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## ISSUES CONCERNING CDC'S AIDS EDUCATION PROGRAMS

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## SUMMARY

CDC has lead agency responsibility for federal AIDS education, and its budget for AIDS activities has grown from about $13.8 million in fiscal year 1984 to about $305 million in fiscal year 1988. Education programs that target persons at increased risk of HIV infection--such as homosexual and bisexual men and intravenous drug abusers--have accounted for the majority of CDC's AIDS education budget, and our work focused on these programs.

Although our work is still underway, we identified three main issues concerning these programs. First, the number of staff CDC has assigned to manage its AIDS education activities appears to be insufficient to monitor state and local health departments and advise them on how to develop and operate effective AIDS education programs. Second, the state and local departments have made limited progress in developing baseline data on the level of knowledge about AIDS in their communities and the practice of behaviors that spread HIV. This limits CDC and the departments' ability to identify specific needs for AIDS health education, set priorities, and establish objectives. Lack of baseline data also inhibits identifying programs that work best, and disseminating information on effective programs to other health departments. Finally, we identified weaknesses in the health departments' efforts to use CDC funds for counseling and testing to reach those groups with the highest risk of HIV infection.

The federal government should take the lead in identifying and promoting those AIDS education and counseling approaches that have the greatest impact. Much remains to be learned about how to motivate long-term changes in the sexual and drug-using behaviors that spread HIV. During this learning process, some false starts and misdirected efforts must be expected as the unavoidable price of experimenting with promising approaches. CDC should continue to evaluate these approaches and to rethink and modify, if necessary, its requirements and guidelines to assure progress is being made in controlling the spread of HIV.

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss our ongoing work on the federal government's education programs to limit the spread of human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS). The federal AIDS prevention strategy focuses on high-priority research to develop a vaccine against HIV and on education. The previous witnesses discussed how we can apply lessons learned from other health education programs to the nation's AIDS efforts. Notably, they presented information on exemplary programs and summarized the academic research on the effectiveness of health education messages. My testimony presents our concerns about programs the Centers for Disease Control (CDC) has in place to deliver these messages to persons who are at increased risk of HIV infection.

CDC has lead-agency responsibility for federal AIDS education. We focused on programs that target persons at increased risk of infection because most of CDC's education budget is spent on these programs. The National Institute on Drug Abuse is also expanding education programs that target intravenous drug users, and we plan to examine how it's programs are coordinated with CDC's.

Our work to date has identified three main issues. First, the number of staff CDC has assigned to manage its AIDS education activities appears to be insufficient to monitor state and local health departments and advise them on how to develop and operate effective AIDS education programs. Second, the state and local departments have made limited progress in developing baseline data on the level of knowledge about AIDS in their communities and the practice of behaviors that spread HIV. This inhibits CDC and the departments' ability to identify specific needs for AIDS health education, set priorities, and establish objectives. Lack of baseline data also inhibits identifying programs that work best and disseminating information on effective programs to other health departments. Finally, we identified weaknesses in the health departments' efforts to use CDC funds for counseling and testing to reach those groups with the highest risk of HIV infection--homosexual and bisexual men, intravenous drug abusers, and the sex partners of high-risk or infected persons.

Because our work is in its early stages, we are not in a position to identify why the above problems exist or to recommend solutions. We plan additional work to more fully develop these issues. Before discussing these topics, I will summarize how CDC manages its AIDS education programs.

## BACKGROUND ON CDC AIDS EDUCATION ACTIVITIES

CDC's budget for AIDS activities has grown substantially in recent years and, for fiscal year 1988, represents about 40 percent of the agency's $772 million budget. CDC's AIDS activities include (1) AIDS education, (2) epidemiological research on how HIV is spread, and (3) surveillance programs to track its spread as well as AIDS education. Table 1 presents CDC's AIDS budgets for fiscal years 1984-88.

**Table 1: CDC's AIDS Budget for Fiscal Years 1984-88**

| Fiscal year | Education (millions) | Other Activities (millions) | Total (millions) |
|---|---|---|---|
| 1984 | $0.9 | $12.9 | $13.8 |
| 1985 | 16.7 | 16.6 | 33.3 |
| 1986 | 34.2 | 27.9 | 62.1 |
| 1987 | 104.7 | 31.3 | 136.0 |
| 1988 | 206.0 | 98.9 | 304.9 |

CDC has identified four principle target groups for education programs: (1) the general public; (2) school and college-aged youth; (3) health care workers; and (4) persons at increased risk of infection. Programs that target this last group have historically accounted for most of CDC's AIDS education budget. Table 2 shows how CDC allocated the AIDS education budget among these target groups for fiscal years 1985-88.

**Table 2: CDC AIDS Education Budget by Target Group for Fiscal Years 1985-88**

| Fiscal year | General public (millions) | School and college-aged youth (millions) | Health care workers (millions) | Persons at increased risk of infection (millions) |
|---|---|---|---|---|
| 1985 | $2.9 | $0.1 | $0.1 | $13.5 |
| 1986 | 3.7 | 0.1 | 0.1 | 30.3 |
| 1987 | 26.8 | 11.3 | 1.4 | 65.2 |
| 1988 | 42.8 | 29.9 | 1.7 | 131.6 |

Several organizations within CDC are involved in AIDS education: (1) the Office of the Deputy Director for AIDS manages programs that target the general public, including a national media campaign, and coordinates CDC's overall program; (2) the Center for Health Promotion and Education manages programs that target school and college-aged youth; (3) the Training and Laboratory Program Office and the Center for Prevention Services manage most programs that target health care workers; and (4) the Division of Sexually Transmitted Diseases, within the Center for Prevention Services, manages programs that target persons at increased risk of HIV infection. As previously mentioned, our work focused on this last group of programs, because most of CDC's AIDS education budget is spent on them.

To educate persons at increased risk of infection, CDC funds health education programs and counseling and testing programs. Health education programs address the general public and known risk groups through public information activities and various targeted education activities. The counseling and testing

programs are designed to reach persons at high risk of infection individually. In the context of these programs, counseling sessions are the critical educational steps in the process because they provide the counselors with the opportunity to provide on a one-on-one basis information on ways individuals can reduce their risk of contracting or spreading HIV infection.

CDC principally funds these programs through cooperative agreements with state and local public health departments, although CDC also provides limited funds to other organizations such as the U.S. Conference of Mayors and the National Hemophilia Foundation. CDC generally funds the programs annually, providing general guidelines on what activities the departments should carry out. The departments' applications describe the specific programs they propose to implement and propose a budget. Program staff from the Center for Prevention Services and other CDC groups review the strengths and weaknesses of the departments' proposed programs. Staff from the Center for Prevention Services then recommend the level of funding to be provided.

CDC assigned management of these cooperative agreements to the public health advisors located at its Atlanta, Georgia headquarters who oversee state and local health department sexually transmitted disease (STD) control projects. CDC selected these staff within the Center for Prevention Services

because they had experience working with state and local public health departments, and because HIV is transmitted through sexual contact. Historically, however, the STD control program has emphasized clinical treatment and epidemiological investigation of identified cases. Education, and efforts to modify sexual behavior have played a minor role in the STD control program.

## LIMITED PROGRAM MANAGEMENT

### STAFF AVAILABLE

The AIDS education program is a relatively new, and rapidly growing, activity for CDC. The key staff managing these programs--public health advisors within the Division of Sexually Transmitted Diseases of the Center for Prevention Services--are expected to monitor state and local health department progress and advise them on how to develop and operate AIDS education programs.

CDC has recognized that staff shortages hamper its ability to manage AIDS activities effectively. As of April 1988, CDC authorized the Center for Prevention Services to hire 26 additional persons, which represented the Center's conservative estimate of the staff needed for fiscal year 1988. To maintain this staffing level, however, the Center will need an increase in its fiscal year 1989 full-time-equivalent staff authorization. Center managers that we spoke to said that, in addition to the 26

persons already being hired, they needed about another 21 staff to manage their fiscal year 1988 AIDS activities.

A number of workload indicators support CDC's concerns about its current staffing. For example, in fiscal year 1987, 9 advisors monitored 58 health education projects, 58 counseling and testing projects, and 66 STD control projects, for an average of 20 projects each. By way of comparison, advisors responsible for immunization, tuberculosis, and diabetes control programs normally monitor about 12 projects each. This difference is particularly noteworthy since the immunization, tuberculosis, and diabetes control programs are well established. In contrast, the AIDS education program is new, growing rapidly, and presents new and unanticipated problems. According to CDC, there is also a growing recognition that the ability of states and local communities to effectively use federal AIDS funding requires more federal on-site technical assistance. During the 2 years ended March 1988, however, the advisors visited each health department an average of about 2 work days per year to monitor both STD control and AIDS education activities. The advisors generally expressed concern that they were unable to spend enough time at the health departments.

## INSUFFICIENT DATA TO SET HEALTH EDUCATION PRIORITIES AND EVALUATE RESULTS

Baseline data concerning a community's level of knowledge about AIDS, and the extent to which behaviors that spread HIV are practiced, are critical to managing state and local AIDS health education programs. CDC refers to such data as Knowledge, Attitude, and Behavior (KAB) data. Using KAB data, a health department can identify gaps in the community's knowledge of AIDS, and the extent to which behaviors that spread HIV are practiced in the community. Further, a health department can use this information to establish priorities for its AIDS education program, and to set objectives for increasing knowledge or reducing risky behavior. Follow-up KAB surveys, then, can provide a basis to measure program impact and evaluate results.

Beginning in April 1986, CDC provided funds to state and local health departments to gather KAB data relating to the general public and high-risk groups. By March 1987, CDC required the departments to use these KAB data to develop measurable program objectives. The departments were specifically asked to evaluate observed changes in knowledge and behavior patterns.

However, some state and local health departments have not gathered KAB data, and, therefore, are hampered in their ability to establish meaningful priorities and target program resources

effectively. In addition, many departments that have conducted surveys have not used the KAB data to set objectives for increasing knowledge or reducing risky behavior, and, therefore, are not able to measure program impact and evaluate results. Table 3 presents details on the progress the 55 health departments that received health education funds in April 1986 have made in gathering and using KAB data.

**Table 3: Progress by 55 Health Departments in Gathering and Using KAB Data, by Group, as of January 1988**

| | Number of health departments that have | |
|---|---|---|
| Group | Gathered KAB data | Used data to set objectives |
| General public | 40 | 15 |
| Gay and bisexual men | 22 | 13 |
| Intravenous drug abusers | 14 | 9 |

We plan to assess how state and local health departments, with limited KAB data, have established meaningful priorities and targeted program resources. Further, we plan to examine how well CDC has been able to promote widespread use of the best educational techniques and to measure the program's overall impact.

## MIXED PROGRESS IN IMPLEMENTING COUNSELING AND TESTING GUIDELINES

Counseling and testing is an important component of CDC's AIDS education strategy. Counselors assess an individual's risk

of infection and help individuals develop plans to reduce risk. CDC has issued guidelines for counseling and testing that address who should be tested and what facilities should offer testing. We visited the public health departments in Colorado, Massachusetts, New Hampshire, and Virginia and selected CDC-supported counseling and testing sites, and noted disparities in how they had implemented CDC guidelines.

CDC's guidelines recommend that individuals who practice high-risk behaviors--such as gay and bisexual men, intravenous drug abusers, and the sex partners of infected or high-risk individuals--should receive priority for counseling and testing services. Survey data indicate that in some locations the HIV infection rate for certain high-risk groups may be as high as 70 percent, compared to generally under 1 percent among low-risk groups. The proportion of individuals tested who acknowledged a recognized factor that made them high-risk for HIV infection in the states we visited varied, ranging from a high of about 72 percent in Massachusetts to a low of about 31 percent in Virginia. We plan to examine further the states' outreach efforts to attract more high-risk individuals to counseling and testing programs.

According to CDC's guidelines, all STD clinics and drug abuse clinics should offer counseling and testing, because these health care settings often treat high-risk individuals.

Colorado, New Hampshire, and Virginia now offer testing at all of their STD clinics, but Massachusetts, which reports a 12-percent HIV infection rate among STD clinic patients, offers testing at only about two-thirds of its clinics. Concerning drug abuse clinics, Virginia offers AIDS counseling and testing at about one-fourth of its methadone maintenance clinics, but the other states did not offer testing at methadone clinics. State data indicate HIV infection rates among those who acknowledge drug abuse as a risk factor that range from about 2 percent in New Hampshire to about 16 percent in Massachusetts. State officials we spoke to told us that lack of resources and clinic staff reluctance to become involved with AIDS had slowed implementation of testing at STD and drug abuse clinics. We plan to examine these and other factors that have slowed state progress, and to look at efforts to coordinate services targeted at intravenous drug abusers by CDC and the National Institute on Drug Abuse.

CDC's guidelines recommend that the sex and needle-sharing partners of infected individuals should be contacted and encouraged to take the HIV antibody test because partners are at high risk of infection. The guidelines also state that health department staff should assure that partners are notified even if the infected person is unable to contact those partners. Of the four states we visited, Colorado has the most aggressive partner notification program, and assigns health department staff to identify and contact partners. Virginia provides health

department staff to contact partners if an infected individual asks for help. In Massachusetts and New Hampshire, counselors discuss the importance of contacting partners, but health department staff do not assist infected persons in making these contacts. We plan to identify barriers that have prevented the states from providing assistance in partner notification.

According to CDC guidelines, counseling is critical to reducing the spread of HIV. Staff at some testing sites, however, told us that clients often do not keep appointments to learn their test results and receive additional posttest counseling. About 57 percent of clients tested at Virginia STD clinics, and about 70 percent at a Massachusetts clinic, did not keep follow-up appointments.

None of the states attempt to contact persons whose tests indicate that they are not infected with HIV. Virginia and Colorado attempt to contact infected persons who do not keep their follow-up appointments, but Massachusetts and New Hampshire do not. Thus, some infected persons may neither be advised that they are infected nor be counseled on the precautions needed to avoid spreading the virus. We believe CDC should consider how state and local health departments can assure that persons tested receive adequate counseling on how to reduce their risk of contracting or spreading HIV infection.

In conclusion, we believe that the federal government should take the lead in identifying and promoting those AIDS education and counseling approaches that have the greatest impact. Much remains to be learned about how to motivate long-term changes in the sexual and drug-using behaviors that spread HIV. During this learning process, some false starts and misdirected efforts must be expected as the unavoidable price of experimenting with promising approaches. CDC should continue to evaluate these approaches and to rethink and modify, if necessary, its requirements and guidelines to assure progress is being made in controlling the spread of HIV.

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This concludes my prepared statement; I will be happy to address any questions you may have.