A CASE STUDY OF IMPLEMENTATION PROCEDURES OF A STATE-MANDATED INSTRUCTIONAL PROGRAM FOR AIDS EDUCATION

By

MARY JANE WALKER

Bachelor of Arts
Louisiana Tech University
Ruston, Louisiana
1978

Master of Arts
Louisiana Tech University
Ruston, Louisiana
1980

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DEDICATION

This project is dedicated to the memory
of my grandmother.

Cecile LeBlanc Walker
(1906 - 1988)

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Thesis Approved:

Randall Koetting

Thesis Adviser

Kenneth M. Clair

Norman N. Durham

Dean of the Graduate College

PREFACE

AIDS is a prevalent concern of society due to the severe nature of the disease. This dissertation focuses on a particular Oklahoma school district that pioneered the implementation of an AIDS education program in the state of Oklahoma. The intent of this study is to describe the school district implementation procedures, the reactions of administrators and teachers of this particular Oklahoma school district, and for the paper to present findings and make recommendations that can enhance future AIDS implementation strategies.

I would like to acknowledge and express gratitude and appreciation to my dissertation committee for their diligence, support, guidance, and direction in the writing of this paper. I also want to express a sincere thanks to them for their patience, understanding, and thoughtfulness in allowing me the time to pursue my doctoral degree while continuing my profession as a special education teacher.

Dr. Russell Dobson, my first friend at Oklahoma State University, provided the initial direction and was a catalyst of motivation for me in my pursuit of this dissertation. I would like to thank Dr. Dobson and express my appreciation of the time and the effort he provided in assisting me through some tough and trying times. I feel indebted and definitely

owe a special thanks to my friend and dissertation advisor, Dr. Randy Koetting, for providing encouragement, enthusiasm, and professional direction throughout the duration of this endeavor. Thanks to Dr. Ken St. Claire, for assisting me with the development of the questionnaire for this study and opening the door to the school district from which this case study was obtained. A genuine thanks to Dr. Ken Wiggins for providing a positive attitude and willingness to offer cooperative assistance at all times.

I am grateful to the many non-professional people that indirectly contributed to the writing of this paper. There is an undying gratitude to my brother, Danni Dugas, other family members, and friends for providing the patience, understanding, support, and encouragement that was needed by me to be able to begin and finish this dissertation.

Finally, to the fourteen case study respondents, who must remain anonymous in order to protect their confidentiality, I express thanks and gratitude to them for providing the information that made this study possible.

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CHAPTER I

INTRODUCTION

The American population is genuinely concerned about the education of their children. In recent years, this commitment and concern has been shown in areas of increased financial support, new laws governing education, and a strong belief that a "good" education is a way to improve the quality of life for all that take advantage of it. Those who are responsible for change have been motivated and are working to change education for the better.

Instructional planning is a continuous process. As instructional programs are developed and implemented, results evaluated, areas of weaknesses identified, recommendations for improvements indicated, instruction can be continuously improved through the years. There is a never ending cycle of planning, development, implementation, and appraisal. In this way, it is hoped that more increasingly effective educational programs will be obtained.

Kapel and Ringer (1981-82, p. 37) have stated:

> School children have the most to gain from a reality-based curriculum that will meet their emotional, psychological, social, and cognitive needs. Acquisition of appropriate decision-making skills and problem-solving capabilities with regard to human sexuality concerns is a major outcome of the integration of this model with the school curriculum. Emotional well-being is another product. If approached and

> discussed correctly, values development, improved self-worth, positive identity, socially appropriate attitudes, reduced conflict (internal as well as external), greater dignity, acceptance of others, and self-actualization would be the results of this program.

The implementation of an AIDS instructional program will not provide the answers to all the social and personal dilemmas surrounding sexual behavior, but it can contribute to reducing or preventing some of these problems. By providing our adolescents with the knowledge and understanding of AIDS, we are enabling them to avoid the fear, guilt, and difficulties associated with this disease.

Problem

AIDS is a frightening incurable disease that is a concern to all. Misinterpretation of factual information about the disease is often due to personal attitudes and feelings. AIDS education in this area was mandated by the government of the state of Oklahoma due to the desire to disseminate factual information to students.

At the time of this study, there were no studies known to the researcher, describing the procedures used and the reactions of administrators and teachers in the implementation of the AIDS education program in Oklahoma.

Purpose

The purposes of this study were to describe the procedures used and the reactions of administrators and

teachers in the implementation of the AIDS curriculum in one Oklahoma school district.

Objectives

This study of the implementation procedures and the reactions of administrators and teachers to the implementation of the AIDS instructional program used in one Oklahoma school district will help: (1) to determine how the program was developed and by whom, (2) to determine how the administrators and teachers were trained to implement this program, (3) to determine how the students were prepared for this program and what their perceptions of it were prior its implementation, (4) to determine if the time allocated to the implementation of this program was adequate, (5) to determine whether or not it was felt that testing students over material presented would be beneficial, and (6) to determine what revisions are felt to be needed in this program before it is to be implemented again.

Assumptions

For the purposes of this study, the following assumptions were accepted by the researcher: (1) that the administrators and teachers who were interviewed participated in this study voluntarily, (2) that the administrators and teachers provided accurate evaluations of the implementation procedures used in the implementation of the AIDS program,

and (3) that the reaction and emotional responses asked of administrators and teachers were answered honestly.

Definitions of Terms

The following terms and definitions were used for this study.

1. AIDS : Acquired Immune Deficiency Syndrome. A fatal illness caused by a virus that damages the body's immune systems.
2. GAO : Government Accounting Office.
3. HIV : Human Immunodeficiency Virus.
4. HHS : Department of Health and Human Services.
5. HTLV-III : Human T-cell Lymphotropic Virus, type III.
6. KSOI : Kaposi's sarcoma and opportunistic infections.
7. LAV : Lymphadenopathy-Associated Virus.
8. MMWR : Morbidity Mortality Weekly Report.
9. NCI : National Cancer Institute.
10. PHS : Public Health Service.

Scope and Limitations of the Study

Limitations of this study were both the number of administrators and teachers interviewed and the direction of the interview. Case Study methodologies were applied in the interviewing of the fourteen participants. The researcher

interviewed four administrators and ten teachers comprised of six counselors, one school psychologist, one school nurse, and two teachers were interviewed for this case study. These persons were directly or indirectly responsible for the implementation of the AIDS program in one Oklahoma school district.

Rationale of the Study

The rationale of this study was to discover, by the use of a qualitative procedure, a view toward justifying or modifying and improving current educational practices used in the implementation of the AIDS program.

Significance of the Study

There are no studies at the present time that describe the procedures used and the reactions of administrators and teachers to the implementation of an instructional program for AIDS education in Oklahoma. This study will answer questions about the implementation procedures used and educator reactions to the program and will provide an addition to the professional literature in its area.

In addition, educators should gain a better understanding of what might be done to improve the implementation of an AIDS program. As a result, all educators and students might eventually benefit if the findings of this study are incorporated into the state

education system.

Organization of the Study

Chapter I has introduced the study, presented the problem, purposes, and objectives to be determined by this study. Chapter II includes the review of the literature consisting of two primary parts: the review relative to contributing factors that established a need for developing an instructional program for Aids education and the review relative to the case study approach. Chapter III reports the methodology used in this study. The findings of the study are presented in Chapter IV. Chapter V includes a summary of the study, conclusions, and recommendations.

CHAPTER II

REVIEW OF LITERATURE

The purpose of this review was to present an overview of the literature pertinent to the study. The review of the literature will address; facts about AIDS, adolescents and AIDS, and guidelines for effective AIDS education.

Facts about AIDS

AIDS (acquired immune deficiency syndrome) is a newly recognized disease caused by a virus that destroys a person's defenses against infections. These defenses are known as the immune system. Clinical and medical research about AIDS has been extensive. The AIDS virus, known as human immuno-deficiency virus, or HIV, can so weaken a person's immune system that he or she cannot fight off even mild infections and eventually becomes vulnerable to life-threatening infections and cancers. These types of infections are known as opportunistic infections.

One of the most common opportunistic infections contracted by AIDS victims is a severe type of pneumonia caused by the parasite Pneumocystis carinii referred to as PCP, (Pneumocystic carinii pneumonia). Other opportunistic infections suffered by AIDS victims are meningitis, encephalitis, esophagitis, persistent diarrhea and extensive

skin inflammation. PCP and these other opportunistic infections are often resistant to treatment and are frequently the immediate cause of death of AIDS victims.

The cancer Kaposi's sarcoma (KS) occurs frequently in those persons with AIDS. Prior to the first recognition of AIDS, KS was generally observed in the United States only among elderly men of Mediterranean origin or organ transplant patients whose immune systems were suppressed by drugs. Other cancers, such as those of the lymphatic system, may also be more common among AIDS victims than among members of the general population.

There are many speculations of the origins of AIDS; to date no one has been able to pin point the exact origins of the disease. The disease was first noted in the United States in the late 1970's and early 1980's. The tracing of AIDS began only when doctors had seen enough of it to recognize that they were faced with a serious, previously unknown disease. It was formally defined for the first time in 1982. For surveillance purposes, the CDC (Centers for Disease Control) has defined AIDS as the presence of a reliably diagnosed disease at least moderately predictive of an underlying immunodeficiency in a person with no known cause for diminished resistance to the disease (CDC, 1982). Recently, the CDC published a new four-stage classification system for AIDS virus infection (CDC, 1986a, p. 334). This new system includes: asymptomatic infection with the AIDS

virus; a mononucleosis-like illness sometimes associated with initial infection with the AIDS virus; ARC; and AIDS. For reporting purposes, the original CDC AIDS definition is used in determining the number of AIDS cases. Table I on the following page was developed by Sandra Panem showing the initial stages of the AIDS epidemic.

By 1981, 266 persons in the United States had been diagnosed by doctors as having AIDS. There were 49,342 Americans diagnosed as having AIDS by December 21, 1987. Medical officials believe that the actual number of persons with the disease is higher. For various reasons, some under-reporting does occur; a study by the Centers for Disease Control estimated that the actual number of AIDS cases is about 10 percent higher than the number officially identified.

High Risk Groups for Developing AIDS

As reported in the "AIDS Weekly Surveillance Report," Centers for Disease Control, December 21, 1987: 88 percent of persons known to have AIDS are homosexuals or intravenous drug abusers; 1 percent are infants who were infected by their mothers during pregnancy or at birth; 4 percent were infected through blood transfusions before the Red Cross and other centers began testing blood for the AIDS antibody in 1985; and for 3 percent the cause is undetermined. Only 4 percent of known AIDS patients became infected with the

TABLE I

THE INITIAL STAGE OF THE AIDS EPIDEMIC:
LATE 1979 - SPRING 1984

	Early Signs
1979-1980	Anecdotal reports of Kaposi's sarcoma in young, homosexual men in New York City, San Francisco and Los Angeles
1981	Report on 5 cases of Pneumocystis carinii pneumonia in homosexual men in MMWR
	Increased requests for pentamidine
	PHS AIDS task force formed
	NCI meeting on Kaposi's sarcoma
	Reports on KSOI in the peer reviewed medical literature
	The Emergence of Risk Groups
1982	Hypothesis that "poppers" cause KSOI discounted
	KSOI diagnosed in Haitians in the United States
	AIDS defined as a syndrome
	Transfusion-related AIDS reported
	Pediatric AIDS reported
	The Hunt for the Cause of AIDS
1983	Immunodeficiency in female sexual partners of men with AIDS reported
	Hypothesis that AIDS is caused by a retrovirus is proposed
	Recommendations for preventing the spread of AIDS are published in MMWR
	GAO audits HIH and CDC AIDS activities
	Science publishes article on LAV by Montagnier and colleagues
	Congressional hearings in Washington on the "Federal Response to AIDS"
	Committee on Government Operations issues report on "Federal Response to AIDS" with dissenting views
	French scientists file first U.S. patent application
1984	Robert Gallo's group reports growth of HTLV-3 in vitro
	Margaret Heckler announces discovery of HTLV-3 as the cause of AIDS
	First HHS patent filed
	Independent isolation of an AIDS retrovirus, ARV, reported by Levy and colleagues

disease through heterosexual contact, although almost half of these came to the United States from foreign countries with high AIDS infection rates.

It is believed by U.S. Centers for Disease Control officials that persons at increased risk of AIDS infection include: 1) homosexual and bisexual men; 2) present or past intravenous drug abusers; 3) persons with clinical or laboratory evidence of infection such as signs or symptoms compatible with AIDS or AIDS-related complex (ARC); 4) persons born in countries where heterosexual transmission may play a major role; 5) male or female prostitutes and their sex partners; 6) sex partners of infected persons or persons at increased risk; 7) all persons with hemophilia who have received clotting-factor products; and 8) infants of high-risk or infected mothers (CDC, 1986b).

Common Ways AIDS Is Transmitted

The study of the AIDS virus in reported AIDS cases indicates that the AIDS virus can be transmitted only by intimate contact with the body fluids of an infected individual. This can occur through: sexual contact, sharing of contaminated needles; and transfusion of blood and some blood products. Women infected with the AIDS virus may also transmit it to their children during pregnancy or, later, during breast-feeding.

To date, the Public Health Service has stated there is

no evidence that AIDS can be contracted from social, work, or family contacts with someone with AIDS. There is no reason to suspect casual contact with AIDS patients or persons who might be at high risk for the illness places others at risk of getting AIDS. Assurances that AIDS cannot be spread through casual contact are based upon studies of health care workers and family members of AIDS patients (CDC, 1985; Hirsch, and et al., 1985; Silberner, 1985; Weiss and et al., 1985; and Sande, 1986). The results of these studies on individuals who have had frequent, close contact with AIDS victims and/or their body fluids provide strong evidence that AIDS cannot be transmitted through casual contact.

Early Symptoms of AIDS

The AIDS virus diminishes the ability of the body's immune system to protect against disease. In addition, the virus may attack the nervous system and cause impairment of the victim's brain. Early symptoms of AIDS are non-specific and include chronic episodes with abnormal bleeding, skin rashes, fatigue, fever, loss of appetite and weight loss, diarrhea, night sweats, headaches, swollen lymph glands in the neck, armpits, or groin, and neurological disorders such as dimentia, memory loss, partial paralysis, and loss of coordination (Mayer and Pizer, 1983).

There are individuals who experience symptoms similar or identical to those found in full-blown cases of AIDS, but who

do not suffer from one of the marker diseases necessary for the diagnosis of AIDS. Some individuals will develop lymphadenopathy syndrome (LAS), which is a persistent, unexplained swelling of the lymph nodes. AIDS-related complex (ARC) is the term used to classify some of the individuals.

Full-blown AIDS can appear suddenly in individuals who have not had LAS or ARC. A dry cough and shortness of breath accompanied by weight loss are predecessors to PCP. Thrush, a fungal infection characterized by white patches in the mouth may also be the first sign of AIDS. In some individuals, the earliest indication may be the purplish skin lesions of Kaposi's sarcoma, while 10 percent may develop neurological symptoms as the first sign of AIDS (Whelon, 1987).

No Cure or Vaccine for AIDS

To date, there is no vaccine to prevent people from becoming infected with the AIDS virus. Many of the illnesses caused by the AIDS virus are treatable, but the AIDS infection itself cannot be cured and can be expected ultimately to lead to illnesses that are fatal.

The public is waiting anxiously for an AIDS vaccine and scientists all over the world are working furiously to produce one. Until a vaccine is found, doctors are treating symptoms of AIDS in individuals with various drugs, which are

believed to delay the progression of the disease. See Table II for the most promising drugs in the war on AIDS (Siwolop, Ticer, Rhein, Therrien, Eklund, Hunter, and Maremont, 1987). Scientists believe that it may take many years before a proven vaccine to prevent AIDS or proven treatments to cure the disease might be available; therefore the most promising way to deal with the deadly threat of AIDS is to prevent infection of the AIDS virus through education.

Adolescents and AIDS

Our society has had the tendency of becoming aware of a "new" risk group only after they are widely infected with the AIDS virus. Presently, attention is focused on the heterosexual population in which AIDS infection was predicted from statistics a few years back. This pattern can be said to be true of another risk group - adolescents, especially sexually active adolescents and for various reasons, those adolescents that use intravenous drugs.

Currently, the number of AIDS cases among adolescents is low. However, teen sexual activity, high rates of sexually transmitted diseases, drug abuse, and recent evidence of AIDS among adolescents suggest risk for youth are growing.

AIDS has been less prevalent among adolescents than adults and younger children. As of November 30, 1987, CDC had reported 195 cases of AIDS among 13-19 year olds, which represents 0.4% of the total 47,298 reported AIDS cases. Of

TABLE II

THE MOST PROMISING DRUGS IN THE WAR ON AIDS

DRUG/Developer	
AZT Burroughs Wellcome	The first drug shown to prolong the lives of AIDS patients, especially those in the early stages of the disease. The drug blocks the virus' ability to reproduce but causes anemia so severe that frequent blood transfusions are necessary. Already approved in Britain and France; full-scale U. S. approval is immenent.
DDC Hoffmann-La Roche	A sister drug to AZT that appears extremely promising in laboratory experiments. Has been tested on only nine patients so far, but some researchers believe it may prove to be more potent and less toxic than AZT.
AL721 Praxis Pharmaceuticals	Developed to treat the symptoms of drug withdrawal, it is in very early stages of testing against AIDS. Trials with eight patients with AIDS-related swelling of the lymph nodes have been encouraging.
GRANULOCYTE-MONOCYTE COLONY-STIMULATING FACTOR Genetics Institute	Animal tests with the substance have been encouraging, but results from the first human tests probably won't be available until late spring.

TABLE II (Continued)

DRUG/Developer	
ALPHA INTERFERON Biogen/Schering-Plough Hoffmann-La Roche/Genentech	Has proven to be an effective treatment of Kaposi's sarcoma, an AIDS-linked skin cancer. It is now being tested against AIDS in combination with other drugs. tests with AZT are planned.
INTERLEUKIN-2 Hoffmann-La Roche/Immunex	Tests with IL-2 alone have been disappointing but limited. Researchers, however, speculate that it may be more effective in combination with other drugs. Tests with AZT are planned.
CYCLOSPORINE Sandoz	A highly toxic drug used to prevent rejection of organ transplants. Last year, French researchers reported that it can control AIDS in early stages. Larger tests are under way in the U. S. and Europe. No results have been reported.

DATA: BW

the total AIDS cases among teens, 88 or 45% are white, 66 or 34% are black, 36 or 18% are Hispanic, and 5 or 3% are of other or unknown races. There were 9,859 cases among 20-29 year olds (21% of the reported AIDS cases). Because of the typically long latency between infection and the onset of symptom of the disease, it is likely that many of these 20-29 year olds became infected as teenagers. New Jersey, New York, and Florida have had the highest incidence reported AIDS cases among adolescents at this time (CDC, 1987a and Koop, 1987).

Becky Adler (1987, p. 11), a senior high school student and Teen AIDS Hot-liner has stated:

> The teen years are times of experimentation and new options. Americans are becoming sexually active younger and younger, and those who do abuse drugs usually start as teenagers. So, if there is such a thing as a "high-risk" group -- it is teen America. And we at the Teen AIDS Hotline are working to save our generation.

In a testimony given by Hein, describing various characteristics of adolescents psychological development, it is better understood how many adolescents fall prey to the AIDS virus.

> Teenagers tend to feel invulnerable, making a future risk of AIDS appear remote. This is compounded by the tendency toward "concrete" rather than "abstract" thinking still prevalent among adolescents. Decisions are thus based on very tangible factors rather than on long term probabilities. Peer pressure is an immediate and important factor that can override abstract and distant risks. The tendency toward denial, shared by all age groups, may be exaggerated in adolescence (Hein, 1987, p. 98).

The transmission and course of the AIDS infection in adolescents appear more like that of the adult cases than the AIDS infection among infants and young children. Adolescents have chiefly become infected with the AIDS virus through sexual activity with an infected partner, drug abusers using contaminated needles, and receipt of contaminated blood and blood products.

Adolescents and Sexual Activity

Sexually transmitted diseases (STDs) are the most destructive and costly communicable disease problem facing adolescents today in the U.S. Premature sexual behavior in conjunction with ineffective methods of contraception place the adolescent at risk for STDs, including AIDS.

The incidence of sexually transmitted diseases is higher among adolescents than any other heterosexual age group. Dr. Mary-Ann Shafer, Associate Director of Adolescent Medicine at the University of California, San Francisco, states:

> More adolescents are engaging in sexual intercourse and are initiating this activity at younger ages than 10 years ago. Fifty per cent of adolescents have initiated sexual intercourse by their sixteenth birthday and over 70% by their nineteenth birthday. Among sexually active adolescent girls aged 15-19 years, almost 2/3 of these girls use no or ineffective contraception, and less than 17% reported using a barrier contraceptive method at last intercourse (15% condoms, 3% diaphragms). It is these latter forms of contraceptives, the barrier methods, that can afford some protection against STDs, including AIDS (Shafer, 1987, p. 48).

The facts that a high incidence of adolescents are sexually active and that rates of STDs are highest among adolescents make young people especially vulnerable to heterosexual transmission of the AIDS virus.

Adolescents and Drug Abuse

Intravenous drug use remains a serious potential risk; even though this practice is not currently prevalent among adolescents. Surgeon General Koop (1987, p. 8) states:

> About 1% of American high school seniors self-report having ever used heroin, 16.7% report having ever used cocaine, and 23.4% report having ever used stimulants; all of these drugs can be taken intravenously. Although teenagers generally do not infect drugs, those who do and share needles are at increased risk for infection with the AIDS virus.

Adolescents that engage in other kinds of needle sharing behavior may also be at some risk. High School football players and other athletes that share needles for steroid injections are putting themselves and other at risk for infection of the AIDS virus (Gordon, 1987).

Guidelines for Effective AIDS Education

The AIDS virus is transmitted almost exclusively by high-risk behaviors performed by individuals. By providing educational programs that are effective in preventing the spread of the AIDS virus; the following will need to be addressed: what are the high-risk behaviors, and how to

avoid these behaviors. The guidelines, to be discussed in this section, incorporated principles for AIDS education that were developed by the President's Domestic Policy Council and approved by the President in 1987 (Appendix A).

The guidelines were developed by CDC in consultation with individuals appointed to represent the following organizations:

> American Academy of Pediatrics
> American Association of School Administrators
> American Public Health Association
> American School Health Association
> Association for the Advancement of Health Education
> Association of State and Territorial Health Officers
> Council of Chief State School Officers
> National Congress of Parents and Teachers
> National Council of Churches
> National Education Association
> National School Boards Association
> Society of State Directors of Health, Physical Education, Recreation and Dance
> U.S. Department of Education
> U.S. Food and Drug Administration
> U.S. Office of Disease Prevention and Health Promotion
>
> Consultants included a director of health education for a state department of education, a director of curriculum and instruction for a local education department, a health education teacher, a director of school health programs for a local school district, a director of a state health department, a deputy director of a local health department, and an expert in child and adolescent development (CDC, 1988, pp. 1-2).

Planning and Implementing an AIDS Educational Program

Schools have been selected to assure that adolescents and young adults understand the nature of the AIDS epidemic

and the specific actions they can take to prevent infection. Because of the nature of this program of discussing AIDS as a fatal disease spread by sexual contact and/or IV drug use; an AIDS educational program should be determined locally and should be consistent with parental and community values. A committee to develop a community AIDS educational program should be comprised of local representatives from the following: the school board, school administrators and faculty, school health services, local medical societies, the local health department, parents, students, minority groups, and religious organization (CDC, 1988).

Preparation of Educational Personnel

Inservice should be provided for representatives from the local school board, parent-teacher associations, school administrators, school physicians, school nurses, teachers, educational support personnel, school counselors, and other relevant school personnel in the following areas:

A. the nature of the AIDS epidemic and means of controlling its spread,
B. the role of the school in providing education to prevent transmission of HIV,
C. methods and materials to accomplish effective programs of school health education about AIDS
D. school policies for students and staff who may be infected (CDC, 1988, p. 3).

School personnel that are directly responsible for the teaching of the AIDS education program should receive more specific training about AIDS. All school personnel,

especially those who teach about AIDS, should be kept abreast of current information about the AIDS epidemic and effective health education interventions available.

Qualified Teachers

Elementary school children are generally taught by one regular classroom teacher. In these grades, AIDS education should be taught by the classroom teacher because this person has received training and is experienced in the areas of child development, age-appropriate teaching methods, child health, and elementary health education methods and materials. In addition, an elementary school teacher is usually sensitive to the variations of learning patterns within their class (CDC, 1988).

The secondary school system utilizes teachers with specialized skills to teach each subject. Because of the training and experience in adolescent development, age-appropriate teaching methods, adolescent health and secondary school health education methods and materials that are needed, a qualified secondary education health teacher should provide the AIDS instruction. When this is not possible, a faculty member with similar training and good rapport with students should be trained to provide effective AIDS education to perspective student (CDC, 1988).

Purpose of the AIDS Education Program

The principal purpose of AIDS education is to prevent the spread of the AIDS virus. The AIDS educational program should be developed with the active involvement of parents and community, addressing the behavior exhibited by adolescents and young adults. Information and skills need to be taught to students that can be adopted and maintained to eliminate their risk of becoming infected with the AIDS virus.

School systems should make programs available that will enable and encourage young people who have not engaged in sexual intercourse or used illicit drugs to continue to-

> Abstain from sexual intercourse until they are ready to establish a mutually monogamous relationship within the context of marriage;
>
> Refrain from using or injecting illicit drugs (CDC, 1988, p. 4).

For young people who have engaged in sexual intercourse or injected drugs, school programs should enable and encourage them to-

> Stop engaging in sexual intercourse until they are ready to establish a mutually monogamous relationship within the context of marriage;
>
> to stop using or injecting illicit drugs (CDC, 1988, p. 4).

And for those young people that are unwilling to adopt behavior that would eliminate their risk to infection, school systems, in consultation with parents and health officials,

should provide AIDS education programs that address preventive types of behavior that should be practiced by persons with an increased risk of acquiring the AIDS virus. These include:

> Avoiding sexual intercourse with anyone who is known to be infected, who is at risk of being infected, or whose HIV infection status is not known;
>
> Using a latex condom with spermicide if they engage in sexual intercourse;
>
> Seeking treatment if addicted to illicit drugs;
>
> Not sharing needles or other injection equipment;
>
> Seeking HIV counseling and testing if HIV infection is suspected (CDC, 1988, p. 4).

Content

Students must develop the ability to acquire complex understanding and integrate skills they will need to prevent becoming infected with the AIDS virus. Complex understanding and the development of preventive skills will not occur in a student seeing one film, hearing one lecture, or attending one school assembly.

Schools should assure that students receive at least the essential information about AIDS (see Appendix B, Essential Information about AIDS for Each of Three Grade-Levels). Local committees should be appointed to determine the exact grades at which students will receive information about AIDS. Because information given at the higher grades builds on information that has previously been given, it will be

necessary for school personnel to be sure that students understand basic concepts before teaching more advanced information. Students should have opportunities to learn about emotional and social factors that influence types of behavior associated with the AIDS virus transmission (CDC, 1988).

Instructional Time and Resources

Schools should allocate sufficient time and resources to personnel, with the appropriate community involvement, that would enable them to develop and implement an AIDS instructional program. Up-to-date materials should be provided. In addition to developing and implementing an AIDS program, it is crucial that sufficient classroom time be provided at each grade level to assure that students: a) acquire essential knowledge of AIDS for that grade level; and b) have time to ask questions and discuss issues raised by the information raised (CDC, 1988).

Program Assessment

Local school boards and administrators can assess the extent to which their programs are consistent with the guidelines listed in the CDC, "Guidelines for Effective School Health Education To Prevent the Spread of AIDS," by determining the extent to which their programs meet each point shown below. Personnel in state departments of

education and health also can use these criteria to monitor the extent to which school in the state are providing effective health education about AIDS.

1. To what extent are parents, teachers, students, and appropriate community representatives involved in developing, implementing, and assessing AIDS education policies and programs?

2. To what extent is the program included as an important part of a more comprehensive school health education program?

3. To what extent is the program taught by regular classroom teachers in elementary grades and by qualified health education teachers or other similarly trained personnel in secondary grades?

4. To what extent is the program designed to help students acquire essential knowledge to prevent HIV infection at each appropriate grade?

5. To what extent does the program describe the benefits of abstinence for young people and mutually monogamous relationships within the context of marriage for adults?

6. To what extent is the program designed to help teenage students avoid specific types of behavior that increase the risk of becoming infected with HIV?

7. To what extent is adequate training about AIDS provided for school administrators, teachers, nurses, and counselors - especially those who teach about AIDS?

8. To what extent are sufficient program development time, classroom time, and educational materials provided for education about AIDS?

9. To what extent are the processes and outcomes of AIDS education being monitored and periodically assessed (CDC, 1988, pp. 8-9)?

Summary

AIDS is a fatal disease that has reached epidemic proportions and has physicians and researchers puzzled. Often, society has unrealistic expectations of medicine in this age of advanced technology, and the inability of the medical community to find a treatment or cure for AIDS has left many frightened. Without a cure or vaccine, education is the best protection against AIDS.

Adolescents may engage in high-risk behavior without conceiving of themselves as members of a risk group, and for this reason, information about the high-risk behaviors must be disseminated. When it comes to prevention, the experts now refer to "high-risk behaviors" rather than "high-risk groups" because anyone who participates in high-risk activities is vulnerable to infection. Becky Adler (1987, p. 134) states:

> Because -- it's not who you are, or <u>what</u> you are, or <u>where</u> you're from, or <u>how old</u> you are, but what you <u>do</u> and <u>how</u> you do it that determines whether you're going to stay healthy or become infected by the AIDS virus.

Young children and adolescents should be the beneficiaries of enlightened educational programs to help them grow up avoiding risk-taking behaviors. To be effective in helping adolescents avoid infection with AIDS, AIDS education must focus on behaviors rather than on the medical epidemiology of the disease. Information should be

straightforward and appropriate to the students' level of development. AIDS education should also include learning experiences that will help adolescents develop skills they need to act on AIDS information and to comply with recommendations to avoid risk behaviors.

A variety of educational methods will be necessary in planning an effective AIDS educational program. Changing high-risk behavior is the primary focus of any comprehensive AIDS prevention program. Current health education theory suggest the following as ways of changing behaviors: 1) increasing knowledge; 2) changing attitudes; 3) enhancing or building skills; 4) influencing the norms of risk populations to support and reinforce behavior change; and 5) establishing services that affect the behavior to be changed, reinforce a commitment to behavior change, and follow-up over a long period of time. Teaching methods could include one-on-one discussion, small group interaction, role playing, lectures, and the use of printed material, electronic media, and audiovisual aids (CDC, 1987b).

Chapter three will focus on the methods used to perform the case study. The chapter will discuss the research, development, boundaries, unit of analysis, and site selection required to conduct the research. It will encompass information which deals with the step-by-step methodology employed in data collection procedures and organization of data, as well as logistics and the analysis of such data.

This will provide a concise, logical format to report and analyze the data to effectively meet the objectives of the case study.

CHAPTER III

METHODOLOGY

Introduction

The major purposes of this study were to describe the procedures used and the reactions of administrators and teachers in the implementation of the AIDS program. Four administrators and ten teachers comprised of six counselors, one school psychologist, one school nurse, and two teachers were interviewed for this case study. These persons were directly or indirectly responsible for the implementation of the AIDS program in one Oklahoma school district were interviewed. The objectives which guided the study were: (1) to determine how the program was developed and by whom, (2) to determine how the administrators and teachers were trained to implement this program, (3) to determine how the students were prepared for this program and what were their prior perceptions of the curriculum, (4) to determine if the time allocated to the implementation of this program was adequate, (5) to determine whether or not it was felt that testing students over material presented would be beneficial, and (6) to determine what revisions are felt to be needed in this program before it is to be implemented again.

This chapter is devoted to the discussion of methods

utilized to accomplish the study's purposes. The specific sections are the research methodology, development of the case study; implementation of the case study, and analysis, verification, and synthesis of the case study.

Research Methodology

Case study methods were used and helpful in the development of this study. A case study is an interpretative presentation and discussion of the case, resting upon evidence gathered during field work. Intensive, in-depth analysis of the procedures used and the reactions of administrators and teachers to the implementation of the AIDS program made available through this study's case study methods might eventually benefit educators and students if the findings of this study are incorporated into the state education system.

Development of the Case Study

Before research data can be collected, several steps need to be taken. The introductory steps in designing a case study are: setting boundaries, defining the unit of analysis, selecting a site, establishing initial contacts, developing data collection systems, and organizing data (Spirer, 1980). Details of each step are discussed below.

Setting Boundaries

Eight major categories were established in setting the boundaries for this study: demographic data, background information, development of the instructional program, faculty preparation, student preparation, AIDS program implementation, AIDS program implementation results, and implementation change strategies. Each category served as a focal point for issues to be raised and information sought in completing the case study interviews. In keeping with the purposes of this study, the objectives were met through the different questions asked under each category concerning the procedures used and reactions to the implementation of the AIDS program.

Determining the Unit of Analysis

The unit of analysis chosen for this study was the AIDS educational program mandated by the government for the state of Oklahoma to disseminate factual information on the subject of AIDS to the students. Because this was the first year this program had been implemented, it provided information for specific data gathering questions and analysis techniques that had a direct relation to the research purposes and objectives.

Selecting a Site

Personal and professional contacts of the researcher's

dissertation committee in the public education system of Oklahoma were especially helpful in directing attention to potential sites. Being able to make contact with school administrators and teachers was a clear consideration in site selection. As a result, the researcher cannot claim the school district chosen was randomly selected. The school district used in this case study was chosen on the basis that it was one of the pioneers in the implementation of AIDS instruction in Oklahoma.

Establishing Initial Contacts

The initial contact was made directly by the researcher with the Assistant-Superintendent in charge of instructional planning of the school district chosen for this study. In this meeting the researcher reviewed why this school district was chosen, explained the purpose of the study, and solicited permission to use the school district for study. Also, assurances were made to protect the confidentiality of the individual participants and the school district. It was emphasized that data collected would be synthesized and reported on a question by question basis. Throughout the meeting the researcher answered questions, gave reasoning and justification for the study. The Assistant-Superintendent granted permission to use the school district for this study's personnel contacts and data gathering.

The next step taken by the researcher was to contact the

school level administrators and teachers responsible for the implementation of the AIDS program. The previously discussed points were reviewed. At this time, individual interview appointments were made by the researcher with the participants.

Developing Data Collection Procedures

Kerlinger (1973, pp. 479-480) states the interview "... is perhaps the most ubiquitous method of obtaining information from people" and "... probably man's oldest and most often used device for obtaining information." The advantages of using the interview in research as outlined by Issac and Michael (1981, p. 138) are:

1. Permits greater depth.
2. Permits probing to obtain more complete data.
3. Makes it possible to establish and maintain rapport with respondent or at least determine when rapport has not been established.
4. Provides a means of checking and assuring the effectiveness of communication between the respondent and the interviewer.

This study's primary data collection procedure was in the form of interviews. Two separate interview schedules were prepared - one for administrators and one for the teachers. Additional follow-up questions were often asked during the interviews. Considerable additional information was obtained by the use of follow-up and probing questions.

The question development was accomplished through a

literature review and several informal task group meetings of graduate students. Another method of developing questions for the interview schedules was through a series of discussions with curriculum specialists.

Kerlinger's (1973, pp. 485-486) criteria for writing questions were followed in developing the interview schedules. These criteria are:

1. Is the question related to the research problem and the research objectives?
2. Is the type of question right and appropriate?
3. Is the item clear and unambiguous?
4. Is the question a leading question?
5. Does the question demand knowledge and information that the respondent does not have?
6. Does the question demand personal or delicate material that the respondent may resist?
7. Is the question loaded with social desirability?

The draft interview schedule was given to peers for review and comment. Appropriate revisions were incorporated based on peer critiques. Pilot-testing was conducted with teachers to identify ambiguous questions and determine the time needed for the interview. Pilot-testing of the questions increased the interviewer's skill in focusing the discussion and in probing, when appropriate, to elicit additional information. The interview schedules used in the study are found in Appendixes C and D.

Organizing Data

A coding system for organizing the data was developed following Spirer's (1980) recommendations. Coding is used to translate question responses and participant information to specific categories for purposes of analyses (Kerlinger, 1973). The categories of classification were demographic data, background information, development of the instructional program, faculty preparation, student preparation, AIDS program implementation, AIDS program implementation results, and implementation change strategies.

The data collected was post-coded. Having recorded the interviewee's responses by taking notes during the interview, the researcher may subject it to content analysis and submit it to one of the available procedures - scaling, scoring, rank scoring, response counting, etc.

Once data from the interviews have been collected, the next stage involves coding and scoring them. Coding has been defined by Kerlinger (1973) as the translation of question responses and respondent information to specific categories for the purpose of analysis. Table III on the following page was developed by Tuckman (1972, p. 190) showing comparisons of the different response modes:

Since the number of coding categories in this study were limited, a physical sorting system of placing data into piles, folders, or on cards was used to sort and organize the data. Finally, the data collected was analyzed and

interpreted in regards to the research objectives.

TABLE III

THE SELECTION OF RESPONSE MODES

Response mode	Type of data	Chief advantages	Chief disadvantages
Fill-in	Nominal	Less biasing; greater response flexibility	More difficult score
Scaled	Interval	Easy to score	Time consuming; can be biasing
Ranking	Ordinal	Easy to score; forces discrimination	Difficult to complete
Checklist or categorical	Nonimal (may be interval when totaled)	Easy to score; easy to respond	Provides less data and fewer options

Implementation of the Case Study

This section of the procedures describes how the case study was implemented. Staff training, logistics of the implementation, and data collection are elaborated on in the following pages.

Staff Training

Since this research was conducted by a single investigator, the need for staff training was not necessary. As primary investigator, the researcher had a clear understanding of the background and purpose of the study. Procedures of interviewing were thoroughly internalized.

Stewart Harral (1954, p. xi) in his description of

interviewing techniques has stated:

> You can't list all the requirements for a successful interview as you list the ingredients of a cake, because each situation is unique and requires special knowledge on the part of the interviewer.

The interviewer took into consideration that to make the interviews most successful, certain preparations had to be made that paralleled staff training. This approach would better assure valid and reliable outcomes, primarily in regard to conducting the interview.

Considerable effort was expended in reviewing proper interview techniques. The following guidelines were followed during the interview (Adams, 1958):

1. Ask the questions exactly as they are worded in the interview instrument.
2. Read each question very slowly and in a conversational manner.
3. Ask the questions in the order in which they are presented in the interview schedule.
4. Repeat questions which are misunderstood or misinterpreted.
5. Do not inject opinions about the interview schedule topics, either verbally or nonverbally.
6. Reinforce the respondent by giving positive feedback in the form of neutral comments.
7. Ask this question frequently, "Is the respondent answering clearly, completely, and relevantly?"
8. Provide smooth transitions between topics.

Probing, another important aspect of interview technique, was done as a part of the conversation connected with the interview. The pretesting of the instrument also

served as a training session for the researcher.

Logistics of the Implementation

During the logistic steps, the interview arrangements were finalized in person, the schedules were coordinated, and the travel plans developed. A minimum of one hour was scheduled for each of the interviews. Interviews were conducted either in the participant's office or classroom.

Supplies needed to implement the case studies were determined prior to data collection. Copies of the survey, note pads, and pens were obtained.

Data Collection

The systematic methods used to collect data were observing, interviewing, and gathering data unobtrusively. Observations data was recorded on participants interactions, their voice tones, and facial expressions.

Interviewing was the second means of data collection in this study. Questions were developed which allow data related to the implementation of the AIDS instructional program to be collected in eight contexts: demographic data, background information, development of the instructional program, faculty preparation, student preparation, AIDS program implementation, AIDS program implementation results, and implementation change strategies. Each of the interview questions was asked of every participant.

The interview took place in private settings and were

preceded by a review of the purpose of the study, the process of selection, and the format of the interview. Guidelines, stated under staff training were followed during the interviews.

Each administrator and teacher participant was asked to provide published educational information on AIDS. The Assistant-Superintendent provided a state mandated AIDS curriculum guide, which contained a review of epidemiology (Appendix E), legislation (Appendix F), a glossary (Appendix G), and a booklet printed by the State Department of Health.

During the teacher interviews, the researcher was provided with a parent permission form (Appendix H) and a section of the curriculum guide (Appendix I) that was previously distributed to the high school students.

Analysis, Verification, and Synthesis of the Case Study

The final section of procedures presents the analysis, verification, and synthesis stage of the case studies.

Analyzing Data

Analyzing and re-analyzing the collected data was an every day ongoing process. During the course of interviewing, probing resulted in additional needed questions. Different themes often resulted from the additional questions asked during the interview. The

researcher was therefore unable to separate collection and analysis into discrete activities. The collected data obtained unobtrusively and through observation was triangulated with the interview data, before, during, and following the interviews.

Data collection was categorized and followed by an in-depth analysis. The coding system as devised by the researcher was utilized and relevant to the data analysis. However, during the data analysis, it became necessary to do some re-coding by adding additional sub-category codes under each of the primary classifications codes. Data information was reviewed several times to establish validity of the themes and patterns to be presented in the following chapter.

A verification procedure was not established. The researcher found it difficult to determine if the interviews gave total reliability in establishing case study methodology. Reasons for questioning the reliability were due to accepting previously stated assumptions: (1) that the participants voluntarily participated in the study, (2) that participants provided accurate evaluations of implementation procedures, and (3) that participants answered all questions honestly.

Reporting and Utilizing the Case Study Finding

The case studies reported in Chapter IV will be

summarized and made available to the administrators and teachers of the AIDS educational programs.

The case study will provide answers to questions regarding implementation procedures and educator reactions to an instructional program for AIDS education. Knowledge gained by these case study answers should provide educators with a better understanding of what might be done to improve the implementation of the AIDS instructional program.

CHAPTER IV

PRESENTATION OF FINDINGS

As our society enters into a new decade, greater social responsibility is being urged upon the educational system. This urging has resulted from the vacuum created by the ever-changing role of the traditional family unit, and the seemingly lack of availability of another institution to fill this need. As new methods of coping with social and personal dilemmas continue to evolve, educators seek to develop and implement responsive educational programs.

A prevailing concern of parents, adolescents, and society, is the AIDS epidemic and the proper response in dealing with this dilemma. The rapid growth of the AIDS epidemic has created new demands for prevention through the public education system. Invariably, controversy over this topic begins with a discussion on the role and responsibility of the public education system, pondering what the system should or should not be doing. The discussion does not stop here; it goes on to the part played by the family, the church and the community. It appears that while almost everyone wants AIDS education in one form or another, the dilemma is who does what, when, where, and how.

Human sexual education is a continuous process. Regardless of whether or not parents and educators take an

active part, human sexual education will go on but perhaps not in the desired direction. As parents and educators, we are compelled to direct the education of our young in the area of sexuality, better enabling them to make the appropriate decisions in dealing with issues such as AIDS.

Parents are the single most important source of sexual values. Sex education is a lifelong process, that is begun before a child is born by their parents' attitude toward sex. Other institutions that provide information to young people are only secondary; the primary responsibility for educating children about sexuality through adulthood has always come from the home. Parents provide the support system of love, warmth, and caring which are essential in developing future values and attitudes. However, the role of the traditional family unit continues to change in today's demanding society. Parents have less time in the home with their children, due to the demographic changes such as marital status and work responsibilities. Now we as parents and educators are compelled to respond and positively address the problems brought about by these changes.

We seek to examine the efforts of segments of our society, to "educate" youngsters as to the nature and risks of AIDS. We do not address the failure, if it is such, of the "family" in our commitment as educators, to sufficiently prepare their offspring to survive in an AIDS-vulnerable world. If positive, comfortable communication about the AIDS

epidemic is unattainable, adolescents may become apathetic toward this issue or turn to misinformed sources to satisfy their inquisitive nature. The outcome of such behavior can be catastrophic, with irresponsible sexual conduct occurring.

As parents and educators, we are obligated to direct the education of our young in the area of AIDS-education: better enabling them to make the correct decisions for themselves as they are maturing. A proper AIDS-education program should provide our adolescents with the knowledge and understanding that would better enable them to avoid the fears, uncertainties, and difficulties evolving from the AIDS dilemma of our emerging society.

This chapter will concentrate on the data supplied by the administrators and teachers in the implementation of the AIDS educational program and the findings as predicated upon such data. The careful review and analysis of this data will assist in meeting the objectives of this study and can possibly lead to the improvement of the AIDS instructional program in the Oklahoma public education system.

Format for Presenting Case Study

This case study will omit a great deal of information that has been collected which may cloud the understanding of the research with trivial and mundane descriptions. During the personal interviews, this researcher has assumed that the respondents have been truthful and candid, allowing for fair

evaluations and conclusions. Hopefully, this is not a myopic viewpoint, but a sound perspective based on results from the pilot study and interviewing techniques employed in this research.

The findings of this research will be arranged in accordance with the interview format. First, the findings of the administrators will be discussed and analyzed, then the data supplied by the teachers will be evaluated in the same manner. In general, responses will be given collectively, while still allowing for individual thought and enlightenment. Demographic characteristics will be explored in each group, as well as background, development of the AIDS instructional program, preparation, and program implementation and results. Implementation strategies and comments are presented.

A brief comparison of the two groups will be discussed after the data from both sides are presented. This will assist in laying the foundation for the analysis, summarization, and recommendations that are necessary to meet the objectives of this study.

Administrators Case Studies.

Four administrators were interviewed for this study. A total of thirty-six questions that were divided into eight section were posed to them.

Section one (questions 1-8) presents the demographic

data supplied by the administrators. This information includes the age, sex, religious preference, educational level, areas of certification, teaching experience, administrative experience, and levels of education currently being supervised by the administrators.

Section two (questions 9 & 10) gives background information of the administrators' campuses.

Section three (questions 11 & 12) discusses the development of the AIDS instructional program, the people responsible for its development, their ages, and classifications of students for which the program was developed, and the role of administrators in the development of this program.

Section four (questions 13-20) addresses the training and preparation that the administrators were given in order to supervise their teachers' implementation of the AIDS program. The administrators expressed their thoughts about the trainers, their qualifications, and the methods used to present the training procedures. Section four also gives the administrators' opinions of the educators who should receive training to teach the AIDS program and the personal characteristics that they feel are important for teachers of the program to possess. Faculty member reactions as observed by the administrators are noted as well.

Section five (questions 21-23) presents methods that were used to prepare students for the AIDS program and

presents the administrators' perceptions of the students attitudes prior to implementation of the program. This section also presents the administrators' viewpoints on the appropriateness of the material for the age of the students for which it was intended.

Section six (questions 24-30) present findings that concern the AIDS program implementation. Discussed in this section are the administrators' viewpoints on delivery styles, teacher time limitations, resources that were provided to the teacher, whether or not the teachers were comfortable with their responsibilities, circumstances that would release a faculty member from teaching the program, and administrators' information on their feelings about a possible correlation on how different administrator types could affect teacher implementation of the AIDS instructional program.

Section seven (questions 31-35) discusses results of the AIDS program implementation. Administrators commented on the benefit of testing students over the material, whether or not the district/school goals were explained, and whether or not the goals were realized.

Section eight (question 36) brings out changes the administrators would like to see made before the AIDS education program is implemented again.

Section I. Four administrators were interviewed for this case study. Ages ranged from thirty-six to fifty-five.

All participants were male and protestant. Three of the participants held Master's Degrees and one, a Doctorate. Areas of certification included social sciences, science, mathematics, elementary education, principalship and administrative certification. Teaching experiences ranged from six to twenty plus years. Areas and levels of education currently being supervised were junior high - seventh, eighth, and ninth grades; and secondary - tenth through twelfth grades.

Section II. Grades on campuses under the administrators ranged from seventh through twelfth. The enrollment on campuses ranged from 501 students to 5000 students.

Section III. The instructional program for AIDS education was developed by the Oklahoma State Department of Education. A select committee of administrators, teachers, and parents interfaced with the state to develop the AIDS education program in conjunction with a medical specialist in the field of immuninology. The intent of this committee was to develop the AIDS program in a manner that could be used by teachers of grades seventh through twelfth.

The administrators interviewed for this study had limited roles in the development of the AIDS educational program. One administrator participated on the state AIDS educational program development committee as a writing consultant. Another administrator, knowledgeable of the innerworkings of the committee and the program, was

responsible to his local school board as to how their mandate concerning this program would be carried out.

Section IV. Training for administrators in preparation to supervise teachers implementing this instructional program ranged from state workshops for some to no training for others. Some administrators attended a staff development workshop. One of the administrators attended a workshop that gave the legal aspects on providing this program and gave important guidelines for it's implementation. These guidelines include the following:

1. Parents must approve of material to be presented to the students.
2. Instructors are to only use state material. All other material must be approved.

Trainers for this instructional program on AIDS education included a licensed MD, a nurse from the State Board of Education, and an Oklahoma University specialist in Immunology. Direct access of information was provided by the State Department of Health Education. The medical doctor, the nurse, the state of Oklahoma, and the counselors on the local level worked together as instructors of the AIDS program. Other personnel involved in training included certified teachers of science and/or counseling.

The teaching methods employed in the presentation of the training materials included lectures, overhead materials, videotape and film presentations. Question and answer sessions were given, along with informative handouts, that

contained statistical information on AIDS.

Suggestions to improve faculty training for the program varied. Although the administrators believed the training received by their faculty was adequate to teach the AIDS education program, all of the them thought inservice training should be closer to the teaching assignment. One administrator commented that his faculty included conscientious individuals and that they would continue updating themselves with new material to enhance their teaching capabilities. Another administrator felt that volunteers should be allowed to present and teach this AIDS educational program, rationalizing that teachers are better motivated to learn when they are interested in the subject matter. One administrator disagreed with the volunteer approach. This administrator thought all teachers should take the assignment as circumstances mandate, unless they have strong, reasonable objections.

The administrators gave a variety of answers when discussing which educators should receive training and why, in dealing with the AIDS educational program. One administrator said that science teachers and student counselors should receive this training, because the science teachers have life-science background and the counselors have background in student behavior. One administrator, a former coach, stated that coaches should be trained as they often have to deal with injuries and bleeding. He also mentioned

that teachers of the university and support personnel such as custodians and secretarial staffs should receive training because of their direct contact with students. A differing viewpoint from one administrator was that only those who teach should receive training with more inservice optional. Our last administrator's response to this question was that all involved in the field of education should receive this training as they may be teaching students who may be victims of this tragic disease. He felt that particular training should be given to those educators and personnel closely related to the health areas, such as science teachers, nurses and counselors, in order to diffuse misinformation concerning this issue.

Section V. Student awareness of the AIDS educational program was brought about by in-school announcements: the school newspaper, bulletin boards, parent meetings, and pre-enrollment forms. Pre-enrollment forms for the AIDS education program were mailed to parents and brought back to school by the students. It was assumed that all students would participate in the program unless the pre-enrollment form was returned indicating parent denial. (Note. Only two of the students did not participate due to parental denial of the program.) Parent meetings were held with a panel of administrators, faculty, and health professionals. During these meetings, material dealing with the AIDS instructional program was distributed and question/answer sessions were

also held. One result of these meetings was the establishment of a parent advisory panel. Perceptions of the administrators concerning the students' attitudes toward this program prior to implementation varied. One administrator felt that students were lackadaisical and apathetic toward the issue of AIDS. Another felt that the students were not really pro and con toward the implementation of this AIDS instructional program. Another administrator felt that the idea was well-received, with many students interested in more information on this subject. One administrator mentioned that he did not have proper contact with the students to make a complete observation, but his first impression was that the students wanted more data on this issue than was obtainable through the news media.

Three of the administrators felt that the material implemented was appropriate for the age of the students. One felt that the teachers did an excellent job in defining terms in the students' vocabulary. Another administrator felt that the film presentation from the Red Cross was "safe", and that the narration of the film was well presented for the student age group. One administrator disagreed and felt the AIDS educational program was geared more for grades ninth through twelfth, and was hard to use with all ages. His opinion was that teachers must adapt the program to younger students (grades seventh and eighth), and they should use primary material relating to this age group.

Section VI. This section is directed toward implementing the instructional program on AIDS education. Administrators were asked if they felt this program allowed for different delivery styles. One administrator said that the curriculum allowed an instructor to teach, test, reteach. This was an indication to him that teachers could choose a method of presentation that was comfortable to them. Another administrator believed that while the program allowed for different delivery styles, there were limitations. This administrator stated that delivery styles may vary, but the materials used in lectures, restricted the faculty to a particular tone. This administrator felt that the limited scope of the material discouraged student interaction. Another administrator thought the AIDS program was so structured that it did not allow for the different delivery styles of instructors. The last administrator believed the program did allow for a balance of delivery styles.

The administrators were concomitant in their answers to the question concerning time limitations on their faculty in implementing this program. One administrator reported that he was limited to two days and part of a third to implement this instructional program on AIDS education. One administrator commented that they could not allow more time for this material as other curriculum had to be taught and that some teachers become upset when time is taken from their other classes. One administrator recommended that two fifty-

five minute instructional periods would be adequate.

In response to the types of resources that were provided to the administrator's faculty, only two replied. One stated that the State Department of Education workshop provided a set of related audio visual studies, and a counselor workshop provided a printed guide. Another stated a school nurse on the junior high and secondary level was on call and available at anytime.

In response to the question of teachers' comfort factors, only one administrator felt the AIDS instruction required the faculty to do or say anything in which they were not comfortable. The administrator commented that the instructional program could create high stress levels for faculty members due to the very nature of the disease, the sexual discussion, and the discussions involving life and death issues. The other administrators said no to this question, with one commenting that the teachers did not feel pressured as they had adequate information to present.

Only two of the administrators discussed the circumstances by which they would release a faculty member from the teaching responsibility of this program. One said that he would only release a teacher if they injected their own beliefs into the program in violation of state mandates. The other said a teacher should be released from this responsibility upon request. This administrator felt that a teacher who did not want to teach this program, for whatever

reason, would have a negative impact and do a poor job.

None of the administrators felt that the way this instructional program was developed and assigned to educators to implement, caused teacher alienation problems. All but one of the administrators believed that there was a direct correlation between the type of administrator methods used and their respective faculty implementation of the program. One administrator said the teachers in his building would take on additional requests for the sake of teamwork. The others agreed with this administrator, due to the professional relationships they had with their faculties. One administrator said that it would probably not have an effect.

Section VII. This section concerns itself with the AIDS instructional program implementation results. Administrators were asked if they felt it would be beneficial to test students over the information learned form the AIDS presentation. The answers varied with brief discussions. One administrator felt the testing of students could determine how effective the teaching had been. The administrator suggested both pre-AIDS instruction and post-AIDS instruction testing of the students as a means to measure the effectiveness of the teaching. Another administrator believed testing could be an effective means to determine how well the teachers were motivated and could be used as a means to improve the program. This administrator

felt testing would result in the student being more attentive to what they were hearing in the classrooms. By testing, this administrator felt the teacher could determine areas that needed to be reemphasized.

The other administrators felt testing would not be beneficial. One said that too many opinions would be assumed, and another administrator said students are tested enough. The administrator mentioned some students may be more attentive and receive more educational benefit by not being required to take a test.

The district/school goals explained to the administrators were general goals. As a district, they were required to comply with the state mandate (House Bill 14-176) and to present an instructional program on AIDS education to every boy and girl this year above the seventh grade and to the seventh grade the following year. Other goals included exposing the student body to facts about AIDS, following the outline in the Oklahoma State Curriculum guide for AIDS, teaching the nature, transmission, and avoidance of the virus.

Individual goals varied. One administrator's goal was to educate students with factual information regarding AIDS, preparing them with the ability to avoid AIDS. Another said that his goals were the same as those of the district/school. One wanted to stress those potentially dangerous activities where one might contract the AIDS virus. Another

administrator's goals were to have instructors teach in a manner that would create no unwanted situations or flack that would jeopardize further implementation and expansion of the AIDS education program.

Three out of the four administrators felt that their goals were realized. One administrator felt that the goals were realized as there had been no complaints, the school board was pleased, the legal obligation was met, and the students gave positive comments. Another administrator was very pleased with attendance - ninety-nine and a half percent.

Feedback from the community was excellent. One administrator reported that the community appreciated their presenting the instructional program on AIDS education. Others reported that they received limited feedback from the community, but what feedback they did receive was positive. The school board and teachers all reported supportive responses to the administrators.

Section VIII. Overall, the administrators were pleased with the instructional program, but had suggestions concerning changes that they thought could improve it. One administrator recommended that a future program should be more in depth. This administrator felt the program should also give the student a basic knowledge of the care and treatment of AIDS victims, the risk versus discrimination of victims by society. The administrator also wanted the

students to have the necessary resources to seek out and make responsible decisions. Two administrators believed the AIDS education program was too general and could be improved by being more specific. Another suggestion was that the program needed to provide more details on different ways AIDS is contacted and that it should provide for more graphic illustrations.

Teacher Case Studies

Ten teachers comprised of six counselors, one school psychologist, one school nurse and two teachers were interviewed. These persons were directly responsible for implementing the AIDS educational program in one school district in Oklahoma were interviewed. A total of thirty-four questions that were divided into eight sections.

Section one (questions 1-6) presents the demographic data supplied by the teachers. Included in this information are age, sex, religious preference, highest degree currently held, areas of certification, and years of teaching experience.

Section two (questions 7 and 8) gives background information of the teacher's campuses.

Section three (questions 9 and 10) discusses how the instructional program for AIDS education was developed, the teacher responses, and the student age and classification for which the program was designed. This section also discusses

teacher involvement with development of the AIDS education program.

Section four (questions 11-18) focuses on faculty preparation to implement the instructional program on AIDS education. The types of training, trainers, and teaching methods used in presenting the training materials are discussed. The teachers gave their opinions as to the types of educators they felt should receive the AIDS instructional program training. The teachers stated some of the characteristics they felt were needed for a teacher of this program to possess. Teachers also gave their reactions of being asked to teach this program. Also discussed was the additional information given to the student that was not mentioned in the program and the nature of this information.

Section five (questions 19-21) gives the teacher perceptions of the student attitudes toward the program prior to its implementation and their thoughts on the material being appropriate for the student age group for which it was intended. This section also brings out student preparation for the AIDS educational program.

Section six (questions 22-28) involves teacher implementation of the instructional program for AIDS education. Discussed in this section are the delivery styles, time limitations on implementation, types of resources provided during the implementation stage of the program, whether the program required them to do or say

anything in which they were not comfortable, and under what circumstances they felt a faculty member should be released from the responsibility of teaching this program. Teachers also expressed their feelings regarding whether the program was developed and assigned to educators for implementation in a manner which may have caused teacher alienation problems. The teachers also provided information on their feelings about a possible correlation between the type of administrator they had and how they implemented the program.

Section seven (question 29 -33) presents the AIDS education program implementation results. Teachers commented on the pros and cons of testing students on the AIDS presentation, on district/school goals, and on whether or not these goals were explained and understood by them. The teachers also discussed personal goals they wanted to obtain while teaching the class, and the ways they believed these goals were or were not realized. Also brought out in this section was feedback the teachers had received from the parents and/or community in regards to the AIDS education program.

Section eight (question 34) is directed toward changes that the teachers would like made in the AIDS instructional program before it would be implemented again. Additional comments were also given by teachers for future implementation strategies.

Section I. The teachers interviewed for this case study

ranged from under thirty-five years to fifty-five years of age. Five of the participants were female and five were male. One of the teachers was Unitarian and the rest were protestant. The instructors that were interviewed consisted of one teacher with a doctorate degree, eight teachers with masters degrees, and one teacher with a bachelor degree. The areas of teacher certification were guidance counseling, education counseling, English, Biology, secondary education, natural science, physics, physical science, chemistry, zoology, earth science, vocational agricultural education, botany, child psychology, mathematics, history, economics, language arts, and geography. Teaching experience ranged from five or fewer years to more than twenty, with the majority of the teachers having between eleven and twenty years teaching experience.

Section II. Grades on campuses under the teachers ranged from kindergarten through the twelfth. The enrollment on campuses ranged from 501 to 5000 students.

Section III. The instructional program for AIDS education was developed for the Oklahoma State Department of Education by a curriculum committee. The committee consisted of administrators, teachers, parents, and three resource persons supplied by the state: a doctor, a nurse, and a medical specialist specializing in immuninology. This state sanctioned committee was to work cooperatively in developing an AIDS education program that could be used by teachers,

grades seven through twelve.

The teachers interviewed in this study had limited to no involvement in the development of this program. Most said that they had no role and were not consulted concerning this program development. Others stated that their only contribution was to adapt the AIDS instructional program to their classroom environment. One respondent (a nurse) that was involved with the program, in its earliest stages, attended workshops, made recommendations, and organized data.

Section IV. Training for teachers preparing to implement this program ranged from workshops and study guides for some, to no training for others. One teacher that attended two state workshops was given study guides and supplemental material to learn. Some of the teachers received training through staff meetings. Other teachers said they received no intensive training and commented that there was not enough access to information or loan material.

The trainers for this AIDS educational program included a licensed MD, a nurse from the State Board of Education, an Oklahoma University specialist in Immuninology, and a nurse who had worked with AIDS patients. A film was presented by the Red Cross. Teaching methods employed in training the teachers included overhead transparencies, lectures, discussions, statistical information handouts, and question/answer sessions.

Teacher responses differed when asked if they felt the

training they received was adequate for preparation to teach this new program. Some teachers felt the training and information provided to them was adequate for them to instruct in a well prepared manner. Other positive responses mentioned were teachers being comfortable with the training received and teachers sharing information on what presentations worked best for them. Teachers who responded negatively, stated they had not received much from the AIDS training program that could assist them with implementation of the program. These teachers were grateful they possessed the innovative capabilities needed for the program implementation.

When the teachers were asked which educators should receive training in dealing with the AIDS educational program, general statements emerged. Their responses were that all educators should receive two hours training along with inservice requirements. The teachers, they felt, should be most involved with implementation were science teachers, because they had backgrounds involving health related matters, and the counselors because of their background involving student behavior. One teacher also mentioned coaches and staff personnel because of the need for everyone to assist in eradicating this disease.

Characteristics these teachers felt were needed by instructors of this program were strong speaking skills, open-minded attitude, truthfulness and honesty with students,

the ability to establish a good rapport, sincerity, enthusiasm, and confidence in the subject matter. One teacher commented that people claiming to be of strong moral convictions should not instruct this material as they tend to be very conservative and will have difficulties. The response most often given by the teachers was that they must have a bond of trust with the students in order to make the instruction of the AIDS education class valuable and meaningful. They also felt a good science background along with the ability to communicate about AIDS without a sense of embarrassment would be important.

Responses to teachers' reactions when they were asked to implement this instructional program varied. Some teachers felt this was just one more imposition on their professional and personal time and just one more responsibility being added to the educational system. One teacher knew of two boys in the school who had lost a brother to AIDS. This teacher felt the AIDS education program would be impactful and beneficial to students and that teachers should be positive about receiving this teaching assignment. Others stated even though they felt overworked, the need for AIDS education was a necessary burden. Another said science teachers should be chosen instead of counselors. The nurse was enthusiastic and very positive toward the program.

Teachers were asked if any additional information had been given to the students that was not mentioned in the

state's AIDS instructional program. Some teachers said additional resource material presented to the students were magazine articles from a publication called SCOPE, "AIDS: The Facts" pamphlet, and a tape from the Red Cross entitled "Beyond The Fear." Others stated that question and answer sessions were held which expounded beyond the given instructional material. One teacher said no, as the law only allowed material sanctioned by the state. Two teachers said they would like more specific information (such as items on kissing) that could enhance their presentations. Others stated that even though they did not have a good understanding of the material, they followed it to the letter. One also said information available from the Surgeon Generals office was not provided to them.

Section V. Initial student awareness of the new instructional program was by in-school announcements. Students taking the AIDS education classes were separated by sex into all boy groups and all girl groups. A pre-enrollment form was sent to parents for consent to allow their children to participate in the program. (Parents were afforded the right to deny this education to their children.) A panel of administrators, teachers, and health professionals met with parents for a question and answer session. A parental advisory board was established at this meeting.

Teachers were asked what their perceptions had been of student attitudes toward this AIDS educational program prior

to implementation. One teacher felt that the students were apprehensive, and believed the students felt they already knew everything and did not need any additional information. Others said their students were curious and anxious to learn more about AIDS, and some of the students had already written papers on the subject. In general, most teachers said their students displayed no anger and appeared receptive to the AIDS educational program.

The majority of teachers felt the material appropriate for the age of the students for which it was intended. One teacher said teachers have the ability to take the material given to them for presentation and, if need be, adapt the material to the age of students being taught. One teacher commented that older students seemed more serious about the material and had received basic information from sex education classes. One negative respondent said the film presentation was inappropriate for seventh graders and more relevant material was needed for teenagers. One mentioned the AIDS instructional material was enhanced by teachers that took the time to explain vocabulary to the students in terms they could understand.

Section VI. All of the teachers surveyed in this study agreed that the AIDS educational program allowed for different delivery styles. One teacher responded that the program required teachers to use many delivery styles. Many teachers mentioned that utilizing visual, audio, overhead

transparencies, and lectures as different means of presenting the material allowed for a variety of presentation styles. In general, teachers reported the material was adaptive to any teaching style and that each teacher could choose a style that was most comfortable to them.

Teachers were asked to discuss the time limitations they had in implementing the program and whether or not the time allotted was adequate for delivery of the AIDS material. Some teachers felt the two fifty-five minute periods for presentation was adequate. Others said more time was required, because much of the first day was spent on the many questions posed to them during the lecture. Another suggestion was that three periods of instruction would permit more time that is needed for teacher-student interaction. Another suggested adding another week to the sex education class, making it a two week class to include this AIDS education program. One of the teachers suggested that five days was needed for the students to study and learn the material. Only one teacher said the current time limitations were fine, but more time would have to be made available if more needed information was added to the program.

The types of resources available to the teachers varied. Some had access to a contact person with the state while others did not. Many teachers received a set of related audio visual studies from the state, while others attended workshops and were given a printed guide from the State

Department of Education. The Red Cross film and pamphlet were made available to teachers, along with question and answer sessions that was also attended by the school nurse and counselors. One teacher reported that they consulted with an administrator to ensure that the materials being used followed state rules.

Teachers were asked if they felt this instructional program required them to do anything with which they were not comfortable. One teacher mentioned being uncomfortable and apprehensive when dealing with the homosexual discussion. Another stated that the state did not allow instructors to teach the abstinence only concept, and that this conflicted with his personal and moral beliefs. Others felt it was an obligation of teachers to instruct this material due to the nature and ramifications of the disease on society. One teacher said the material was easy to discuss with students. Another indicated religious feelings made it difficult to define AIDS in any terms except immoral.

Teachers were asked under what circumstances a teacher should be released from the teaching responsibility of implementing this program. One stated that there was no need of a particular criteria and that a teacher should be released from this responsibility if they did not want to instruct the new program. Others said that a teacher not giving correct information or injecting their own personal views should be released. Another said that a teacher who

had prejudice against homosexuals and AIDS victims should not instruct this program. Others felt that forcing a teacher to present and implement the program against their will would cause them to do a poor job.

Most teachers felt the way the AIDS educational program was developed and assigned to educators to implement, did not cause teacher alienation. Many said they felt a responsibility to help the students gain factual information concerning this disease. Two teachers said that not teaching the abstention only concept would force some educators to go against personal convictions.

The majority of teachers felt that there was a correlation between the type of administrator they had and how they implemented the program. One said suggestions from their administrator demonstrated support and appreciation. A couple of teachers thought their administrator was fair and appreciative of their taking the additional responsibility of teaching the AIDS instructional program. One teacher said there was no correlation because they were professional teachers and had confidence in themselves and their abilities to correctly implement the program.

Section VII. This section concerns itself with the AIDS education program's implementation results. Teacher were asked whether they felt students should be tested on the information learned from the AIDS presentation. One felt testing would be beneficial in determining whether the

students had received correct information on the AIDS issue. Another teacher stated testing could serve as a means of determining how attentive the students were in class and serve as a means of motivating the students to learn the material. One teacher said that this educational program should be treated as any other and that the students should be tested, while another teacher felt that the students were tested enough. An additional comment stated testing would allow for needed adjustments in the program and would update information. A negative respondent said testing a seventh grade class was not beneficial as the students were more concerned with their test grade than with the material. A final response suggested pre-AIDS instruction and post-AIDS education testing would serve as a means to measure instructor effectiveness.

The district/school goals were outlined in the State Guide. The district's goal was to comply with the state mandate (House Bill 14-176), teach the student body the facts, and expose the myths about AIDS. School goals included discussing ways of contracting AIDS, stressing abstention, the use of condoms, having all students receive the factual information that is needed to reduce their anxieties, misconceptions and the unnessary fear relating to AIDS. Another goal was to create empathy for AIDS victims.

The individual goals of the teachers often paralleled the goals of the district/school. There was a general

consensus among the teachers to emphasize the danger of AIDS and methods of AIDS prevention to the students. The teachers expressed an overwhelming desire to establish student understanding of the AIDS victim's problems. Also mentioned was their desire to teach students to be less judgemental about persons who had contacted the disease and accept their individual responsibility in dealing with AIDS. Others wanted students to realize the entire scope of the problem including economic, political and social ramifications. One teacher's goal was to make certain students realized that they were not going to live forever and that they needed to become realistic on matters concerning their life decisions.

Most teachers felt their goals were realized to some degree of success. Teachers reported students had positive comments, expressing empathy for AIDS victims. Others stated that there were no complaints from the school board, parents, or teachers. One mentioned that the state mandate had been carried out in proper fashion. One teacher felt it was too early to determine whether goals were reached since the AIDS education program was not an exact science. One teacher said students would place more priority in what peers told them than what they were taught.

Teachers received limited feedback from the parents and/or community. All comments they received were positive. One teacher reported that parents were thankful for the AIDS education program. Teachers received only positive

comments from students.

Section VIII. In this final section, teachers discuss what changes they would like made in the program before it would be implemented again. General responses included lengthening the implementation period, updating information, add more specific, direct material dealing with the virus and how it functions, and teaching more on the heterosexual relationship with AIDS. One teacher suggested film presentations should be more related to an age group rather than one film for all age groups. Another suggested that if boys and girls were not divided into groups by sex, they would be more comfortable discussing AIDS prevention. One respondent felt that more inservice training should be given to instructors on the program and that different teachers should present the AIDS instructional material the next time it was taught. Another suggestion was to have smaller groups of students. This would permit instructors to have more personal interaction with individual students. Two instructors suggested that more information on research be presented.

Additional comments from the teachers were limited. One instructor wanted to make students more comfortable with the lectures so they would not be appalled by specific questions. Another reiterated that instructors needed to be honest and needed to give more specific instruction in order for them to do a better job. Our final comment was that teachers need to

be more sensitive to students' feelings and needs and to encourage their students to feel that they make important contributions to the class.

Conclusion

The introduction of this chapter focused on the changing roles and new social demands being placed upon the educational system. Our study narrowed this focus to one particular Oklahoma school district and its need to implement a necessary instructional program that could deal with one of these demands - AIDS. The two groups that were studied included administrators and teachers from this district. The goal of this chapter was to present the actual findings from both groups and organize them in a manner that would allow a valid evaluation of the AIDS instructional program on AIDS education implemented by this school district. The findings as predicated upon this data, have enabled this goal to be realized.

The data from the two case studies will be compared and analyzed in Chapter V. The research will show evolving themes from the comparison and will summarize the case studies and make recommendations necessary to meet the objectives of this study.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

As previously stated, the major purposes of this study were to describe the procedures used and the reactions of administrators and teachers in the implementation of the AIDS instructional program in one particular Oklahoma school district. The objectives which guided this study were (1) to determine how the program was developed and by whom, (2) to determine how the administrators and teachers were trained to implement this program, (3) to determine how the students were prepared for this program, (4) to determine if the time allocated to the implementation of this program was adequate, (5) to determine whether it was felt that testing students over material presented would be beneficial, and (6) to determine what revisions are felt to be needed in this program before it is to be implemented again.

The case study presented in chapter four has allowed for the accomplishment of these objectives. Each objective will be analyzed and summarized by presenting findings from the two groups of the study. Upon completion of discussing these objectives, recommendations for future implementation strategies will be given. Also, important themes evolving

from this study will be included throughout this chapter.

Objective 1

Objective 1 was to determine how the AIDS educational program was developed and by whom. The case study showed that the AIDS educational program was developed by the Oklahoma State Board of Education, under a mandate from the state legislature (House Bill 14-176). A select committee of administrators, teachers, and parents interfaced with state personnel during the development of this program. The program was specifically developed for students of grades seven through twelve. The Red Cross presented a film on the subject matter that was made available to the school district. Administrators and teachers from the district had very little if any input in the development of the program with the exception of one administrator who was on the state writing committee.

Objective 2

Objective 2 was to determine how the administrators and teachers were trained to implement this AIDS instructional program. The findings from the case study showed that training ranged from some to no training at all. The trainers for the AIDS educational program included a licensed MD, a nurse from the State Board of Education, and an Oklahoma University specialist in Immunology. Those

administrators and teachers who received training attended state workshops, staff meetings, viewed overhead transparencies and film presentations on the subject matter, received handouts with statistical information, and attended lectures with question and answer sessions. Some teachers felt that their training had not been intensive enough and that they did not have enough access to information or loan material.

Objective 3

Objective 3 was to determine how the students were prepared for the AIDS education program. Students were prepared for the new program through in-school announcements and pre-enrollment forms that were mailed to their parents to gain parental consent. It is important to note that in preparing the students, a parental advisory panel was established as parents have the right to deny this education to their children. Boys and girls were separated by sex, into different groups.

Objective 4

Objective 4 was to determine if the time allocated to the implementation of the AIDS instructional program was adequate. The data taken indicates the general consensus of teachers and administrators was that more time must be allowed for implementing this instructional program. The

very nature of the disease and the dilemma that students will face in society requires more instructional time for them to be able to digest and understand the material. Many felt that at least one to two weeks of additional time should be given to this instructional program and that it should be incorporated and taught with the sex education program. Also, they felt that more question and answer time should be given to the students.

Objective 5

Objective 5 was to determine whether it was felt that testing students over material presented would be beneficial. In general the data indicated the administrators and teachers had mixed feelings concerning testing students on the AIDS educational material. Many of the respondents felt that testing would show how effective the program and its instructors were in presenting the AIDS material. Others said that testing would determine student attentiveness and student interest of the program. Negative responses stated that students already felt that they were over-tested and would be negative toward additional testing. Overall, the majority responses of administrators and teachers concluded that testing would be beneficial.

Objective 6

Objective 6 was to determine what revisions are felt to

be needed in the AIDS educational program before it is to be implemented again. Overall, the administrators and teachers interviewed for this study were pleased with the program but had suggestions which they felt would enhance future program implementations. Suggestions included additional in-service time, updated information on AIDS, and material more relevant for the age groups being taught, and more personal interaction with students. The administrators and teachers suggested the AIDS educational program be more specific and direct with issues such as the care treatment of patients, associated risks, and discrimination of AIDS victims. Another suggestion was to provide more details on the causation of the disease, and utilize more graphic data as a means of making the students more comfortable when discussing the program content and their individual concerns about AIDS.

Conclusions

While researching this case study, the researcher found many consistencies between the administrators' and teachers' viewpoints and comments. While position and experience often differed between the group of administrators and the group of teachers, the demographic characteristics such as age, religious preference, and educational backgrounds were very similar. The first few sections of the two groups of this case study (Sections 1-4) gave basic, factual information in response to the questions posed. Other questions dealing

with matters such as, "Do you feel the training was adequate for the faculty?" showed a general response pattern. For example, this researcher had no trouble determining which teachers worked for the administrator who said teachers were conscientious individuals that would continue updating themselves with new material to enhance their teaching capabilities. These same teachers strongly stated that their relationship with their administrator made them feel encouraged and willing to take on this new instructional program as a team. Another similarity occurred when both groups of administrators and teachers were asked, "What characteristics do you feel a teacher of this program should possess?" The responses were general and the characteristics mentioned by each group seemed to reflect those of the other group. Both groups felt that improved training procedures would enhance this educational program and that more time should be allotted to properly implement the program. Both groups had similar goals for themselves in implementing the instructional program, and both groups felt that the program required little change.

At times the responses seemed too patented as to what the participants felt they should say, even though their confidentiality was assured. The researcher's personal observation is that many of these administrators and teachers followed this line of thinking in order to meet the state's mandate. Throughout the interviews, the researcher was told

that in the beginning many of the participants were uncomfortable with the implementation of this program. However, as time progressed toward the implementation period, they felt more confident in presenting this material.

Prior to starting the interview process for this case study, the researcher had hoped for more diversity in the answers given by the respondents. The researcher had hoped to hear strong, constructive criticism given by the participants to the questions. This did not occur as some participants seemed to feel uncomfortable or afraid to speak their thoughts. At times, many off-the-record comments were more candid than those given for the questionnaire. One administrator was unhappy because more burden was being placed upon teachers that were already overworked. Whereas, the administrator would give these personal thoughts to the interviewer, the administrator would not publicly voice objections to colleagues due to job visibility. Other individuals expressed the same concern that if they objected or told their superiors that they were unhappy with this responsibility; they would jeopardize themselves and their positions.

The respondents who did make these statements were small in number, but those who did left questions for the researcher to ponder, such as why can't colleagues and their superiors be more comfortable when discussing difficult responsibilities. The many answers to that question could

easily lay the foundation for another case study. Even though certain participants did not feel comfortable in discussing all of their feelings for the interview format, the researcher still feels that the respondents were truthful. Those who did not speak off the record seemed to either say what they felt or had no comment at all.

A last observation of this researcher while working on this case study is that the researcher became more aware of the growing dilemma of AIDS and how it has effected students, teachers, health-officials, and administrators. The attitudes, perceptions, and pre-conceived or factual knowledge that these individuals possessed were diverse and far-reaching and that their thoughts on this subject could affect political, social, economical, and ethical conduct by our society in dealing with this and other dilemmas in the future.

Recommendations for Future Implementation Strategies

The following recommendations are based on the interview findings of administrators and teachers and from personal knowledge and insight obtained by the researcher during this case study.

1. Provide better and more consistent channels of information to all persons involved with the responsibility of program implementation.

2. Continue to update information as new data evolves concerning the treatment and AIDS virus research.

3. Provide educational material that is relevant to the ages of the students being taught, such as film presentations to be used in upper-level grades (10-12).

4. Provide more time for implementing the program. More implementation time should provide for a better quality of instruction and additional time should enable the student to better digest the material for understanding.

5. Provide more time for in-service meetings, staff meetings, and training of instructors to improve their knowledge of the AIDS subject material.

6. Include this program to a limited degree with health science courses and correlate this program into the instruction of the sex education program.

7. Emphasize prevention and individual responsibility to the students.

8. Add courses on the university level to better prepare teachers for the AIDS educational program teaching assignment.

9. Plan community meetings at the school periodically with respected health officials and community leaders. These meetings should help the schools obtain community support.

10. Have a panel of different members from the community clergy talk with parents and students about the AIDS educational program and prevention. Again, this panel should help the schools obtain additional community support.

11. Have the Surgeon General's facts on AIDS available to the teachers and administrators.

12. Release teachers from the responsibility of teaching the AIDS instructional program if they have reasonable personal objections.

13. Test willing students who have participated in the AIDS educational program. Use testing results to measure teaching and material effectiveness.

14. Require future AIDS educational programs to deal with the care treatment of AIDS victims, the risk, and discrimination of AIDS victims by society.

15. Seek and provide teaching methods that allow students to feel comfortable discussing AIDS program information with their teachers and classmates.

As has been previously stated; program planning is a continuous process. After implementation of a program; areas of weaknesses are identified and recommendations are suggested to improve the program. This researcher hopes that the findings and recommendations of this study can contribute and be helpful with future AIDS instructional program implementation in the Oklahoma school districts.

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APPENDIXES

APPENDIX A

THE PRESIDENT'S DOMESTIC POLICY COUNCIL'S PRINCIPLES FOR AIDS EDUCATION

The President's Domestic Policy Council's Principles for AIDS Education

The following principles were proposed by the Domestic Policy Council and approved by the President in 1987.

Despite intensive research efforts, prevention is the only effective AIDS control strategy at present. Thus, there should be an aggressive Federal effort in AIDS education.

The scope and content of the school portion of this AIDS education effort should be locally determined and should be consistent with parental values.

The Federal role should focus on developing and conveying accurate health information on AIDS to the educators and others, not mandating a specific school curriculum on this subject, and trusting the American people to use this information in a manner appropriate to their community's needs.

Any health information developed by the Federal Government that will be used for education should encourage responsible sexual behavior - based on fidelity, commitment, and maturity, placing sexuality within the context of marriage.

Any health information provided by the Federal Government that might be used in schools should teach that children should not engage in sex and should be used with the consent and involvement of parents.

APPENDIX B

ESSENTIAL INFORMATION ABOUT AIDS FOR EACH OF THREE GRADE-LEVELS

Essential Information about AIDS for Each of Three Grade-Levels

Early Elementary School

Education about AIDS for students in early elementary grades principally should be designed to allay excessive fears of the epidemic and of becoming infected.

AIDS is a disease that is causing some adults to get very sick, but it does not commonly affect children.

AIDS is very hard to get. You cannot get it just by being near or touching someone who has it.

Scientists all over the world are working hard to find a way to stop people from getting AIDS and to cure those who have it.

Late Elementary/Middle School

Education about AIDS for students in late elementary/middle school grades should be designed with consideration for the following information.

Viruses are living organisms too small to be seen by the unaided eye.

Viruses can be transmitted from an infected person to an uninfected person through various means.

Some viruses cause disease among people.

Persons who are infected with some viruses that cause disease may not have any signs or symptoms of disease.

Persons who are infected with some viruses that cause disease may not have any signs or symptoms of disease.

AIDS (an abbreviation for acquired immuno-deficiency syndrome) is caused by a virus that

weakens the ability of infected individuals to fight off disease.

People who have AIDS often develop a rare type of severe pneumonia, a cancer called Kaposi's sarcoma, and certain other diseases that healthy people normally do not get.

About 1 to 1.5 million of the total population of approximately 240 million Americans currently are infected with the AIDS virus and consequently are capable of infecting others.

People who are infected with the AIDS virus live in every state in the United States and in most other countries of the world. Infected people live in cities as well as in suburbs, small towns, and rural areas. Although most infected people are adults, teenagers can also become infected. Females as well as males are infected. People of every race are infected, including whites, blacks, Hispanics, Native Americans, and Asian/Pacific Islanders.

The AIDS virus can be transmitted by sexual contact with an infected person; by using needles and other injection equipment that an infected person has used; and from an infected mother to her infant before or during birth.

A small number of doctors, nurses, and other medical personnel have been infected when they were directly exposed to infected blood.

It sometimes takes several years after becoming infected with the AIDS virus before symptoms of the disease appear. Thus, people who are infected with the virus can infect other people - even though the people who transmit the infection do not feel or look sick.

Most infected people who develop symptoms of AIDS only live about 2 years after their symptoms are diagnosed.

The AIDS virus cannot be caught by touching someone who is infected, by being in the same room with an infected person, or by donating blood.

Junior High/Senior High School

Education about AIDS for student in junior high/senior high school grades should be developed and presented taking into consideration the following information.

The virus that causes AIDS, and other health problems, is called human immuno-defificiency virus, or HIV.

The risk of becoming infected with HIV can be virtually eliminated by not engaging in sexual activities and by not using illegal intravenous drugs.

Sexual transmission of HIV is not a threat to those uninfected individuals who engage in mutually monogamous sexual relations.

HIV may be transmitted in any of the following ways: a) by sexual contact with an infected person (penis/vagina, penis/rectum, mouth/vagina, mouth/penis, mouth/rectum); b) by using needles or other injection equipment that an infected person has used; c) from an infected mother to her infant before or during birth.

A small number of doctors, nurses, and other medical personnel have been infected when they were directly exposed to infected blood.

The following are at increased of having the virus that causes AIDS and consequently of being infectious: a) persons with clinical or laboratory evidence of infection; b) males who have had sexual intercourse with other males; c) persons who have injected illegal drugs; d) persons who have had numerous sexual partners, including male or female prostitutes; e) persons who received blood clotting products before 1985; f) sex partners of infected persons or persons at increased risk; and g) infants born to infected mothers.

The risk of becoming infected is increased by having a sexual partner who is at increased risk of having contracted the AIDS virus (as identified previously), practicing sexual behavior that results in the exchange of body fluids (i.e., semen, vaginal secretions, blood), and using unsterile needles or paraphernalia to inject

drugs.

Although no transmission from deep, open-mouth (i.e., "French") kissing has been documented, such kissing theoretically could transmit HIV from an infected to an uninfected person through direct exposure of mucous membranes to infected blood or saliva.

In the past, medical use of blood, such as transfusing blood and treating hemophiliacs with blood clotting products, has caused some people to become infected with HIV. However, since 1985 all donated blood has been tested to determine whether it is infected with HIV; moreover, all blood clotting products have been made from screened plasma and have been heated to destroy any HIV that might remain in the concentrate. Thus, the risk of becoming infected with HIV from blood transfusions and from blood clotting products is virtually eliminated. Cases of HIV infection caused by these medical uses of blood will continue to be diagnosed, however, among people who were infected by these means before 1985.

Persons who continue to engage in sexual intercourse with persons who are at increased risk or whose infection status is unknown should use a latex condom (not natural membrane) to reduce the likelihood of becoming infected. The latex condom must be applied properly and used from start to finish for every sexual act. Although a latex condom does not provide 100% protection -because it is possible for the condom to leak, break, or slip off - it provides the best protection for people who so not maintain a mutually monogamous relationship with an uninfected partner. Additional protection may be obtained by using spermicides that seem active against HIV and other sexually transmitted organisms in conjunction with condoms.

Behavior that prevents exposure to HIV also may prevent unintended pregnancies and exposure to the organisms that cause Chlamydia infection, gonorrhea, herpes, human papillomavirus, and syphilis.

Persons who believe they may be infected with the AIDS virus should take precautions not to infect others and to seek counseling and antibody

testing to determine whether they are infected. If persons **are not** infected, counseling and testing can relieve unnecessary anxiety and reinforce the need to adopt or continue practices that reduce the risk of infection. If persons **are** infected, they should: a) take precautions to protect sexual partners from becoming infected; b) advise previous and current sexual or drug-use partners to receive counseling and testing; c) take precautions against becoming pregnant; and d) seek medical care and counseling about other medical problems that may result from a weakened immunologic system (CDC, 1988, pp. 5-8).

APPENDIX C

ADMINISTRATOR QUESTIONNAIRE

Administrator Qestionnaire

Date_____

Time_____

School_____

Respondent's Name_____

Address_____

_____

Home phone number_____School phone number_____

May I contact you if needed at a later date? _____yes

_____no

I. DEMOGRAPHIC DATA

1. What is your age?
   _____a. Under 35
   _____b. 36-45
   _____c. 46-55
   _____d. 56-65
   _____e. older than 65

2. What is your sex?
   _____a. Male
   _____b. Female

3. What is your religious preference?
   _____a. Baptist
   _____b. Catholic
   _____c. Church of Christ
   _____d. Jewish
   _____e. Methodist
   _____f. Other/specify _____

4. What is the highest degree that you presently hold?
   _____a. Bachelor's degree
   _____b. Master's degree
   _____c. Specialist's degree
   _____d. Doctor's degree
   _____e. Other/specify _____

5. What are your areas of certification?

_____
_____
_____
_____
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_____
_____

6. How many years of teaching experience do you have?

_____a. 5 or fewer years
_____b. 6-10 years
_____c. 11-15 years
_____d. 16-20 years
_____e. More than 20 years

7. How many years have you served as an administrator?

_____a. 5 or fewer years
_____b. 6-10 years
_____c. 11-15 years
_____d. 16-20 years
_____e. More than 20 years

8. What area and level of education are you currently supervising?

_____
_____
_____
_____
_____
_____
_____

II. **BACKGROUND INFORMATION**

9. What grades are included on your campus?

_____
_____
_____
_____
_____
_____
_____

10. What is the enrollment on your campus?
_____a. 100 or fewer
_____b. 101-250
_____c. 251-500
_____d. 501-1000
_____e. 1001-5000

III. DEVELOPMENT OF THE AIDS EDUCATIONAL PROGRAM

11. How was this program developed? By whom? For what age/classification students?

_____
_____
_____
_____
_____
_____
_____
_____

12. What was your role in the development of this educational program?

_____
_____
_____
_____
_____
_____
_____
_____

IV. FACULTY PREPARATION FOR THE AIDS EDUCATIONAL PROGRAM

13. What type of training did you receive in preparation to supervise teachers implementing this educational program?

_____
_____
_____
_____
_____
_____
_____
_____
_____

14. Who were the trainers for this educational program? What were their qualifications?

15. What teaching methods were used in the presentation of the training materials?

16. Did you feel the training your faculty received was adequate in preparation to teach this new educational program? If so, how? If not, how do you feel the training can be improved?

17. Which educators do you feel should receive training in dealing with the AIDS educational program? Why?

18. What personal characteristics do you feel are important for a teacher of this educational program to possess? Why?

19. What were the reactions of your faculty members when asked to implement this educational program?

_____
_____
_____
_____
_____

20. To your knowledge was additional information given to the students that was not mentioned in this educational program? If so, what was the nature of this information?

_____
_____
_____
_____
_____

V. STUDENT PREPARATION FOR THE AIDS EDUCATIONAL PROGRAM

21. How were the students prepared for this new educational program?

_____
_____
_____
_____
_____

22. What were your perceptions of the students' attitudes toward this educational program, prior to implementation?

_____
_____
_____
_____
_____
_____

23. Was the material implemented appropriate for the age of the student for which it was intended? Please state examples for both yes and no responses.

_____
_____
_____
_____

VI. AIDS INSTRUCTIONAL PROGRAM IMPLEMENTATION

24. Does this instructional program allow for different delivery styles? If so, which ones? If not, why?

25. What time limitations did your faculty have in implementing this instructional program ? Was the time adequate for delivery of this instructional program? If not, in your opinion what would be adequate time for implementation of this instructional program?

26. What type of resources (resource person, guide, materials) was your faculty provided with during the implementation stage of this instructional program?

27. Do you feel this instructional program required your faculty to do or say anything with which they are not comfortable? If yes, what?

28. Under what circumstances would a faculty member be released from the teaching responsibility of teaching this instructional program?

29. Do you feel the way this instructional program was developed and assigned to educators to implement may have caused teacher alienation? If yes, how?

30. Do you feel there is a correlation between the type of administrator you are and how your faculty members implemented this instructional program? Please elaborate on yes and no responses.

VII. AIDS INSTRUCTIONAL PROGRAM IMPLEMENTATION RESULTS

31. Do you feel it would be beneficial to test students over information learned from the AIDS presentation? Please discuss yes and no responses.

32. What were the district/school goals explained to you for your faculty to obtain in teaching this instructional program?

33. What goals were you hoping to achieve by the implementation of this instructional program? (tangible and intrinsic)

34. In what ways do you feel the goals were realized? In what ways were your goals not met?

35. What type of feedback have you received from parents and/or community in regards to the teaching of the AIDS instructional program?

VIII. AIDS INSTRUCTIONAL PROGRAM IMPLEMENTATION CHANGE STRATEGIES

36. What changes would you like to see in this educational program before it is implemented again?

IX. ADDITIONAL COMMENTS

APPENDIX D

TEACHER QUESTIONNAIRE

Teacher Questionnaire

Date_____

Time_____

School_____

Respondent's Name_____

Address_____

_____

Home phone number_____School phone number_____

May I contact you if needed at a later date? _____yes

_____no

I. DEMOGRAPHIC DATA

1. What is your age?
   _____a. Under 35
   _____b. 36-45
   _____c. 46-55
   _____d. 56-65
   _____e. older than 65

2. What is your sex?
   _____a. Male
   _____b. Female

3. What is your religious preference?
   _____a. Baptist
   _____b. Catholic
   _____c. Church of Christ
   _____d. Jewish
   _____e. Methodist
   _____f. Other/specify _____

4. What is the highest degree that you presently hold?
   _____a. Bachelor's degree
   _____b. Master's degree
   _____c. Specialist's degree
   _____d. Doctor's degree
   _____e. Other/specify _____

5. What are your areas of certification?

_____
_____
_____
_____
_____
_____
_____

6. How many years of teaching experience do you have?

_____a. 5 or fewer years
_____b. 6-10 years
_____c. 11-15 years
_____d. 16-20 years
_____e. More than 20 years

II. BACKGROUND INFORMATION

7. What grades are included on your campus?

_____
_____
_____
_____
_____
_____
_____

8. What is the enrollment on your campus?

_____a. 100 or fewer
_____b. 101-250
_____c. 251-500
_____d. 501-1000
_____e. 1001-5000

III. DEVELOPMENT OF THE AIDS EDUCATIONAL PROGRAM

9. How was this program developed? By whom? For what age/classification students?

_____
_____
_____
_____
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_____
_____
_____

10. What was your role in the development of this educational program?

IV. **FACULTY PREPARATION FOR THE AIDS EDUCATIONAL PROGRAM**

11. What type of training did you receive in preparation to implement this educational program?

12. Who were the trainers for this educational program? What were their qualifications?

13. What teaching methods were used in the presentation of the training materials?

14. Did you feel the training you received was adequate in preparation to teach this new educational program? If so, how? If not, how do you feel the training can be improved?

15. Which educators do you feel should receive training in dealing with the AIDS educational program? Why?

16. What personal characteristics do you feel are important for a teacher of this educational program to possess? Why?

17. What was your reaction to being asked to implement this educational program?

18. To your knowledge was additional information given to the students that was not mentioned in this educational program? If so, what was the nature of this information?

V. STUDENT PREPARATION FOR THE AIDS EDUCATIONAL PROGRAM

19. How were the students prepared for this new educational program?

20. What were your perceptions of the students' attitudes toward this educational program, prior to implementation?

21. Was the material implemented appropriate for the age of the student for which it was intended? Please state examples for both yes and no responses.

VI. AIDS INSTRUCTIONAL PROGRAM IMPLEMENTATION

22. Does this instructional program allow for different delivery styles? If so, which ones? If not, why?

23. What time limitations did you have in implementing this instructional program ? Was the time adequate for delivery of this instructional program? If not, in your opinion what would be adequate time for implementation of this instructional program?

24. What type of resources (resource person, guide, materials) wwer you provided with during the implementation stage of this instructional program?

25. Do you feel this instructional program required you to do or say anything with which they are not comfortable? If yes, what?

26. Under what circumstances do you feel a faculty member be released from the teaching responsibility of teaching this instructional program?

27. Do you feel the way this instructional program was developed and assigned to educators to implement may have caused teacher alienation? If yes, how?

28. Do you feel there is a correlation between the type of administrator you have and how you implemented this instructional program? Please elaborate on yes and no responses.

VII. AIDS INSTRUCTIONAL PROGRAM IMPLEMENTATION RESULTS

29. Do you feel it would be beneficial to test students over information learned from the AIDS presentation? Please discuss yes and no responses.

30. What were the district/school goals explained to you to obtain in teaching this instructional program?

31. What goals were you hoping to achieve by the implementation of this instructional program? (tangible and intrinsic)

32. In what ways do you feel the goals were realized? In what ways were your goals not met?

33. What type of feedback have you received from parents and/or community in regards to the teaching of the AIDS instructional program?

VIII. AIDS INSTRUCTIONAL PROGRAM IMPLEMENTATION CHANGE STRATEGIES

34. What changes would you like to see in this educational program before it is implemented again?

IX. ADDITIONAL COMMENTS

APPENDIX E

REVIEW OF EPIDEMIOLOGY

ACQUIRED IMMUNODEFICIENCY SYNDROME:

REVIEW OF EPIDEMIOLOGY

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Acquired Immunodeficiency Syndrome: Review of Epidemiology

H. DAN CAMERON, JR., MPH

The AIDS epidemic began in relative obscurity with initial disease reports to the Centers for Disease Control in June 1981. By August 1985, over 12,000 cases have been reported. The total cases have doubled in the past year, with public concern and scientific knowledge of the disease increasing at even greater rates. This article will review the epidemiology of AIDS, current statistics, and public health intervention programs.

The acquired immunodeficiency syndrome (AIDS) was first described during the spring of 1981. The Centers for Disease Control (CDC) published the first recognition of an unusual pattern of disease in young homosexual men during June and July 1981.[1,2] These initial reports of 26 patients with Kaposi's sarcoma and 15 patients with *Pneumocystis carinii* pneumonia spurred the subsequent reporting of an additional 70 cases within six weeks.[3]

Surveillance for this apparently new syndrome was initiated in June 1981, reaching 1,000 reported cases by February 1983. By August 1985, over 12,000 cases had been reported, twice the total of just one year earlier. Public concern has increased at a rate comparable to the increase of reported cases. A significant fatality rate and the potential for disease transmission through blood or blood products has fueled the increasing public demand for research and control measures by public health agencies.

This article will review the epidemiology of AIDS within the United States and in Oklahoma. The geographic distribution and patient characteristics are remarkably similar between this state and the nation. A companion article[4] will describe the clinical manifestations and management of the AIDS patient.

Case Definition

The case definition for AIDS was established by the CDC for the purpose of disease surveillance. The primary criteria are: (1) The presence of a reliably diagnosed disease at least moderately indicative of cellular immune deficiency and (2) the absence of an underlying cause for the immune deficiency or of any defined cause for reduced resistance to the disease. A serologic test for antibodies to the virus has been added to the surveillance criteria. In spite of this, the definition remains primarily clinical and is further discussed in the accompanying article.[4]

Disease Trends

Cases of AIDS reported in the United States and Oklahoma are presented in the figure. The epidemic curve for the United States shows a sharp increase in reported cases over the past four years. The first case of AIDS in Oklahoma was reported in January 1983 and reporting has not increased as dramatically as the national reports. Through August 31, 1985, a

From the Oklahoma State Department of Health.
Corresponding author: H. Dan Cameron, Jr., MPH, Director, Sexually Transmitted Disease Division, Oklahoma State Department of Health, PO Box 53551, Oklahoma City, Oklahoma 73152.

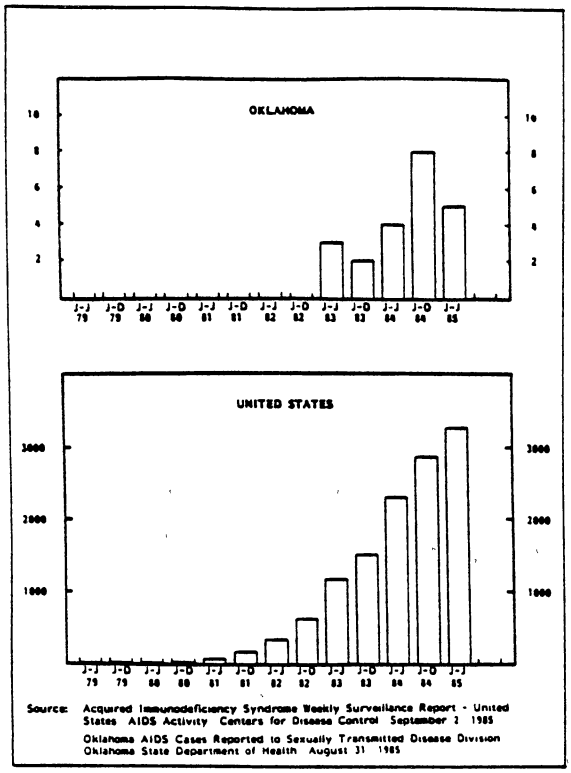

Figure.—Reported AIDS cases in Oklahoma and the United States by six-month periods 1979-1985.

total of 26 cases were reported in persons with onset of symptoms occurring while they were living in Oklahoma. Physicians have reported an additional 15 cases among Oklahoma residents whose onset of symptoms occurred while the individuals were residents of another state. Most frequently, these latter patients have returned to Oklahoma to be closer to family after a diagnosis of AIDS in California (6 patients) and New York (4 patients). Of the 41 total cases, 28 have died. The 68% mortality reported in Oklahoma is higher than the nationally reported mortality rate of 50% (6,481 deaths among the total 12,932 reported cases) through September 2, 1985.

Among those who died, the average time from date of diagnosis to date of death has been 5.6 months in Oklahoma. Those patients returning to this state after a diagnosis of AIDS had an average of 8.2 months. Differences may be attributable to a selection bias, as more severe cases may not survive long enough to make the transition to another state.

Geographic Distribution

The majority of cases are reported from larger metropolitan areas, primarily New York City, San Francisco, and Los Angeles (Table 1). Distribution of cases by state reveals 36% of the cases have been reported in New York and 23% in California, with Florida, New Jersey, and Texas ranked third through fifth respectively In Oklahoma, 34% of the cases are reported from the Tulsa metropolitan area and 50% from the Oklahoma City metropolitan area.

Risk Characteristics

Distribution of individuals within the identifiable risk groups has remained fairly constant since the first 1,000 cases were reported. Table 2 presents the major patient characteristics listed as a hierarchy of mutually exclusive groups. Data for Oklahoma closely resemble the national trends, with homosexual or bisexual men representing the majority (73%) of cases. The second major group (17%) consists of intravenous drug abusers.

Age distribution is clustered in the third decade of life, with a mean age in Oklahoma of 35 years Comparison of age distribution for Oklahoma and the nation is presented in Table 3.

Racial and ethnic distribution in the United States and Oklahoma has remained fairly constant Differences between Oklahoma trends and national trends may be attributed to relative differences in racial makeup of the primary reporting cities Oklahoma has reported 21 cases in whites (81%) and 5 cases in blacks (19%). Nationally, 60% of cases have been in whites and 25% in blacks.

The vast majority of cases occur in males Although 100% of Oklahoma cases are male, 93% of nationally reported cases are male.

Transmission Patterns

Initially, the described patterns of infection were remarkably similar to those of hepatitis B infection and suggested a similarly transmissible agent. Risk of infection increases with the number of sexual partners.[5-7] While the greatest risk occurs among homosexual or bisexual men, heterosexual transmission has occurred.[8,9]

Drug abuse is second in the hierarchy of risk characteristics. Use of inhalant drugs such as amyl and butyl nitrite is associated with AIDS, however, it appears to be a coincidental association with frequent receptive anal intercourse.[10-12] The use of parenteral drugs has been implicated and the primary risk appears to be the sharing or reuse of contaminated needles.[13] Greatest risk from this activity is reflected by incidence in New York City and New Jersey where "shooting galleries," apartments, or other secure locations frequented by addicts are greatest in number

Hemophiliacs have been at increased risk for AIDS due to treatment of their disease with concentrated clotting factors derived from pooled plasma. A single lot of this clotting factor concentrate is produced from donations of 2,500 to 25,000 commercial donors. Recipients of Factor VIII concentrate began to show seropositivity to human T-cell lymphotrophic virus type III (HTLV-III) antibody in 1979, with substantial increases in antibody prevalence during the past six years.[14] Recommendations to replace therapy with heat-treated concentrates should significantly reduce the risk of AIDS among hemophiliacs.

Transmission of AIDS by blood transfusion or use of blood products was first reported in December 1982.[15] This led to the March 1983 Public Health Service recommendations advising members of groups at risk for AIDS to refrain voluntarily from donating blood.[16] Relatively long intervals, sometimes exceeding four years, between a suspect blood transfusion and subsequent diagnosis of AIDS in the transfusion recipient have been reported.[17] This suggests that the impact of voluntary donor deferral might not be evident for several years. The availability of a serologic test in March 1985 should further enhance the safety of the blood supply and virtually eliminate transfusion-associated AIDS cases in the future.

Table 1. — All AIDS Cases Per Million Population (from the 1980 Census), by Standard Metropolitan Statistical Area (SMSA) of Residence, Reported from June 1, 1981 to September 2 1985 — United States

SMSA of residence	Cases	Percentage of total	Cases per million population
New York, NY	4286	33	469 9
San Francisco, CA	1463	11	450 1
Miami, FL	430	3	264 5
Newark, NJ	319	2	162 3
Los Angeles, CA	1092	8	146 0
Elsewhere (irrespective of SMSA)	5342	41	26 2
Total — United States	**12932**	**100**	**56.8**
Oklahoma City, OK	13	50	15 6
Tulsa, OK	9	35	13 1
Elsewhere	4	15	2 7
Total — Oklahoma	**26**	**100**	**8.6**

Source Acquired Immunodeficiency Syndrome Weekly Surveillance Report — United States AIDS Activity Center for Disease Control September 2 1985
Oklahoma AIDS Cases reported to Sexually Transmitted Disease Division Oklahoma State Department of Health August 31 1985

Acquisition of AIDS by infants and children occurs by two predominant routes: (1) Infection as a result of blood transfusion or blood products, and (2) infection as a result of birth to a mother who has AIDS or is in a high-risk category.[18] Transmission to infants by an infected mother appears to occur in utero, but does not necessarily occur in all subsequent births.[19] Transfusion-associated cases in children have shorter intervals — 8 months — between transfusion and onset of symptoms, when compared to adults.[20]

Transmission by casual person-to-person contact has never been shown to occur. There are no documented cases of transmission to household nonsexual contacts of AIDS victims.

Etiology

The variety of factors that contribute to the risk characteristics and occurrence of disease in recipients of blood suggests the existence of a transmissible agent.[21] In Paris, isolation of a new human retrovirus from a homosexual male experiencing persistent lymphadenopathy was reported in 1983 as lymphadenopathy-associated virus (LAV).[22] The identification of an apparently similar virus in the United States was reported in 1984 and labeled as human T-cell lymphotrophic virus type III[23-25] or AIDS-associated retrovirus (ARV).[26] The HTLV-III infects and kills T-lymphocytes called helper cells. Several studies have reported population groups with a high percentage of individuals with seropositivity for HTLV-III antibody, though current prevalence of AIDS is low[27,28]; these observations suggest that host defenses against this virus may exist.

This virus has been isolated from semen, blood, saliva, tears, and lymph nodes of infected individuals.[22-24,29-31] Greatest risk of transmission appears to relate to blood and semen. Transmission by saliva and tears has not been demonstrated. Further research may clarify the mechanism of disease development more precisely. A potential for cofactors in disease development has been suggested.[32] While additional research will expand the knowledge surrounding the development of AIDS, adequate information already exists to establish some effective control measures.

Serologic Testing

The Food and Drug Administration (FDA) licensed the first serologic test for HTLV-III antibody on March 2, 1985. An enzyme-linked immunosorbent assay (ELISA) is both highly sensitive (97.3%) and

specific (98.6%).[33] Specificity can be further confirmed using a Western Blot electrophoresis technique.[34] These assays are being applied for confirmation of clinical diagnosis, for screening of blood products, and for epidemiologic purposes. However, it must be stressed that these are not tests for AIDS. These tests identify antibodies to HTLV-III, indicating only that an individual has been exposed to the virus and may be potentially infectious. It appears that a minority of seropositive patients develop AIDS.[35]

Blood Banking

Following FDA licensure of an ELISA, the blood banking community began a nationwide effort to test all units of blood donated within the United States. Notification of the blood bank donors with positive tests is made only after repeatedly positive ELISAs (two tests of the specimen to eliminate nonspecific reactions) and confirmation by Western Blot. Plasma centers may notify a donor prior to availability of the Western Blot results since these individuals tend to donate more frequently.

Table 2. — Patient Characteristic Groups — United States and Oklahoma

United States

Patient groups	Adult/Adolescent Males	(%)	Females	(%)	Total Cases	(%)
Homosexual or bisexual men	9365	(79)	—	(—)	9365	(73)
Intravenous (IV) drug user	1733	(15)	425	(53)	2178	(17)
Hemophilia/coagulation disorder	82	(1)	4	(0)	86	(1)
Heterosexual Contact[†]	15	(0)	114	(14)	129	(1)
Transfusions with blood/blood products	113	(1)	82	(10)	195	(2)
None of the above/other[‡]	618	(5)	196	(23)	814	(6)
Total	11926	(100)	841	(100)	12767	(100)

	Pediatric[*] Males	(%)	Females	(%)	Total Cases	(%)
Hemophilia/coagulation disorder	9	(9)	0	(0)	9	(5)
Parent with AIDS/or at increased risk for AIDS[§]	62	(63)	54	(81)	116	(70)
Transfusion with blood/blood products	18	(18)	7	(10)	25	(15)
None of the above/other	9	(0)	6	(9)	15	(9)
Total	98	(100)	67	(100)	165	(100)

Oklahoma

Patient Groups	Cases	(%)
Homosexual or bisexual men	21	81%
IV drug abuser	2	8%
Blood transfusion	1	3%
None/other	2	8%
Total	26	100%

Groups listed are ordered hierarchically, cases with multiple characteristics are tabulated only in the group listed first.
[*]Includes patients under 13 years of age at time of diagnosis
[†]With a person with AIDS or at risk for AIDS
[‡]Includes 341 persons born in countries in which most AIDS cases have not been associated with known risk factors
[§]Epidemiologic data suggest transmission from infected mother to child before, at, or shortly after the time of birth

Source: Acquired Immunodeficiency Syndrome Weekly Surveillance Report — United States, AIDS Activity, Centers for Disease Control, September 2, 1985
Oklahoma AIDS Cases Reported to Sexually Transmitted Disease Division, Oklahoma State Department of Health, August 31, 1985

Nationally, reports from American National Red Cross indicate 1,593,969 units have been tested, and 3,209 (0 20%) were found repeatably positive for HTLV-III antibody from March through June. Oklahoma blood banks have tested 77,445 units through August 1985 and found 171 units (0 22%) repeatably positive

Public Health Intervention

Public health intervention begins with an accurate description of the disease morbidity and mortality. The extend of AIDS morbidity and mortality has brought this epidemic to national attention. The public concern has been that an uncontrollable epidemic will spread to the general population and not remain limited to the recognized risk categories. The toll on society has been great, even though limited within a few high-risk categories.

Oklahoma began development of an AIDS program with the establishment of AIDS as a reportable disease in July 1983. Surveillance includes the voluntary reporting by physicians of patients with AIDS. This cooperative relationship between public health personnel and practicing physicians is crucial to an accurate description of the extent of the problem in Oklahoma.

Sites have been established to provide testing for HTLV-III antibody to individuals in high-risk categories and to persons concerned about possible exposure to AIDS. These "alternative" testing sites were established to further safeguard the blood supply. They allow individuals to be tested without donating blood and provide strict confidentiality to persons tested.

While an effective treatment or cure for AIDS is not currently available, control programs can have an impact through professional and public education. The potential for spread of this epidemic beyond the recognized risk groups in the United States is real. Transmission of this disease in homosexual and bisexual men appears to be related to sexual promiscuity among members of these groups. In Africa, the same disease, apparently, is frequently spread among promiscuous heterosexual populations.[36-38] Successful control measures may depend on the ability to modify sexual behavior through public education efforts. Selected studies have reported modifications in sexual behavior among homosexual and bisexual men,[39] and changes can be measured by the reduction of associated diseases, such as reports of rectal gonorrhea in San Francisco. Knowledge of risk is not always enough to effect behavior modification, as demonstrated by seat-belt use and alcohol consumption, but further research into educational methods may improve the public response in AIDS risk-reduction efforts.[40]

Table 3. — Age Distribution — Oklahoma and United States

Age	Oklahoma Cases	Oklahoma (%)	United States Cases	United States (%)
Under 13	—	(—)	165	(1)
13 - 19	—	(—)	61	(0)
20 - 29	8	(31)	2726	(21)
30 - 39	13	(50)	6069	(47)
40 - 49	2	(8)	2701	(21)
Over 49	3	(11)	1184	(9)
Total	26	(100)	12932	(100)
(Mean age, 35 years)				

Source Acquired Immunodeficiency Syndrome Weekly Surveillance Report — United States, AIDS Activity, Centers for Disease Control September 2 1985
Oklahoma AIDS Cases Reported to Sexually Transmitted Disease Division Oklahoma State Department of Health August 31, 1985

The pervasive nature of public concern over AIDS has extended the boundaries beyond the initial concern with high-risk groups. Careful and deliberate planning is necessary to establish recommendations or guidelines for situations where legitimate concerns for disease transmission exist. Through careful planning, recommendations may be formulated that give due consideration to individual civil rights, the patients' rights to confidentiality, and the rights of the public at large in the protection of public health. The Centers for Disease Control provided "Precautions for Clinical and Laboratory Staffs" in November 1982.[41] Guidelines for children in public schools and day-care facilities were issued August 1985.[42] These recommendations suggest exclusion of children with AIDS from day-care facilities. A confidential panel should be convened to make a decision regarding school attendance for each child with AIDS. These decisions should be based on the child's behavior, neurologic development, and physical condition. In each case, risks and benefits to both the infected child and other school children or employees should be carefully considered.

Acknowledgments. I wish to express my appreciation for the statistical data by Marilyn D. Best and manuscript preparation by Yvonne A. Myers.

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Herbert Daniel Cameron, Jr, MPH, is the director of the Sexually Transmitted Disease Division of the Oklahoma State Department of Health He earned his master's degree in public health from the University of Oklahoma College of Health, Oklahoma City, in 1980.

The young man knows the rules, but the old man knows the exceptions. . . . The young man feels uneasy if he is not continually doing something to stir up his patient's internal arrangements. The old man takes things more quietly, and is much more willing to let well enough alone.

—Oliver Wendell Holmes

APPENDIX F

LEGISLATION

An Act

ENROLLED HOUSE
BILL NO. 1476

BY: WHITE, HAMILTON (Jeff), BASTIN, DAVIS (Guy), HUTCHCROFT, LAPAGLIA, LASSITER, LITTLEFIELD, THOMPSON, WILLIAMS (Freddye), HOWSON, SNIDER, LEWIS, HARRIS (Robert), GLENN, MORGAN (Jim), HOLT, VANALLA, ROSS, ANDERSON and SIOTTLEMYRE of the HOUSE

and

SHIPP, HERRIOT, TAYLOR, BROWN, CAIN, HANEY, HORNER, RIGGS and DICKERSON of the SENATE

AN ACT RELATING TO EDUCATION; MANDATING AIDS PREVENTION EDUCATION FOR STUDENTS; PROVIDING PROCEDURES AND REQUIREMENTS FOR SUCH EDUCATION; PROVIDING FOR CODIFICATION; PROVIDING AN OPERATIVE DATE; AND DECLARING AN EMERGENCY.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 11-103.3 of Title 70, unless there is created a duplication in numbering, reads as follows:

A. Acquired immune deficiency syndrome (AIDS) prevention education shall be taught in the public schools of this state. AIDS prevention education shall be limited to the discussion of the disease AIDS and its spread and prevention. Students shall receive such education:

1. at the option of the local school district, a minimum of once during the period from grade five through grade six;

2. a minimum of once during the period from grade seven through grade nine; and

3. a minimum of once during the period from grade ten through grade twelve.

B. The State Department of Education shall develop curriculum and materials for AIDS prevention education in conjunction with the State Department of Health. A school district may also develop its own AIDS prevention education curriculum and materials. Any curriculum and materials developed for use in the public schools shall be approved for medical accuracy by the State Department of Health. A school district may use any curriculum and materials which have been developed and approved pursuant to this subsection

C. School districts shall make the curriculum and materials that will be used to teach AIDS prevention education available for inspection by the parents and guardians of the students that will be involved with the curriculum and materials. Furthermore, the curriculum must be limited in time frame to deal only with factual medical information for AIDS prevention. The school districts, at least one (1) month prior to teaching AIDS prevention education in

any classroom, shall conduct for the parents and guardians of the students involved during weekend and evening hours at least one presentation concerning the curriculum and materials that will be used for such education. No student shall be required to participate in AIDS prevention education if a parent or guardian of the student objects in writing to such participation.

D. AIDS prevention education shall specifically teach students that:

1. engaging in homosexual activity, promiscuous sexual activity, intravenous drug use or contact with contaminated blood products is now known to be primarily responsible for contact with the AIDS virus;

2. avoiding the activities specified in paragraph 1 of this subsection is the only method of preventing the spread of the virus;

3. sexual intercourse, with or without condoms, with any person testing positive for human immunodeficiency virus (HIV) antibodies, or any other person infected with HIV, places that individual in a high risk category for developing AIDS.

E The program of AIDS prevention education shall teach that abstinence from sexual activity is the only certain means for the prevention of the spread or contraction of the AIDS virus through sexual contact. It shall also teach that artificial means of birth control are not a certain means of preventing the spread of the AIDS virus and reliance on such methods puts a person at risk for exposure to the disease.

F. The State Department of Health and the State Department of Education shall update AIDS education curriculum material as newly discovered medical facts make it necessary.

SECTION 2. This act shall become operative July 1, 1987

SECTION 3. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the House of Representatives the 15th day of April, 1987

L. Gibbs
Speaker Pro Tempore of the House of Representatives

Passed the Senate the 16th day of April, 1987.

ACTING Herb Rozell
President of the Senate

OFFICE OF THE GOVERNOR

Received by the Governor this 23rd day of April, 1987, at 1:10 o'clock P. M.

By Robyn Hunn-Roberts

Approved by the Governor of the State of Oklahoma the 24th day of April, 1987, at 11:31 o'clock P M

Henry Bellmon
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Secretary of State this 24th day of April, 1987, at 1:42 o'clock P. M.

By: Esta M. Phipps

APPENDIX G

GLOSSARY

GLOSSARY

abstinence - (Sexual abstinence) Refraining from all types of sexual intercourse (oral, anal, and vaginal)

acquired - Resulting from events which occur after birth, not inherited.

addiction - To feel unable to do without something, such as drugs or cigarettes, to be "hooked" on something

AIDS - Acquired Immune Deficiency Syndrome A fatal illness caused by a virus that damages the body's immune system

AIDS-Related Complex (ARC) - A condition in which a person infected with human immunodeficiency virus (HIV) has a set of specific symptoms, but has not developed AIDS

anal intercourse - Insertion of the penis into the rectum

antibiotic - Substance which kills or prevents multiplication of bacteria.

antibodies - Substances in the blood made by the immune system to fight against germs.

antiviral - Substance which prevents multiplication of viruses

anus - The rear opening of the digestive tract Bulk waste (feces, stool) passes out of the body through this opening

ARC - See "AIDS-Related Complex "

artificial - Not natural. Artificial methods of birth control include chemical and mechanical methods

AZT - Azidothymidine. A drug which may help to prevent opportunistic infections in some patients with AIDS

birth control - A substance or material used to prevent pregnancy, such as condoms, spermicides, and oral contraceptives ("the pill").

bisexual - A person who has sexual intercourse with both men and women.

casual contact - Nonsexual body contact including touching, hugging, handshaking, and sitting closely together

chemotherapy - Medications used to treat certain viruses, bacteria, or cancer cells.

chlamydia - A sexually transmitted disease caused by bacteria that can infect males and females, often without causing symptoms. If left untreated, may cause sterility.

communicable disease - Disease that can be passed from person to person caused by bacteria, viruses, and other organisms

condom - A rubber cover or sheath worn over the penis. Used during sexual activity to prevent AIDS, other sexually transmitted diseases, and pregnancy

contaminated - Come in contact with or made impure by exposure to material or organisms such as bacteria or viruses.

coordination - Control over body movements.

counseling - To help an individual better understand a situation or problem so that he or she can make decisions and take appropriate actions.

deficiency - Lack of or insufficient amount of.

diagnose - Identifying the disease which a patient has.

disease organism - Living thing which causes disease.

disruption - Upset, disturbance.

Factor VIII - A blood protein that stops bleeding.

feces - Bulk waste made by the body that leaves the body through the anus (bowel movement).

genitals - The external sex organs.

gonorrhea - A type of sexually transmitted disease (STD) caused by a bacteria that can infect males and females, often without causing symptoms. If left untreated, may cause sterility

hemophilia - A hereditary clotting disorder characterized by excessive, sometimes spontaneous bleeding

heterosexual - A person who prefers sexual intercourse with someone of the opposite sex.

HIV - Human Immunodeficiency Virus. This is the virus that causes AIDS. It has other names: HTLV-III, LAV, ARV are some.

homosexual - A person who prefers sexual intercourse with someone of the same sex.

immune - Resistance to a disease.

immunodeficiency - Weakness of the immune system; the body cannot fight germs properly.

infection - A disease caused by germs, such as viruses and bacteria.

intravenous - Injected into a vein.

Kaposi's sarcoma - A rare form of skin cancer which is common in persons with AIDS.

lymph node - Part of the immune system which can sometimes be felt near the surface of the body; "glands."

misconceptions - Mistaken idea or incorrect notion.

mucous membrane - The soft, moist skin that lines the body cavities such as the mouth, vagina, urethra, eyelids, and rectum.

opportunistic diseases - Cancers and infections that invade a person whose immune system is weakened.

organism - Any living thing.

paralysis - Inability to move.

plasma - Liquid part of the blood which does not contain cells.

pneumocystis carinii pneumonia - Severe form of lung infection commonly seen in AIDS patients.

precautions - Steps to prevent something.

promiscuous - Frequent change of sexual partners or multiple sexual partners.

radiation - A form of treatment for certain types of cancers using X-rays.

saliva - The clear liquid in the mouth, also called "spit."

screen - To test, especially when testing a large number of people, such as all blood donors for HIV antibody

sexual partner - A person with whom another person has sexual intercourse.

sexual intercourse - Sexual union with the penis in the vagina (vaginal sex), penis in the rectum (anal intercourse), or penis in the mouth (oral intercourse).

sign - Measured or objective evidence of a disease as determined by a physician.

spermicide - A substance which kills sperm. Some spermicides may also kill viruses and bacteria. Certain spermicides may also kill the HIV.

STD - Sexually transmitted disease caused by organisms which are usually transmitted person-to-person; including bacteria, fungi, protozoa, and viruses.

symptoms - Changes in a person's health that can be seen or felt. Subjective evidence of an illness.

syndrome - A pattern of signs and symptoms.

syphilis - A sexually transmitted disease which can infect men, women, and unborn babies. If not treated, it can cause severe damage to many organs.

syringe - Holds substance to be injected.

therapeutic - Useful in treating a disease.

transmitted - Passed from one person or place to another.

urine - Liquid waste matter of the body excreted by the kidneys, a yellowish, watery fluid.

vagina - The tube that leads from a woman's uterus (womb) to the outside of her body. Also called the birth canal.

vaginal secretions - Fluids that can be found in the vagina.

virus - The smallest organism that can cause diseases.

APPENDIX H

PARENT PERMISSION FORM

Dear Parents:

At different times during the school year programs on a wide range of topics are presented to students who are interested in them. They are provided for small groups of atudents (50-60) and are scheduled during the course of the regular school day. Some of the topics in the area of health and life education require parental consent, as some parents think that this information should not be presented to their teenagers in a public school program. Although most of these are incorporated in the Driver Education/Health Education class, other students do have access to them. Programs in this area include:

1) STD's -- Sexually Transmitted Diseases

   The program on venereal disease informs students about the major kinds of venereal disease, the indications of the disease, and methods of treatment.

2) Cancer

   Although all students learn about cancer in general and the early warning signs, a part of the program is presented to sexually segregated audiences. Girls learn the techniques of the breast self-exam; boys learn about testicular cancer and self-examination.

3) Birth Control

   The program on birth control describes the legitimate birth control methods in existence and how they function. The topic of abortion is mentioned. Medical personnel discuss the advantages and disadvantages of the methods discussed in the film and emphasize the importance of personal health. This program is presented to sexually segregated audiences whenever presented to Driver Education classes. However, when the program is shown in Mini-Assemblies to 11th and 12th grades, audiences may be co-ed.

PLEASE INDICATE YOUR WISHES ON THE FORM BELOW AND RETURN WITH THE STUDENT AT ENROLLMENT TIME.

NAME OF STUDENT_____ CLASSIFICATION 10 11 12

	HAS MY PERMISSION	DOES NOT HAVE MY PERMISSION
TO ATTEND PROGRAMS ON:		
STD'S	_____	_____
Cancer	_____	_____
Birth Control	_____	_____

SIGNED_____

DATE_____

SPECIAL NOTE: In accordance with the Oklahoma law passed in the spring of 1987, is required to present AIDS prevention education to all students. The legislation specifically requires identification of activities that place one at high risk for contracting the AIDS virus and the methods of preventing the spread of the virus. No student shall be required to participate in AIDS prevention education if a parent or guardian of the students objects in writing to such participation. All parents will have the right and opportunity to view all materials approved by the local Board of Education and the State Department ofEducation for use in the AIDS Education Project.

APPENDIX I

STUDENT HANDOUT

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

PREVENTION EDUCATION

Curriculum Guide
For Teachers

Oklahoma State Department of Education
John M. Folks, Ed.D.
State Superintendent of Public Instruction

Oklahoma State Department of Health
Joan K. Leavitt, M.D.
Commissioner of Health

1987

The Board of Education is intricately interested in providing the basic rudiments for a well-rounded educational program during these trying and difficult times. One aspect of our curriculum, as mandated by State statute, is an AIDS Prevention Program. The Board of Education vividly recognizes our responsibility in providing a curriculum that meets the welfare and interests of our students and community.

It is our hope and most fervent desire that this AIDS curriculum will be a positive step in educating our youth and community concerning this dangerous peril. If there are any questions in regard to the nature and content of this curriculum material, please contact the Board of Education.

Superintendent of Schools

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

PREVENTION EDUCATION

GENERAL OBJECTIVE: Be aware of the forms of the disease, the methods of transmission, and prevention of Acquired Immune Deficiency Syndrome (AIDS).

EXPECTED OUTCOMES:

1. Understand origin and history of Acquired Immune Deficiency Syndrome.
2. Define AIDS.
3. Name the cause of AIDS.
4. List the methods of transmission of AIDS.
5. List the methods of prevention.
6. List and describe the forms of the HIV infections.
7. Identify tests for the HIV infections.
8. Describe methods of care and treatment.
9. List the groups at high risk for acquiring the HIV infection.
10. Understand that a woman who is infected with the HIV and becomes pregnant, is more likely to develop ARC or classic AIDS.
11. Identify misconceptions about AIDS.
12. Identify authoritative sources of information about AIDS used in the development of this publication.

    (1) "AIDS Update" pamphlet distributed by Oklahoma State Department of Health, 1000 NE 10th, Oklahoma City, Oklahoma 73152

    (2) Surgeon General's Report on Acquired Immune Deficiency Syndrome distributed by the U.S. Department of Health and Human Services

    (3) AIDS Acquired Immune Deficiency Syndrome, Junior High School Program, Dade County Public Schools, Miami, Florida

    (4) Title 70 O.S. 1987 Supp. § 11-103.3 (A complete copy of this legislation is found in the appendices.)

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

PREVENTION EDUCATION

EXPECTED OUTCOMES:

1. **Understand origin and history of Acquired Immune Deficiency Syndrome.** AIDS was not recognized or described as a disease until 1981 The tracing of AIDS only began when doctors had seen enough of it to recognize that they were faced with a serious, previously unknown disease In 1981, 316 people in the United States had AIDS By August, 1987, there were over 40,845 reported cases of Acquired Immunodeficiency Syndrome (AIDS) in the United States. Of these cases, about 157 were among teenagers (13-19 years old), and some 8,554 cases were among young adults (20-29 years old) The incidence of AIDS continues to grow at an alarming rate. IT IS PROJECTED THAT BY THE END OF 1991, 270,000 PERSONS WILL HAVE BEEN DIAGNOSED WITH AIDS IN THE UNITED STATES WITH A TOTAL OF 179,000 DEATHS SEVENTY-FOUR THOUSAND CASES WILL BE DIAGNOSED AND FIFTY-FOUR THOUSAND PEOPLE WILL DIE IN THAT YEAR ALONE!

   The exact origin of AIDS is not known It is either a new human disease which developed recently, or it is a disease that was until recently isolated in a particular geographic group of people The common denominator here is a type of behavior, a lifestyle, or a particular practice that predisposes one to AIDS. The geographic area, racial, ethnic, or socio-economic group may have little, none, or a great deal to do with the acquisition of the AIDS disease. The disease was first noted in Africa in the late 1970's and early 1980's about the same time it came to attention in the United States

   Eighty percent of people with AIDS have died within two years of diagnosis. So far no one is known to have survived the disease for more than five years.

   There is no vaccine, no cure, and no treatment which actually stops the progression of the disease. The only sure method of slowing the expansion of AIDS is to prevent infection in the first place To do this, people need clear and accurate information on AIDS, and if necessary, support in changing behaviors which could increase their likelihood of contracting the disease

2. **Define AIDS.** AIDS is an abbreviation for Acquired Immune Deficiency Syndrome. AIDS is a life-threatening disease that damages the immune systems of otherwise healthy persons. (1)

   Acquired means that AIDS is not inherited, but rather is passed from person to person.

   Immune refers to the body's natural mechanism to protect itself from disease.

   Deficiency means that the immune system is not working.

   Syndrome indicates that a pattern of symptoms has developed. (1)

3. **Name the cause of AIDS.** Acquired Immune Deficiency Syndrome (AIDS), identified in 1981, is caused by a virus that attacks the body's immune system. Many rare infections and cancers can then attack the defenseless body. Many of the infections and cancers are treatable, but the underlying immune problem is not. The virus is called Human Immunodeficiency Virus (HIV). (1)

4. **List the methods of transmission of AIDS.** People do <u>not</u> become infected with the HIV in day-to-day, casual contact with family, friends, acquaintances, or the population at large, unless that contact involves sexual encounters or the sharing of needles or syringes from intravenous drug use contaminated by an infected person.

   The virus that causes AIDS lives in certain body fluids, especially blood and semen. People most commonly become infected with HIV after their blood system has come into direct contact with the semen, blood, or vaginal secretions of someone else who is infectious. Although the HIV has been isolated from other body fluids such as saliva, tears, perspiration, or urine, transmission has never been proven to have occurred in contact with these.

Transmission occurs through:

a. Sexual contact--male to male, male to female, female to male--often with several persons, and most commonly in the form of anal intercourse, as has usually been the case in homosexual men **(77% of reported cases)** (4)

b. Shared use of needles or syringes for intravenous drug use (and possibly the use of nonprofessional tattoo needles). **(17% of reported cases)** (1) (3) (4)

c. From infected mother to child before or during birth. (1)

d. Contact with contaminated blood products. (4)

5. **List the methods of prevention.**

"AIDS prevention education shall specifically teach students that engaging in homosexual activity, promiscuous sexual activity, intravenous drug use or contact with contaminated blood products is now known to be primarily responsible for contact with the AIDS virus." Title 70 O.S. 1987 Supp § 11-103.3

a. **Abstinence.** Practice abstinence. Since HIV can be transmitted by either heterosexual or homosexual intercourse, the avoidance of sexual intercourse is the most effective manner of not contracting or spreading the HIV. Abstinence from sexual activity is the only certain means for the prevention of the spread or contraction of the HIV through sexual contact. Learn to say "NO!" (4)

b. **Artificial means of Birth Control.** Know that artificial means of birth control such as condoms and spermicides are not a certain means of preventing the spread of the HIV and reliance on such methods puts a person at risk for exposure to the disease. Sexual intercourse, with or without condoms, with any person testing positive for human immunodeficiency virus antibodies, or any other person infected with the HIV, places that individual in a high risk category for developing AIDS (4)

c. **Don't share needles and syringes.** Sharing needles and syringes to inject heroin, cocaine, and other drugs is directly related to the risk of getting AIDS.

All drugs and alcohol reduce the ability of the body to resist infection More importantly, drugs and alcohol may alter the user's judgment, making the person more likely to participate in sex activities

d. **Promote blood supply safety.** Persons in high risk groups should not donate blood. Because of sophisticated screening and processing, the chances are about one in one million of getting AIDS from a blood transfusion. A person cannot contract AIDS while donating blood because new and sterile equipment is used.

6. **List and describe the forms of the HIV infections.**

a. **No Signs.** Some people remain apparently well after infection with the HIV. They may have no physically apparent symptoms of illness These infected individuals can spread the virus to others through sexual intercourse or sharing needles. Anyone who thinks he or she is infected or involved in high risk behaviors should not donate his or her blood, organs, tissues, or sperm because they may now contain the HIV.

b. **ARC.** AIDS-Related Complex (ARC) is a condition caused by the HIV in which the patient tests positive for HIV infection and has a specific set of clinical symptoms. However, ARC patients' symptoms are often less severe than those with the disease called classic AIDS. Signs and symptoms of ARC may include loss of appetite, weight loss, fever, night sweats, diarrhea, tiredness, lack of resistance to infection, or swollen lymph nodes. These are also signs and symptoms of many other diseases and a physician should be consulted.

c. **AIDS.** Only a qualified health professional can diagnose AIDS, which is the result of a natural progress of infection by the HIV AIDS destroys the body's immune (defense) system and allows otherwise controllable infections to invade the body and cause additional diseases. These opportunistic diseases would not otherwise gain a foothold in the body. These opportunistic diseases may eventually cause death. A woman who is infected with the HIV and becomes pregnant, is more likely to develop ARC or classic AIDS

Some symptoms and signs of AIDS and the "opportunistic infections" may include a persistent cough and fever associated with shortness of breath or difficult breathing. These may be the symptoms of pneumocystis carinii pneumonia. Multiple purplish blotches and bumps on the skin may be a sign of Kaposi's sarcoma HIV in all infected people is essentially the same; the reactions of individuals may differ.

d. **Long term.** The HIV may also attack the nervous system and cause delayed damage to the brain. This damage may take years to develop and the symptoms may show up as memory loss, indifference, loss of coordination, partial paralysis, or mental disorder These symptoms may occur alone, or with other symptoms mentioned previously (2)

7. **Identify tests for the HIV infections.** As with most other infections, there is no single test for diagnosing AIDS. There is now a test for antibodies (substances produced in the blood to fight disease organisms) to the virus that causes AIDS. Presence of the HIV antibodies means that a person has been infected with the HIV. The antibody test is used to screen donated blood and plasma and to assist in the prevention of cases of AIDS that result from blood transfusions or the use of blood products, such as Factor VIII, needed by people with hemophilia. The test is available through private physicians and community organizations. The Oklahoma State Department of Health has established testing sites in five County Health Departments for people who feel they may have been exposed to AIDS. Counseling before and after the test is available at these sites. Test results will not be given over the telephone. (A list of these testing sites is given in the appendices.) **(1) (3)**

8. **Describe methods of care and treatment.** Casual contact with AIDS patients or persons who might be at risk for the illness does NOT place others at risk for getting the illness. No cases have been found where AIDS has been transmitted by casual household contact with AIDS or persons at high risk for getting the illness. Although the HIV has been found in saliva, there have been no cases in which exposure was shown to have resulted in transmission. Ambulance drivers, police, and fire-fighters who have assisted AIDS patients have not become ill. Nurses, doctors, and health care personnel have not developed the HIV infection from caring for persons with the HIV, except when care givers have been in direct contact with the HIV.

   Everyone should follow safety procedures carefully when handling blood and tissue specimens from persons with potentially transmissible diseases, including AIDS. School districts should also have guidelines for dealing with accidents involving blood or other body fluids to prevent the spread of the disease.

   Currently there are no antiviral drugs available anywhere that have been proven to cure AIDS, although the search for such a drug is being pursued vigorously. Some drugs like azidothymidine (AZT) have been found that inhibit the virus, but they do not cure the infection. Though no treatment has yet been successful in restoring the immune system of an AIDS patient, doctors have had some success in using drugs, radiation, and surgery to treat the various illnesses of AIDS patients. Therapeutic agents are needed for all stages of AIDS infections, to block action of the virus once infection has occurred, and to build up immunity in patients who have developed AIDS symptoms. **(3)**

9. **List the groups at high risk for acquiring the HIV infection.** AIDS does not discriminate by race, sex, or age. Although the initial discovery was in the homosexual community, AIDS is not a disease only of homosexuals. AIDS is found in heterosexual people as well. AIDS is not just a male disease. AIDS is found in women; it is found in children. AIDS is found in all races. In the future AIDS will probably increase and spread among people who are not homosexual or intravenous drug abusers in the same manner as other sexually transmitted diseases like syphilis and gonorrhea.

   a. **Men who have sexual relations with other men are especially at risk.** About 70 percent of people with AIDS throughout the country are male homosexuals and bisexuals. This percentage probably will decline as heterosexual transmission increases. Infection results from a sexual relationship with an infected person.

      The risk of infection increases according to the number of sexual partners one has, male or female. The more partners you have, the greater the risk of becoming infected with the HIV.

   b. **Drug abusers who inject drugs into their veins are another population group at high risk and with high rates of infection by the HIV.** Users of intravenous drugs make up 25 percent of the cases of AIDS throughout the country. The HIV is carried in contaminated blood left in the needle, syringe, or other drug-related implements and the virus is injected into the new victim by reusing dirty syringes and needles. Even the smallest amount of infected blood left in a used needle or syringe can contain live HIV to be passed on to the next user of those dirty implements.

   c. **Some persons with hemophilia (a blood clotting disorder that makes them subject to bleeding) have been infected with the HIV either through blood transfusion or the use of blood products that help their blood clot.** Now that we know how to prepare safe blood products to aid clotting, this is unlikely to happen. This group represents a very small percentage of the cases of AIDS throughout the country.

   d. **Some people may have had a blood transfusion prior to March, 1985 before blood was screened for safe transfusion and may have become infected with the HIV.** Blood that has been collected for use is tested for the presence of antibody to the HIV. Fortunately, there are not now a large number of these cases. With routine testing of blood products for antibody to the HIV, the blood supply for transfusion is now safer than it has ever been with regards to AIDS. Persons who have engaged in homosexual activities or have injected street drugs since 1977 should never donate blood. If they admit to such activities, they are not allowed to donate.

e. **Heterosexual partners of persons infected with the HIV also are at high risk for developing HIV infections.** As of now, most cases of heterosexual-acquired cases of AIDS have occurred among sex partners of intravenous drug users HIV infection occurs from male to male, male to female, or female to male sexual contact

f. **Children born to HIV-infected mothers may be infected.** The mother can pass the HIV to her unborn child Approximately one third of the babies born to AIDS infected mothers will also be infected with the HIV. Most of the infected babies will eventually develop the disease and die. Several of these babies have been born to wives of hemophiliac men infected with the HIV by way of contaminated blood products. Some babies have also been born to women who became infected with the HIV by bisexual partners who had the virus Almost all babies with AIDS have been born to women who were intravenous drug users or the sexual partners of intravenous drug users who were infected with the HIV. More such babies can be expected (2)

10. **Understand that a woman who is infected with the HIV and becomes pregnant, is more likely to develop ARC or classic AIDS.** Studies have shown if a woman is infected with HIV, and becomes pregnant, she is twice as likely to develop classic AIDS

11. **Identify misconceptions about AIDS.** There are no known medically documented cases caused by:

a. donating blood
b. sharing food or drinks
c. touching or hugging someone
d. insect bites
e. riding buses
f. toilet seats
g. sinks
h. swimming pools
i. hot tubs
j. drinking fountains
k sharing telephones
l. sharing pencils
m sharing paper
n. someone coughing or sneezing on you
o. shaking hands
p. sharing tools
q. social kissing
r. crying
s. sharing bed linens, towels, cups, straws, dishes, or any other eating utensils
t. doorknobs
u. office machinery
v. household furniture

VITA

Mary Jane Walker

Candidate for the Degree of

Doctor of Education

Thesis: A Case study of Implementation Procedures of a State-Mandated Instructional Program for AIDS Education

Major Field: Curriculum and Instruction

Biographical:

Personal Data: Born in Shreveport, Louisiana, February 2, 1957, the daughter of Charles Cecil Walker and Mary Jane Kellogg.

Education: Graduated from Neville High School, Monroe, Louisiana, in May, 1975; received a Bachelor of Arts Degree in Special Education from Louisiana Tech University in November, 1978; received a Master of Arts degree in Special Education from Louisiana Tech University in February, 1980; completed requirements for the Doctor of Education degree at Oklahoma State University in July 1990.

Professional Experience: Special Education Teacher, Milton Elementary School, Lafayette Parish Public Schools, Lafayette, Louisiana, February, 1980 to June, 1986 and August, 1988 to Present.