills and the effects of alcohol and drug use on decision making, notably in grades 4-6, 7-8, and 9-12. Though less commonly addressed at the lower grade ranges, skills to obtain HIV-related health services and compassion for persons infected with HIV were topics most respondents addressed in grades 7-8 and 9-12. Skills to avoid sexual intercourse and ways to express sexual feelings other than sexual intercourse were addressed primarily after grade 6. Skills to avoid sharing needles also were more likely to be addressed after grade 6. More than two-thirds of the districts said this topic was covered in grades 7-8 (68.6%), and an almost equal proportion said the topic was covered in grades 9-12 (67.2%). Skills to use condoms generally were not included until high school. Even then, fewer than one-half (48.2%) the districts reported this topic was addressed in grades 9-12.

Whether HIV education was required for students with specific disabilities varied by type of disability. For example, 80.6% and 70.4% of districts reported HIV education was required for speech impaired and learning disabled students, respectively. In addition, 57.6% reported HIV education was required for hearing impaired students, and 50.7% said it was required for the visually impaired. However, fewer than one-half the districts required HIV education for students with other types of disabilities, such as the mildly mentally retarded and the emotionally disturbed.

The most frequent method of preparing teachers to implement HIV education involved providing written information or guidelines (68.8%), followed by inservice training (57.0%). Of districts that provided inservice training, just under one-half (47.5%) specified the minimum number of hours of training (range = 1-30; median = 3 hours). Less than 10% reported that no teacher preparation was provided for HIV education.

Most districts (71.2%) reported having established a school or community advisory committee to review and recommend HIV education concepts and materials. More than three-quarters (77.5%) reported having a process for revising the HIV education curriculum. Most districts also involved parents (70.0%) and public health officials (61.5%) in developing HIV education curricula for students. Representatives of community-based organizations (50.6%), the clergy (48.1%), and physicians (45.7%) were involved in curriculum development to a lesser extent.

With regard to parental education, fewer than one-half the districts (42.2%) provided written information about HIV to educate parents. Additionally, 36.3% of districts said they sponsored educational meetings for parents, 25.9% supported HIV education programs provided by the Parent Teachers Association (PTA), and 13.4% reported advertising the HIV education services of other organizations. Nearly one-third (32.3%) of districts did not educate parents about HIV.

Parental support for HIV education in districts that required HIV education was rated as either moderate (42.2%) or high (36.2%). Only 10.7% of these districts reported low parental support. Most districts (79.4%) reported students may be excused from HIV instruction either on request of the parents or after their parents review the curriculum and materials; 11.7% reported students may not participate until parental permission is provided.

Almost two-thirds (65.0%) of the districts allocated funds to support HIV education for students. Of these, 49.8% directed the largest proportion of funds to purchase instructional materials, 22.5% for curriculum development, and 21.0% for teacher inservice. Finally, among districts that required HIV education, 65.3% stated the school board had adopted a written policy requiring HIV education for students. Of these, almost two-thirds (65.5%) adopted the policy in 1988 or 1989.

Among all districts (regardless of whether they had a requirement for HIV education), 60.3% had a written policy on school attendance for students infected with HIV, 41.2% had a written policy on employment of persons infected with HIV, and 48.4% had a written policy requiring use of infection control procedures to prevent spread of disease, including HIV. When all districts were asked to identify which personnel had been provided HIV education since June 1989, almost two-thirds indicated that teachers (65.5%) had been provided HIV education, followed by school nurses (53.1%), school-based administrators (50.8%), guidance counselors (44.4%), and central administrators (40.1%). The proportion of districts that provided HIV education to other selected groups of school personnel, such as bus drivers or custodial staff, ranged from approximately one-fourth to one-third. Only 18.8% of districts provided education for the school board. Finally, nearly one-quarter (24.8%) of all districts reported they had not provided HIV education for any school district personnel in the past year.

Health Education

Most districts (79.5%) reported they required a planned, multi-grade, sequential, and documented program of health education as part of the district curriculum. Only 23.0% of the districts, however, had a staff position with full responsibility for coordinating the health education program.

More than 70% of the districts required health education at each grade level from K-6th grade, reaching a high of 81.3% in fifth grade (Figure 4). An almost equal proportion of districts (81.1%) required health education in grade 6. Notably, from grades 6-12, the percentage of districts requiring health education decreased markedly, reaching a low of 17.9% in 12th

grade.

When asked about specific topics addressed in the health education curriculum at each of four grade ranges (Figures 5 and 6), most districts reported their health education curriculum helped students build skills to avoid tobacco (≥ 76.8% at each grade range), alcohol (≥ 77.1%), and illegal drugs (≥ 75.1%). The health curriculum also included topics to help students establish healthy food choices (≥ 72.4%), and maintain regular physical activity (≥ 74.6%).

Figure 4
Percentage of Districts That Require Health Education by Grade Level

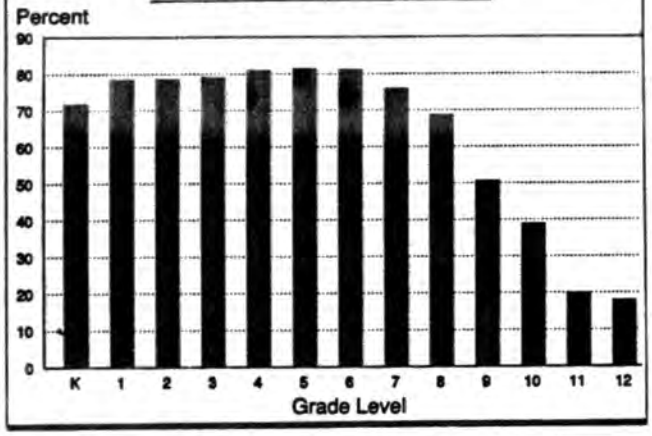


Figure 5
Percentage of Districts That Address Selected Topics in Health Curricula by Grade Range

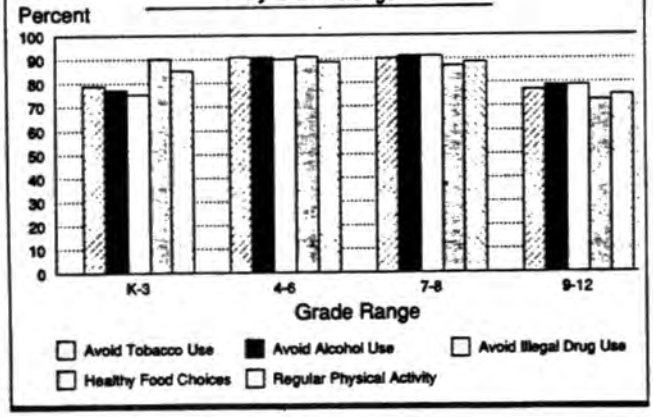
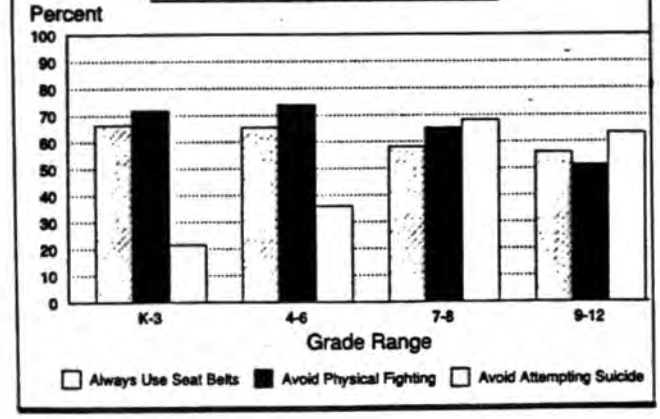


Figure 6
Percentage of Districts That Address Selected Topics in Health Curricula by Grade Range



Curricula that included skills to always use seat belts were reported by at least 56.1% of districts, and skills to avoid physical fighting were reported by at least 51.3% of districts in each grade range. Skills to avoid attempting suicide were included by more than 60% of districts in grades 7-8 and in grades 9-12. Only about one-quarter to one-third of the districts addressed suicide in the curricula in grades K-3 and 4-6, respectively. Finally, nearly all districts (91.3%) reported that they collaborated with their community's health and social service agencies to foster the health and welfare of students.

DISCUSSION

Unlike previous surveys of school districts,[9-11] this survey was the first to assess the K-12 HIV and health education requirements of a national probability sample. However, some limitations of the data should be considered. The data were self-reported, and though confidentiality was assured, respondents may not have wanted to show their programs in a negative light. Further, the survey provided information about what districts required, not what schools actually provided or what students actually received in the way of HIV and health education.

Another limitation is that some questions may have been interpreted differently by respondents. For example, when districts were asked whether the HIV curriculum addressed skills to use condoms, some districts questioned whether this meant a discussion of condoms as a method to prevent HIV infection or a demonstration of how they should be used. Thus, the survey data could not determine how the topic was addressed in the district curricula, only that it was addressed in some form at a particular grade range. Similarly, the question regarding whether districts had a planned, multi-grade, sequential, and documented program of health education required as part of the curriculum was broadly interpreted. Many districts responded affirmatively to this question if any one of the four components of the question was applicable. So, while the survey could assess whether districts had a general requirement for health education, it could not determine which, or how many of the four components were characteristic of the requirement. However, the survey produced some important findings.

While most of the nation's school districts require HIV education, these results show that at least one-third do not. Furthermore, requirements vary by grade level, increasing through grades 5 and 6 and declining from grades 7 to 12. The drop in requirements for HIV and health education after 10th grade is especially striking. When students are most likely to engage in risk behaviors,[18] HIV and health education are least likely to be required.

This finding causes even greater concern when coupled with the fact that specific topics to reduce the risk of HIV infection were more likely to be addressed at the higher grade ranges, most notably, skills to avoid sexual intercourse, skills to express sexual feelings in

ways other than sexual intercourse, and skills to avoid sharing needles. While skills to use condoms was least likely to be addressed at any grade range, this topic, too, was more likely to be covered in the higher grades. Thus, a large proportion of school districts may not be addressing critical risk reduction skills for young people at a time when they may most need them.

Many districts did report a range of policies and practices that support HIV education, including providing teacher training, requiring HIV education for students with specific disabilities, establishing advisory committees to review HIV materials, and involving the community. Most districts also reported they allocated funds to support HIV education for students and had written policies requiring HIV education.

Like HIV education, health education was required by most districts. Health education requirements by grade level, however, showed a somewhat different pattern when compared to HIV education requirements (Figure 7). While most districts required health education in grades K-4, fewer than one-half required HIV education for these same grades. Though more school districts required HIV education during the middle grades (5-9), health education still was the predominant requirement in these grades. Requirements for both HIV and health education began to decline after grade 7, again, at grades when students are more likely to engage in risk behavior. Notably, in the last two years of high school, fewer districts required health education than HIV education. Indeed, one of the reasons why HIV education is not required at the higher grade levels may be because health education courses into which HIV education could be incorporated are not provided.

Among eight health education topics, at least 70% of districts reported that building skills to avoid or establish behavior related to five topics (alcohol, tobacco, illegal drugs, nutrition, and physical activity) were included in the curriculum at each grade range. A smaller proportion of districts addressed seat belts, physical fighting, and suicide in their health education curricula. Notably, all three topics are associated with injuries, the major cause of mortality among adolescents.[19]

In comparing these findings to recommendations in the CDC publication, "Guidelines for Effective School Health Education to Prevent the Spread of AIDS,"[20] many school districts have implemented HIV education programs that incorporate essential components identified in the guidelines. For example, the CDC guidelines recommend that parents, teachers, students, and appropriate community representatives be involved in developing, implementing, and assessing HIV education policies and programs. The survey showed that more than 70% of school districts that required HIV education established a school or community advisory committee to review and recommend HIV education concepts and materials. Most also involved parents, public health officials, and representatives of community-based organizations in developing the HIV education curriculum.

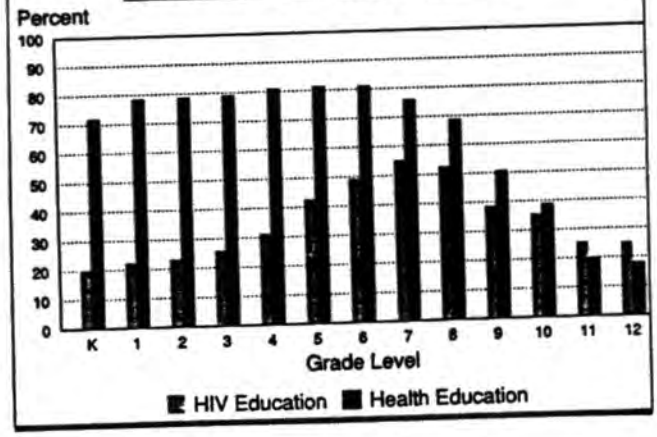
The CDC guidelines also recommend school administrators, teachers, nurses, and counselors, especially those who teach about HIV, be provided adequate training. The survey found that almost 66% of districts instruct teachers about HIV, and 57% of those that require HIV education provide inservice training to teachers engaged in HIV education. Moreover, about one-half (50.8%) the districts reported they provided HIV education to school-based administrators. In general, districts were less likely to educate other categories of personnel about HIV.

Though the survey attempted to measure number of hours of annual HIV instruction and health instruction districts required at each grade level, response to these questions was relatively low and varied by grade level. For example, across all grades, 10.6% to 31.8% of districts specified hours of annual HIV instruction. For these districts, the median number of hours of annual instruction ranged from two to four. CDC guidelines recommend that sufficient program development time, classroom time, and educational materials be provided for HIV education. While these estimates may not accurately reflect the number of hours of annual HIV instruction, the amount of time dedicated to HIV instruction seems generally insufficient for the instruction to be effective.[21]

Increasing the number of hours of HIV instruction is just one area in which HIV education may be improved. While school districts nationwide have implemented policies and practices that support HIV education, a sizable proportion require neither HIV nor health education. Moreover, they do not require HIV and health instruction at the upper grade levels, where skills to prevent HIV infection are more likely to be addressed. Other areas are lacking as well. One-third of the districts offer no teacher training for HIV education. As yet, HIV education is not required for students with certain disabilities. Parental education also is limited in a number of districts. Relevant HIV-related policies, such as school attendance by students infected with HIV and the use of infection control procedures to prevent disease, are missing in from one-third to one-half of the districts surveyed.

To complement research at the district level, additional investigations of what HIV instruction is actually provided by schools and received by students also is needed. The difference between these findings, which showed that almost 67% of school districts required

Figure 7
Percentage of Districts That Require HIV and Health Education by Grade Level



HIV education, and the estimate found by the national survey of schools (46%),[12] could indicate, as mentioned, that what is required by districts is not always provided by schools. However, it is also possible that increases in HIV education have occurred since the 1987-1988 school year.

The survey can, however, estimate the number of students in districts with HIV education requirements. The proportion of students in districts requiring HIV education was calculated as a ratio of the total weighted student enrollment of responding districts to the total weighted student enrollment of responding districts that require HIV education. Based on these data, almost 85% of the nation's estimated 45 million K-12th grade students were enrolled in school districts that required HIV education.[22] However, this proportion is likely to vary by grade level. The proportion of students who have received HIV education in school has been estimated from current national studies, but these estimates have included only students from the upper grade levels, and one cannot determine from these studies at which grade level HIV instruction was received. Thus, results from these surveys are not directly comparable to estimates from the current analysis.

CONCLUSION

It is difficult to evaluate how much progress has been made over the past few years in school-based HIV education. Differences in units of analysis, samples, and questions make comparisons of this investigation with other surveys difficult. Because this survey involved a national probability sample of school districts, however, it can serve as a baseline from which to evaluate change in the status of HIV and health education requirements over time across all grade levels.

Additional research about state and district policies, what schools provide, and what students receive in the way of HIV and health education will help determine progress toward achieving the Year 2000 Objective to "Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education."[23] To achieve this objective, education and health professionals need to work closely together to enable the nation's youth to avoid HIV infection and other important health problems. ■

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