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## **Implementing AIDS Education: Policies and Practices**

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### **Abstract:**

The world has been challenged by the AIDS epidemic for 15 years. In 1985, the U.S. Department of Health and Human Services, Centers for Disease Control, allocated funds to all state departments of education to assist schools in the development of AIDS education policies and programs. Yet, these policies do not ensure that all students receive effective AIDS education. On September 21, 1991, the Arizona Legislature passed Senate Bill 1396, which requires public schools to annually provide AIDS education in grades K-12. The bill was rescinded in 1995. With prohibitive curriculum guidelines, limited teacher training opportunities and tremendous instructional demands, this educational policy was implemented in disparate forms. By examining the perspectives of the Arizona educators (representing three school districts), this qualitative study reveals how teachers ultimately controlled the delivery and nature of AIDS instruction based upon personal values, views of teacher roles, and their interpretation of the mandate itself.

### **INTRODUCTION**

Adolescents are particularly vulnerable to contracting the Human Immunodeficiency Virus, the virus considered by many to be responsible for the opportunistic infections associated with AIDS. Because of the disease's latency period, more than 20 percent of persons reported with AIDS in the United States are under the age of 30 and were probably infected during their teens (WHO, 1993). Whether out of curiosity, the wish to experiment, peer pressure or low

self-esteem, teenagers engage in pre-marital, high risk sexual intercourse. Many activists maintain that without a vaccine, the only means of AIDS prevention is through education (Aiken, 1987).

In 1985, the U.S. Department of Health and Human Services allocated block grants to state departments of education to assist schools in the development of AIDS educational policies, teacher training programs and curricula. However, the development of specific AIDS curriculum guidelines has been particularly challenging. Politicians and educators are cognizant not only of resource allocation but of constituent and public opinion associated with the stigma surrounding AIDS. As a result, the task of delivering a curriculum which responds to such questions as: What is AIDS?; How is it transmitted?; How can it be prevented? and; Who should teach this? remains politically charged.

In addition, few teachers have the training and theoretical tools to address such questions in the classroom (Aiken, 1987; Dodds, Volker & Viviani, 1989; Eckland, 1989; DiClementi, 1990; GAO, 1990; Nadel, 1990; SIECUS, 1991; NASBE, 1993; Popham, 1993b). Therefore, the intent of this research is to reveal how the teachers of Arizona, interpreted, and implemented a mandated AIDS education policy despite these challenges.

## **DATA COLLECTION**

The flexibility of qualitative methodology allows for the use of multiple methods and strategies for analysis. Qualitative methods call for thick, rich descriptions of processes and are concerned with the meanings which participants attribute to social interactions and situations (Geertz, 1973). This inquiry is based upon participant behaviors, actions and meanings, not assumptions about these constructs.

It is for these reasons that a qualitative approach was employed for this study of the "practice" of AIDS education. The following data collection techniques were used: direct observations, participant observation, structured interviews of participants and the analysis of documents.

### **Direct Observations**

The observation of state district AIDS teacher training sessions, enabled the researcher to witness a variety of interactions, activities and responses regarding the implementation the Arizona AIDS K-12 education mandate. Because of the unique social construction of AIDS, the observation of participant interactions helped establish beliefs regarding the mandate during different stages and levels of its implementation. Observation sites included the following teacher training sites: the Arizona Department of Education (ADE) Comprehensive Health Department; district A-suburban (K-8) health education unit; district B-urban (K-12) comprehensive health education unit; district C-rural (9-12) health education unit; elementary and secondary teacher training sessions held at District A,B,C designated school sites; three parent/community AIDS education information meetings, and; three school board meetings.

Attending state-sponsored teacher training sessions helped to establish contacts with teachers who have served or would serve as site AIDS instructors. These contacts also helped to identify the nature of various district and school AIDS education efforts. These observations began in October 1992 and continued through December 1993. Observations of parent meetings, ADE curriculum development and organizational activities took place between November 1992 and June 1993.

Three districts, representing rural, suburban and urban settings were randomly selected from Maricopa County, the largest county in the state.

Requests to observe classroom AIDS lessons were, for the most part, denied, as principals

(five from each of the three districts) refused to allow access to view AIDS instruction. The principals gave a variety of responses, ranging from an unequivocal "No," (with little explanation attached), to directing me to review district policy (because that is what they felt their teachers taught), to assuring me their schools had already delivered the ADE curriculum in 1992-'93 and they had not yet established plans for the 1993-'94 academic year.

## **Interviews**

Structured interviews revealed the multiple perspectives and views of those charged with implementation of the AIDS education mandate: policy-makers, state and district administrators, as well as teachers. Through the course of these structured interviews, questions which pertain to beliefs regarding Arizona AIDS education policies, resource allocation, curriculum development, teacher training and instructional practice were raised. The interviewees included members of the Governor's Task Force on AIDS; the Arizona School Boards Association, and; the Arizona Legislature Education Committee;

Persons charged with the implementation of the mandate were also interviewed. Taking part were the Arizona Department of Education AIDS specialists, three district health education administrators; ten principals; nine secondary public school teachers representing three districts, and; nine elementary public school teachers representing three districts.

The perspectives of these participants helped determine relevant background information and context, as well as identified the antecedents which prompted the creation of the policy in its present form. The tape-recorded interviews (see Appendix A interview protocol) took place at the state department of education, district teacher training sites, and specific school sites.

Data was then transcribed and coded for the purposes of analysis. Core categories that emerged include policy development issues, teacher training processes, barriers to instructional practice, compliance circumvention, and evaluation methods.

## **The Use Of Documents**

Numerous documents were collected and analyzed. They played a vital role in providing information about organizational structure, funding and evaluation efforts. The following documents were reviewed: the Arizona AIDS education mandate, S.B. 1396; legislative minutes related to S.B. 1396; CDC Guidelines for Effective School Health Education To Prevent the Spread of AIDS; an external evaluation of the Arizona Department of Education HIV/AIDS Prevention education program; Arizona Department of Education K-12 HIV/AIDS curriculum guides; parent information and consent forms; staff training materials; the Council of Chief State School Officers' Profile of State AIDS Education Survey Results, and; the National Association of State Boards of Education report on AIDS and School Health Education--State Policies and Programs.

The analysis of documents provided information regarding the CDC guidelines pertaining to funding, records concerning legislative sessions regarding policy development, the Arizona AIDS mandate itself, curriculum standards and evaluation concerns. This content analysis yielded information about the organizational norms derived from participant beliefs regarding AIDS education efforts. Since the review of documents is an unobtrusive research method, this began a particularly important part of this study, since the sensitive nature of the issues involved caused the participants to be hesitant to respond freely to the interview questions. Also, the review of documents helped generate additional interview questions which were otherwise overlooked.

Documents which reflected quantitative data collection were also examined. Since different kinds of research questions can be addressed when using multi- methods, quantitative

data provided, for example, such data as: the percentage of schools providing AIDS instruction by school administrators; the percentage of the schools providing AIDS instruction as reported by teachers; the distribution of AIDS education provided at various grade levels, and; the percentage of obstacles to AIDS instruction as perceived by the teacher themselves. Together, each quantitative and qualitative methods help to stimulate research question as well as establish assertions regarding the findings. In addition, by combining qualitative and quantitative methods, bias was reduced.

This interpretive research sought to address questions related to the "hows and whys" of the implementation process. The final phase of this study began with the synthesizing of the data for the purposes of identifying categories of phenomena and the relationships between them. This required a careful review of tape recordings, transcripts, documentation and fieldnotes. From these categories, ideas and themes were generated. Listening to personal accounts shared by the participants also helped to establish rapport, and raise additional research questions.

By identifying and categorizing problematic areas, a focused synthesis followed. A "focused synthesis" (Doty, 1982) consists of the selective review of information, relevant to the policy study's research questions.

In general, this policy study employed naturalistic methods in order to arrive at a valid, corroborated, interpretation of the data required to answer the research questions. These methods included: direct observations, one-on-one structured interviews, analysis and deconstruction of documents, the review of quantitative data, the creation of core categories and themes, and the focused synthesis of the data set. The findings were then integrated into an overview of the development and implementation of the AIDS education policy by its practitioners--professional educators.

## **AIDS INSTRUCTION IN ARIZONA-- DISTRICT A SCHOOLS**

Society is ambivalent about the role for teachers when entrusting them with a set of life choices and values to put before their students. It is the educator, however, who is charged with implementing mandates and devising programs whose foundations rest on moral questions. The following cases illustrate how Arizona teachers strived to implement AIDS education programs in both secondary and elementary public school settings.

In September 1991, the legislature of the state of Arizona passed its own AIDS education mandate, Senate Bill 1396. It requires Arizona public schools to provide AIDS education in grades K-12 annually. Each district is free to develop its own course of study for each grade. According to the mandate, the curriculum must reflect the following: 1) grade level appropriateness; 2) medical accuracy; 3) abstinence; 4) drug prevention, and; 5) modes of AIDS transmission. In addition, the curriculum cannot promote a homosexual lifestyle, portray homosexuality as a positive alternative life-style or suggest that some methods of sex "are safe forms of homosexual sex" (ADE, 1992, 2). All school districts are required to hold parent meetings to describe the curriculum prior to providing AIDS instruction. In addition, each school must notify parents of their right to withdraw their children or "opt out" of AIDS instruction if they so choose.

In 1992, District A (grades K-8) developed a program based upon the state's AIDS curriculum recommendations. The district committee also sought to adapt the state curriculum to meet specific areas of concern. The committee, comprised mostly of District A nurses, felt the AIDS curriculum should emphasize the disease process and in particular, should include a discussion regarding common illnesses and how they are contracted. This focus resulted in the development of supplemental lesson plans for teachers to use in conjunction with the state curriculum. In addition to the state department of education-sponsored AIDS in-services, District A offered its own training sessions for their school personnel.

All District A teachers are responsible for delivering the AIDS curriculum. Because of the nature of the self-contained elementary school classroom, the teachers are instructed through the district and state teacher training in-services that the AIDS lessons should be presented within the context of the health education unit. The teachers of District A appeared to be comfortable when providing the curriculum within this unit, that is, if they had participated in an AIDS teacher training in-service. Two teachers noted:

At first I thought there was no way I could teach this curriculum. To be honest, what I knew about AIDS I learned from TV, the papers. After I went to the trainings, I felt better equipped to teach the subject. But that doesn't mean I felt more comfortable about it. So I taught a few of the lesson plans during health ed, when I talked about the body, the immune system, and how it protects us. I used the lessons that were appropriate for my class (District A teacher 1, interview, January 22, 1994).

In my kindergarten class, I talked to the students about germs, infection and how they can lead to such illnesses as colds. We also discussed hygiene. That's what the AIDS lesson plans cover at this level, that's what our curriculum focuses on. It's odd this basic health information falls under the AIDS ed umbrella. But I think the kids will come to understand the illness if their future teachers give the lessons in the correct sequence. I felt comfortable fitting it into my health ed unit, and the trainings helped me to understand how to do that (District A teacher 2, interview, January 23, 1994).

Other teachers had not yet participated in a state department of education or district AIDS teacher training in-service. Although they were expected to begin providing AIDS instruction in the 1992-'93 academic year, there were District A teachers who did not take part in the trainings, nor did they deliver the curriculum to their classes. None of these teachers described any punitive measures taken against them by their site or district administrators. One fifth grade teacher explained:

I didn't attend an AIDS in-service last year. I probably shouldn't be telling you this. But it's not because I didn't want to teach it. It's because I just didn't have the time. I teach third grade LEP (Limited English Proficient) and I spend a lot of time preparing for my class. The state only offered a limited number of spaces for their trainings and when I signed up, the in-services were full. The district in-services are after school, and I'd rather spend that time with my own kids. So I didn't teach the AIDS curriculum last year [1992-'93]. But I did go to the department of ed training this fall. Then I found out the curriculum wasn't translated into Spanish. I'll have to do that myself, so I probably won't give the lessons until sometime this spring [1994], (District A teacher 3, interview, January 29, 1994).

Every year it seems like we have to teach something else. So I wasn't thrilled about this AIDS education mandate. Last year (1992- '93) I didn't go to an in-service and I didn't teach the curriculum because I was busy and wasn't prepared. I received a memo from my principal that I had to attend one this year. Why should I? Am I getting paid extra? I'll probably teach the lessons this semester [1994], but I still feel this is just another thing we have to do. This [AIDS education] should be taught at home (District A teacher 5, interview, February 8, 1994).

For the teachers who did present the AIDS curriculum in the classroom, they found the controversial nature of the content to be tempered by the health concepts introduced at each grade

level. Initially, there were concerns for those students' whose conservative parents would choose to opt their child out of the AIDS education program. According to the District A Health Education Administrator, only one student reportedly "opted-out" of the program last year. She noted, "Most parents want us to teach their children about the disease and how not to get it" (interview, November 16, 1993).

The District A AIDS teachers acknowledged that once they felt familiar with the curriculum, they were able to integrate it within their health education or family health units. One sixth grade teacher recalled:

When I began the AIDS curriculum, I was worried about how it would work with the rest of the health unit. At this grade level we begin to talk about some of the specifics of the disease, such as the transmission of AIDS through bodily fluids. We did an activity that I learned about at the 2-day training. We mixed food coloring, water and chemicals in one another's test glasses and shared 'fluids.' If the mixture changed colors, we learned whether we were 'infected' or if we infected someone else. The students enjoyed it. During our discussion, I introduced the topic of abstinence. I stressed to my students that abstinence is the best way to minimize the risk of getting infected (District A teacher 6, interview, February 7, 1994).

One District A kindergarten teacher, found her students and their parents to be concerned about a variety of issues:

During our parent meeting, the principal had asked a teacher from each grade level to present an overview of the curriculum. We wanted to assure the parents what was being taught was grade appropriate. I discussed the kindergarten section, answered their questions, got some feedback. I learned about some of their concerns, which were mostly about whether there was going to be a discussion about sex and homosexuality. They seemed relieved when I told them we would be discussing things like germs, infection and hygiene, not sex.

The biggest challenge faced by the District A AIDS teachers in the classroom pertained to the students' concerns about where the virus came from, who it affects and how it is transmitted. Following the introduction of basic health concepts, the discussion of the immune system, and the definition of AIDS and AIDS, the teachers found it difficult to dispel the myths about the virus, as required by the mandate. The District A AIDS teachers were continually faced with a variety of misconceptions held by students, regardless of grade level. The teachers acknowledged that while the AIDS in-services prepared them to discuss basic issues, student concerns were more specific and frank. The teachers found it difficult to anticipate all of the students' questions and provide responses which did not violate the mandate's guidelines.

District A AIDS teachers' discussions with students often reflected the restrictions set forth by the state curriculum guidelines. The guidelines limited discussions about how AIDS is transmitted, whether the acts of sexual expression be heterosexual and homosexual. Instead, students received information about where AIDS could be found (i.e. blood, semen, and vaginal fluids). Students were informed that only by maintaining an exclusive monogamous relationship with an uninfected partner would they be insured of eliminating the risk of contracting AIDS. While this promotes the mandate's abstinence message, the teachers did not address the issues regarding the identification of an infected partner, nor did it allow for discussion about why students should remain monogamous, only that they should. District A teachers tended to equate sexual expression with punishment, disease, and eventually, terminal illness:

I told my eighth grade girls that they should wait until marriage before having sex.

That way they could get to know their partner. I told them that pre-marital sex leads to trouble, teen pregnancy, sexually transmitted diseases, and AIDS. I told them, 'Do you want to live or die?' These girls need to learn to say 'No' (District A teacher 8, interview, February 21, 1994).

These kids need to know that homosexuality kills. That's not a politically correct thing to say, I know. But the majority of people who are contracting the disease are still homosexuals. When I taught the seventh grade boys last year, I told them that this behavior is not okay. I don't care how many gay rights bills are passed and how many of them march on Washington. Homosexuality is wrong and gays are dying because of it. That's all really what these kids need to know (District A teacher 9, interview, February 22, 1994).

In the 1992-'93 academic year, various District A teachers presented the AIDS curriculum in the manner they felt was in compliance with the 1991 mandate. Although the teachers presented the curriculum within the context of the health education unit, none introduced material beyond what was required of them. Follow-up activities generally consisted of post-tests or quizzes which sought to measure student knowledge about the content presented to them regarding such topics as: personal hygiene, the immune system, the definition of AIDS and AIDS and the importance of abstinence.

## **AIDS INSTRUCTION IN DISTRICT B SCHOOLS**

Prior to the passage of the Arizona AIDS K-12 education mandate in September 1991, AIDS education was not a formal part of the District B curriculum. Following the passage of the bill, District B set out to develop its own curriculum (although very similar to that of the state department of education). District B made a concerted effort to provide training for teachers in order to emphasize the recommendations established by its own Health Education curriculum committee. Similar to the state recommendations for providing AIDS instruction, District B strives to integrate the AIDS content into a school's pre-existing health education program. Unique to District B is its development of a separate health and safety unit, the "Community Survival Curriculum," for those parents who have opted their children out of the AIDS and sex education programs.

Occasionally, District B principals would acknowledge that not all of the teachers were willing participants in the AIDS teacher training in-services. When principals would send a memo to a teacher who had not attended an in-service, they would, at times, encounter resistance from those teachers. One principal recalled:

I had teachers who didn't want to attend any of the in-services. And I can't say that I blamed them. These teachers are overwhelmed by all of the things they have to do in the classroom. They aren't interested in teaching a curriculum they had very little input in developing. They have enough on their minds, lesson plans, test preparations, motivating kids. Of course I tell them they are required to attend the in-services, but I let them know that I empathize with them and that I understand their reluctance (District B principal 4, October 19, 1993).

Of the District B teachers who did not attend an AIDS teacher training in-service, they maintained it was not because of ideological or moral concerns. They reiterated that while they were aware of the seriousness of the AIDS epidemic, they had other concerns which they felt were more pressing:

I knew I was supposed to go to one of those in-services, but I never did. I had too many other things to do. Teaching third grade keeps me busy. And besides, I've seen the [AIDS] curriculum and it basically just covers health issues. And that's what I teach in my class anyway, so I don't see why it is so important that I go to one of those things. I'll probably go to one this year, at the district, at least those are shorter than the state trainings (District B teacher 2, interview, October 25, 1993).

Of the District B teachers who did attend an AIDS in- service, they found that by presenting the curriculum within a broad health education framework enabled them to discuss such issues as disease transmission, the immune system and hygiene. However, some teachers found that this approach also revealed the limitations of the AIDS curriculum. One eighth grade teacher said:

Even with the [AIDS] training I had, I was concerned about how I was going to present this topic to the girls. You know, at this level we separate the kids by gender, as we get into the Family Life [sex education] unit. The girls need to know about how their bodies function and how to have to take care of themselves in a variety of ways, from nutrition to exercise, to decision-making. We need to go beyond discussions about menstruation and reproduction, and actually, the AIDS unit starts to get us there. When you really sit and think about it, this material is very difficult to deliver. I want to talk about health as a whole, but how can I do that when I can't even talk about the issues that matter to them. I tell the girls that AIDS is carried in blood, semen, and they have a lot of questions, but I know my answers can't stray away from the emphasis on abstinence. I have to stick to the biological information (District B, teacher 4, November 1, 1993).

These kids [seventh graders] say more than I can teach about AIDS. Well, at least they're not afraid to speak their minds. They know it's spread through sexual intercourse but they're not exactly sure how. Of course I'm not supposed to mention those kinds of things. But they've heard about Magic Johnson. And I have students who say 'Only faggots get that.' They have 'sound bites' of information, some are true, some are false. So in the long run, it's ridiculous what we can and cannot talk about. How can I get at these myths when I can't talk about them? (District B teacher 5, November 2, 1994).

When confronted with questions which were not directly addressed in the state or District B AIDS curricula, the teachers often had to separate what they felt was practical information from the content they were required to deliver. faced with conflicting kinds of information posed a special challenge to the District B instructors who did not want to leave misinformation unaddressed. And yet, they did not want to delve into topics which were "off limits" according to the state curriculum guidelines. For the most part, these topics, and the myths surrounding them, concerned the ramifications of homosexuality, monogamy and promiscuity. The District B teachers were aware that these issues were taboo, even though they were the same topics the upper grade students were most interested in. One eighth grade teacher recalled:

Actually, these girls love the idea of monogamy. It's so romantic to them. They don't see themselves getting AIDS. I brought in an news article. It was about a woman in her 30s, with three kids. She was AIDS positive, and she got it from her ex-husband. My students were intrigued by the fact that the ex-husband 'did it to her,' and they were glad to learn that he had died. 'He deserved it,' was their response to that story. They felt 'The woman didn't deserve it. She was only with her husband and look

what happened to her.' The girls seemed genuinely troubled by the idea that men fool around, as if that's an accepted part of their nature. 'That's why you really have to be a good wife,' one student said. Now that really stuck in my mind, because then we got into a discussion about what makes a good wife. 'Pleasing your man,' was the general response. One thing about teaching the AIDS curriculum, it really opens up a can of worms. But I'm really not so sure that the abstinence message is just a retelling of the fairy tale (District B teacher 7, interview, February 11, 1994).

The Arizona AIDS curriculum did have its supporters. Several teachers expressed that they were very comfortable presenting the lesson plans within a biological context. They did not feel limited by the mandate's focus on abstinence, or the exclusion of the homosexuality as a topic of discussion. In some ways, the teachers felt that those guidelines made the delivery of the mandate much less controversial and consistent with their personal values. The teachers recognized that the guidelines also made the curriculum more palatable for parents. One sixth grade teacher said:

When I taught about AIDS, I told my students [sixth graders], right off the bat, we are not going to talk about homosexuality. We are not going to talk about how to have sex outside of marriage. We're not allowed to, and I don't want to because I don't believe in either of those lifestyles. I told them we were going to define AIDS, AIDS and how this disease infects the immune system. Once I said that, the kids knew I wasn't playing games and they shouldn't play games with their lives (District B teacher 9, interview February 23, 1994).

## **AIDS INSTRUCTION IN DISTRICT C SCHOOLS**

In August, 1991, while the passage of the Arizona AIDS K-12 mandate was still one month away, District C high schools had already organized an AIDS education committee (composed of volunteer educators) and had developed a curriculum which would generally mirror that which was published by the state in 1992. By the 1992-'93 academic year, committee had designed an "AIDS Awareness Week" to present to staff and students district-wide.

Teachers responsible for providing AIDS instruction in District C schools did so on a voluntarily basis, regardless of content area specialization. "Teacher teams" would travel from class to class and provide the AIDS instruction throughout the week. Once District C AIDS classroom instruction began, teachers were at times taken aback by their students' responses. One AIDS instructor found one student's notions about the disease to be extremely troubling. She explained:

We are required to emphasize to our students abstinence and to make better choices in risky situations. But consider the kind of information students have. One student talked to me after a presentation. She said she felt she was a virgin because she had anal sex. That was her form of birth control....'That way I won't get pregnant' she said. But what she didn't really understand was that anal sex is the highest AIDS risk behavior! (District C AIDS teacher 4, interview, December 14, 1993).

The AIDS instructors faced a number of questions from students which were frank and were not addressed in the state curriculum. Instructors found eleventh and twelfth grade students to be interested in whether or not they could contract AIDS by 'French kissing,' having intercourse during menstruation or while engaging in oral sex. Such questions were easily recalled by the AIDS instructors because they were sensitive in nature, miles away from the issue of abstinence and were the most difficult to answer. One teacher said:

These kids want to know more than abstinence. They demand it. When the students ask these kinds of questions, there's always a bit of laughter. Part of it is because they want to see how I'm going to respond. I try to approach these questions from the biological angle. That may seem like I'm avoiding the issues. Then I tell them AIDS is transmitted through bodily fluids and which includes blood and semen. I tell them there are still many questions that researchers don't have the answers yet. My bottom line is they're not going to get AIDS if they sit on a toilet. They're not going to get it if someone spits on them. Or if a gay person sits next to them on the bus. The bottom line here is that these kids want to know the answers, and these kids are the juniors, the seniors, the ones who about to begin their adult lives. (District C AIDS teacher 3, interview, December 13, 1993).

Having "the right answers" proved to be a challenge to the site AIDS instructors. Although many participated in the ADE sponsored teacher training in-services, their responses to student questions did not always come quickly or easily. While several of the presenters had some form of health education background, this did not necessarily mean they were able to address all of the questions the students raised. Group activities helped ease the pressure some teachers experienced while trying to answer sensitive questions:

At the beginning of our third session, after the biology and the discussion about transmission, I sensed that the students still felt this was a gay disease and the dialogue just shut down. They didn't participate in the discussions and I felt that I was just talking to myself. So then I told them, 'Let's play, 'What's My Line?'' This is a role play in which the kids receive cards identifying different types of people, for example, a single mother, a male dancer, a father of five. It's up to the other students to determine who is AIDS positive. They ask the ones who received the cards questions. The cards they hold have scripted responses written on the back, but the kids are free to elaborate. So of course, the class expects the AIDS infected person to be the male dancer. But they guess wrong, it's the father of five. So the class is confronted by their own stereotypes. In their silence afterward, I felt that they got the message (District C AIDS teacher 5, interview, October 20, 1993).

This is not to say that all students were responsive to the instruction. A number of the District C AIDS teachers found it difficult to engage students in discussions and cooperative learning activities. While it may have been more efficient to distribute the AIDS teaching resources to those classes who requested a team, this process also had its drawbacks. Establishing rapport with a new class, and with a sensitive curriculum to deliver, was not always the most effective context for instruction. The "AIDS teaching teams" found that students were not always willing to share their ideas, or were uncomfortable discussing sensitive topics in front of their peers. Often times it became difficult for the teams to gauge whether or not their instruction was, "Sinking in," as one teacher wondered.

Because instruction was not provided in a broad, comprehensive health context, some AIDS teachers felt awkward when beginning instruction. Classes were not prepped before the AIDS instruction began. The teams entered different classroom settings and began discussing such issues as: the immune system, sexually transmitted diseases, human sexuality, stereotypes and decision-making techniques:

Going into a new class to teach about AIDS was something I took too lightly. Although I volunteered to be an instructor, went through the two- day in-services and considered myself very AIDS aware, these things didn't really prepare me to teach the 27 new teenage faces that week. Why would they want to open up to a

stranger? We didn't have time to meet with the teachers of the classes we presented to beforehand. I mean, consider this, in the previous Friday's homeroom, the kids probably talked about the vacation schedule. On Monday, we began teaching what one student described as, 'that AIDS stuff.' So many of us went in cold. In time, as we got to know the students, it became easier to talk with them and get them involved in the activities we had planned. But we still only had 20 minutes each morning. (District C AIDS teacher 7, interview, January 21, 1994).

The uneasiness with the process of instruction emanated primarily from the framework in which the AIDS instruction was provided in District C. With the curriculum being delivered in the homeroom setting, and not necessarily by homeroom teachers, the AIDS instructors found themselves unaware of the particular nuances of the classes. While some presenters taught classes that were more inhibited, when encountering their own classes, a camaraderie had often been established and dialogue developed freely. One teacher said:

One topic I got asked about was condoms. Now that's something we really aren't supposed to talk about. The kids want to know what kinds there are. They want to know where to get them. They want to know if they can fully prevent AIDS. These are touchy subjects because I know they are not part of our district's curriculum. I worry about how my responses could easily be misconstrued and shared with a parent who may not want to ever hear the word 'condom.' On one hand you feel like you are withholding vital information, information that could save a life. So I tell them that they can be bought at any supermarket. But I know I must drive the discussion back to abstinence. I felt guilty about my response. (District C AIDS teacher 6, interview, January 20, 1994).

Other AIDS teachers experienced similar limitations. Many felt they had to develop quick responses to questions they were not prepared for. Curriculum restrictions also left exposed content areas which had not been previously discussed or resolved in teacher-training activities. The issues surrounding sexual expression, both heterosexual and homosexual, were prime examples of topics of interest to secondary students, even though the AIDS teachers did not have free reign to discuss them. While one AIDS instructor would choose to unabashedly discuss such topics, another would circumvent the issues:

During one of my classes, the students [sophomores] wanted to know why homosexuals aren't just quarantined. 'Fags started it!' they say. This kind of thinking is tough to accept without a discussion, at least for me. I reminded them it isn't just homosexuals who transmit the disease. There are different theories why the disease struck this group first. Then we talked about other carriers, heterosexuals, the carriers who are asymptomatic and may be infecting others and not even know about it. We discussed the issues surrounding the latency period. I asked them what would be the point of isolating people? Who would pay for it? I reminded them of the situation in Africa, where the disease has affected heterosexuals. I tried to impress upon them that we need to identify and stop risk behaviors, instead of blaming groups. Maybe I was defending gays, their lifestyle, which is something we're not supposed to do, according to the state and district guidelines. But I felt the students' misconceptions were so great that I couldn't let them go unchallenged (District C AIDS teacher 5, interview, October 20, 1993).

In my class of juniors, they were very vocal. One guy in the back said something to the effect of 'Kill all fags, let 'em die anyway, it's their fault.' Then someone else

would say, 'It's not just fags who get it. Look at Magic Johnson. He got it.' And at that point it was time for me to stop the discussion, at least at that level. I told the class we don't know where the disease originated. Then I moved on to another topic. Afterwards I knew what the group really was interested in, and perhaps could have benefited from, was a discussion about the different types of sexual expression, that it's not just a gay versus straight morality issue. But I wasn't allowed to talk about that because maybe it would seem I was promoting the gay lifestyle. So I didn't pursue the topic any further (District C AIDS teacher 3, interview, December 13, 1993).

It soon became apparent to the District C AIDS teachers that a discussion of monogamy could not be sustained without a discussion of relationships and how sexual intercourse becomes a part of them. The teachers discovered that students had not given these issues much consideration. Student views often emanated from some personal experience, television or films and experiences they had witnessed in their own families. And it were these views which caused discussions to stray away from the abstinence message. One teacher recalled:

To be honest, when I began the abstinence discussion, one female student mentioned her 16-year-old sister just had a baby. Another student added that her 17-year-old cousin had a baby, too. It was then that I realized the topic of abstinence certainly wasn't appropriate for a number of my students. After all, their peers had children. What's stopping them from becoming involved? But I had no idea how to address them, with the abstinence message looming over my head and their comments suggesting they needed to discuss something else (District C AIDS teacher 4, interview, December 14, 1993).

My students were pretty up front when it came to the discussion on monogamy. I mentioned to them that even though they may be with one boy or girlfriend doesn't necessarily mean that you were their first. We call this 'serial monogamy.' We talked about what they thought makes a good relationship. They said things like commitment, being able to share feelings, having things in common. Abstinence is a hard sell (District C AIDS teacher 1, interview, December 3, 1993).

By the week's end, the District C AIDS teachers acknowledged that while the delivery of the curriculum did pose certain challenges, they felt confident their efforts were, for the most part, important. They were, however, uncertain about their effectiveness.

## **FINDINGS**

Principal findings reveal the impact of the federal and state governments' role in the development and implementation of AIDS educational policies. Federal policies designed to give direction to the country's AIDS education efforts have been slowed because of the conflicting views of morality held by policy makers who risk offending constituents. Many constituents fear that frank AIDS and sex education curricula will encourage promiscuity and illegal behaviors. This notion, while unsubstantiated, has persisted throughout the history of sex education in the United States (Brandt, 1987).

The federal government, through the Centers for Disease Control, require that the content of the nation's AIDS education efforts be determined locally and reflect community values. In order to receive federal funding, which is the only source of funding for AIDS education for the majority of the states, community review boards are required to take part in local policy and curriculum development, but the boards need not include representatives from at-risk groups.

This emphasis on local control and community values reflects the inclusion of restrictive sex education principles which were established by President Ronald Reagan's Domestic Policy Council in 1987.

Funding for state AIDS education programs has been further complicated by amendments attached to federal appropriation measures at the insistence of conservative legislators which require that no federal funds be used to "promote homosexuality." The CDC, reacting to this legislation, has adopted regulations that prohibit federal funds from being spent on AIDS education materials which may offend some members of the community, even if the materials are not targeted to those parties who might be offended.

With the use of illicit drugs and non-prescription syringes unlawful in all states and sodomy illegal in 25, it is unlikely that the federal government will challenge the laws established by the states and endorse an educational policy which contains material which may contradict these laws.

Despite the emphasis of AIDS educational policy on abstinence by federal, state and local curriculum review boards during the first decade of the epidemic, the CDC itself has reported that the number of AIDS cases has increased most rapidly among adolescents, young adults and women through heterosexual transmission (1993). However, the absence of an effective national AIDS education policy has not been recognized as contributing to the country's inability to contain the spread of the disease.

Arizona adheres to the CDC's AIDS education policies and encourages school districts to develop educational materials which reflect the values and culture of their local communities. The state's AIDS Curriculum Review Board developed an education program which reflects, for the most part, the values of the dominant, conservative community. What curricula does not reflect the diversity of class, race, ethnicity, gender or sexual orientation of the broader community. In fact, teachers related that the curriculum they delivered to students did not adequately address explicit issues and needs often raised by the diverse students they taught in the classroom.

Principals have been slow to respond to the mandate, and did not consistently encourage teachers to attend AIDS education in-service training sessions, deliver instruction, and were lax in the arrangement of follow-up AIDS education activities. With no compliance mechanism in place, some principals did not perceive the need to act beyond what was minimally required of them by the state and the district. If their school's AIDS education effort consisted of showing a single video, they felt they were in compliance.

However, evidence was found that a handful of principals chose to make AIDS education a priority at their local school sites. They perceived the severity of the epidemic and supported AIDS education efforts in their school prior to the passage of the mandate, granted release time for teachers to attend conferences and even attended in-services themselves.

Nevertheless, principals and teachers alike recognized the additional demands placed upon them in an already crowded curriculum. Many teachers were reluctant to serve as their site's AIDS educator. Those who did volunteer acknowledged a personal commitment to the issue and to their students. They provided instruction with limited resources available to them and with minimal training. Often times the AIDS instructors debated internally about which topics to discuss with students, topics deemed taboo by Arizona's AIDS education policy standards. Many teachers chose to discuss explicit issues with their students despite the restrictions of the policy.

For those teachers unhappy about having to provide AIDS instruction, the knowledge they did deliver to students could easily be controlled. Abbreviated forms of the curriculum were presented which emphasized that unless abstinence and heterosexuality are adhered to, death is certain and deserved. By providing such fragments of the curriculum, the demands on the teachers remained minimal and manageable, especially for those who were uncomfortable or unfamiliar with the AIDS/HIV curriculum.

As the teachers sought to find ways to reconcile the state mandated AIDS education policy with their own beliefs and value systems intact, it became clear that many found it difficult to reconcile what the state was asking of them, and what kinds of information the students requested and needed. For the most part, the teachers had to use their own personal and professional judgment when determining what kind of information to discuss with their students. Often times, teachers responded with a rationale or defense when describing the curriculum they delivered which exceeded the terms of the mandate.

In the end, this educational policy was transformed then, into a series of personal, unofficial guidelines and coping strategies created and controlled by the practitioners, in this case, the teachers. The federal and state mandated pieces of the puzzle were jammed into place by the policy makers who were eager to legislate with values in hand, without an understanding of the ramifications of the issue, adequate resources, compliance mechanisms, and without a complete awareness of what is being asked of the practitioners.

Setting the stage for a formal AIDS education program in the Arizona public schools was the 1991 passage of the AIDS education mandate. While previous efforts sought to enact an AIDS education mandate in a variety of different forms, final passage of the mandate became a reality after compromises were struck among stakeholders concerning such issues as the role of the schools, the political climate and the inclusion of anti-homosexual language. These compromises were the result of the actors taking into account what other stakeholders were doing or were about to do, in this case, constituents.

However this was hardly possible in the case of the development of the Arizona AIDS K-12 mandate, where those most versed in confronting the epidemic, gay AIDS social service agencies and organizations representing risk groups, such as Latinos and African-Americans, were excluded.

Prior to the passage of the mandate, Districts A and B did not have a formal AIDS education program in place. Once the mandate was approved, even with its carefully constructed language, getting district A and B teachers to attend and participate in the AIDS training in-services proved to be difficult. Principals did not consistently encourage teachers to attend training in-services, or were lax in the arrangement of follow-up AIDS education activities for the next academic year. With the support of their principals, district C teachers were quick to respond to the AIDS crisis by organizing its own district-wide curriculum committee and instructional strategies before the state of Arizona had even passed the mandate.

District A and B K-5 teachers who attended AIDS in-services emphasized hygiene and basic health skills, as required by the mandate. Some teachers at this level, however, simply chose not to deliver the AIDS education curriculum because they either chose not to attend an in-service, felt it was another curriculum task (on an already full-plate) that they were not being compensated for, or argued that any discussion of sexuality was against their personal values. As a result, mandated instruction was transformed then, into a series of personal, unofficial guidelines and coping strategies created and controlled by the practitioners, in this case, the teachers.

District B and C middle school and secondary teachers sought to find ways to balance the state mandated AIDS education guidelines with their own beliefs and value systems, it became clear that many found it difficult to reconcile what the state was asking of them, with the kinds of information the students requested and needed. For the most part, the teachers had to use their own personal and professional judgment when determining what kind of information to discuss with their students. Often times, teachers responded with a rationale or defense when describing curriculum delivery which was either not acceptable under the terms of the mandate, or was simply inaccurate or incomplete.

All of the teachers appeared fearful of challenging the tenets of a mandated AIDS educational policy, and having their instruction be misconstrued by students who might relay that

information to conservative administrators and parents. Other teachers felt constrained by the mandate's guidelines because they felt it was out of touch with student needs. Other teachers acknowledged that they delivered the curriculum poorly because they felt inadequately prepared, were uncomfortable about teaching material they received in "a crash course," felt the content did not reflect their personal value system, or believed schools should not be held accountable for provided that "should be taught at home."

Also evident were those teachers who were confident in their ability to engage students in discussions which, at times, strayed from the topics deemed acceptable by the mandate. Working around and within the limitations of a restrictive policy with keen communicative skills became a pedagogical technique several of the secondary AIDS educators appeared to be quietly proud of.

Several participants concluded that having an educational policy in place "was better than not having one," since the AIDS curricula probably would not be delivered to students at all. Also evident were proactive administrators and teachers in District C were able to anticipate students' needs. Evidence of "pre-mandated" AIDS education programs could be found in District C schools in which the participants felt a personal belief in the importance of the issues at hand. Networks of educators interested in clarifying, developing, and implementing a policy collaboratively allowed one school district to respond more quickly to the mandate than others.

In the end, it can be said that without an understanding of participant perspectives, of the educators who work directly with students, that the efforts of policymakers will never rise above the symbolic. Mandated, restrictive policies imposed from above without dialogue, adequate training, resources or accountability, only succeed in alienating the practitioners and ultimately, failing to meet the needs of all student.

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## **Appendix A--Interview Protocol**

1. What is the Arizona AIDS education policy?
2. How was the policy developed into its present form?
3. Who is responsible for implementation?
4. What can be taught about AIDS? How was this determined?
5. Who decided at the federal level?
6. Who decided at the state level?
7. Who decided at the district level?
8. What learning outcomes are expected at the state level?
9. How is the implementation of the mandate being funded?
10. How are districts delivering the curriculum?
11. How are schools delivering the curriculum?
12. What kinds of instructional obstacles have arisen?
13. How have educators confronted them?
14. How could the curriculum and pedagogy be improved?
15. How is compliance being monitored?
16. How is instruction being evaluated?
17. What occurs if a parent, student or staff member does not want to participate in the AIDS education unit?

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