# HIV/AIDS: EFFECTIVE EDUCATION IN JEWISH SETTINGS

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*This article describes an effective, cost-effective, and replicable model for HIV/AIDS education and prevention in Jewish settings. The AIDS Education and Training Program, which reached over 2,400 individuals in the 1991 program year, has resulted in increased awareness of HIV/AIDS in the community, particularly among teenagers, and has fostered the implementation of appropriate organizational policies on HIV/AIDS. Its research component has enabled the refining of curricular approaches to meet unmet needs.*

*"Thou shalt not stand idly by the blood of your neighbor."* (Leviticus 19:15)
*"A parent has three duties before his child—to teach him Torah, to teach him a trade and to teach him to swim."* (Kiddushin 30B)

Jewish tradition has applied these values broadly to require that we act to warn others of dangers and that we prepare our children to save their own lives. In the second decade of the HIV/AIDS epidemic, the organized Jewish community has begun to implement these values more systematically in the area of HIV/AIDS education and prevention. In addition to the efforts sponsored by Jewish organizations in larger urban areas, many mid-sized and smaller cities are also mounting AIDS education programs. The Council of Jewish Federations has also recognized the importance of these efforts by giving the 1992 William J. Shroder award to the New York UJA-Federation Coordinated AIDS Education and Training Program (AET). This article describes the AET model and summarizes some of its research findings in order to facilitate development of HIV/AIDS education programs in other Jewish communities.

HIV/AIDS education in the Jewish community has come none too soon in light of the continuing impact of HIV/AIDS on Jews and non-Jews alike. Conservative estimates suggest that nationally at least 4,000 Jews had full-blow AIDS by 1991, and at least 25,000 were HIV+ (National Jewish AIDS Project, 1991). In the New York metropolitan area alone, 7,300 core-connected Jewish households used HIV/AIDS services in a 1-year period from 1990-91 (NY Metropolitan Jewish Population Study, 1991). This figure falls within earlier projections of approximately 5,000 to 15,000 Jews infected with HIV in the New York metropolitan area.[1] In addition, data reported in studies from all parts of the country — from rural and suburban, as well as

Copies of all AET publications, including the Trainers Manual, are available free or for a nominal handling fee for rush orders from The AIDS Project, UJA-Federation, 130 E. 59th Street, Room 631, New York, NY 10022.

[1]These estimates are based on projections of 100,000 to 150,000 male homosexuals in the New York area with a seroprevalence rate of 50%, of whom 10% to 20% are Jewish. This does not include the numbers of Jews who were infected through heterosexual transmission, injection drug use, or transfusion, nor the numbers of Jews who have already died from AIDS.

urban areas — indicate alarming increases in HIV infection, particularly among teens (*MMWR*, 1992; *Newsweek*, 1992).

These demographic data point dramatically to the need for rapidly expanded services and equally dramatically to the urgent need for AIDS education aimed at preventing the spread of the epidemic. Unfortunately, in a period of fiscal limitation, the emphasis on services has often come at the exclusion of prevention. It is critical therefore to examine effective, cost-efficient, and replicable models for HIV/AIDS education and prevention.

AET was established in 1988 to provide broad HIV/AIDS education throughout the Jewish community in the eight counties served by UJA-Federation. These counties — including the five boroughs of New York City, Nassau, Suffolk, and Westchester — had 44,091 cases of diagnosed AIDS and an estimated 350,000 HIV-infected individuals as of August, 1992. AET originally operated under the joint sponsorship of UJA-Federation, Jewish Board of Family and Children's Services, Jewish Community Services of Long Island, and Westchester Jewish Community Services.

AET works to ensure that (1) members of the Jewish community do not put themselves at risk due to insufficient information and (2) that staff and communal leaders are prepared to respond to HIV/AIDS-related questions in an informed and sensitive manner. The program has four objectives in meeting these goals:

1. to increase factual knowledge about HIV/AIDS
2. to increase awareness of the vulnerability of all segments of the population
3. to increase the trainees' sense of personal responsibility in helping stop the spread of HIV/AIDS
4. to disseminate curricular and other materials specifically designed for HIV/AIDS education in the Jewish community

## PROGRAM STRUCTURE AND CONTENT

AET services are provided free of charge to any Jewish organization in the New York metropolitan area and include consultation in designing HIV/AIDS education efforts, as well as the actual implementation of programs. AET is staffed by a part-time professional AIDS educator and a program supervisor in each of the participating family service agencies. These agencies have long-standing relationships with the other Jewish organizations in their areas, facilitating local outreach. Each of the AIDS educators is able to provide a variety of training modules — from brief, single-session presentations to multisession, comprehensive staff training or client education — tailored to the needs of all host groups in their area. AET staff do not specialize in particular types of presentations or target groups.

AET supervisory staff oversee outreach and monitor program implementation and responses to issues of community concern. Throughout its years of operation, the sponsoring agencies have sent a number of general AET promotional letters, flyers, and brochures to Jewish organizations in each catchment area, followed by phone contacts and, as often as possible, face-to-face consultations with rabbis, religious school directors, program and/or teen staff in Jewish Community Centers, or other community leaders. This outreach effort allows these "gatekeepers" the opportunity to meet the AET staff, discuss any concerns or apprehensions, and design the most effective presentation module for each setting.

At the beginning of the program, the sponsoring agencies also developed a list of initial target sites for HIV/AIDS education sessions, based on the host organization's likely receptivity to an AET program and its potential influence on other host organizations. However, staff were always open to doing presentations that might not have been considered to be of the highest priority in order to establish AET's reputation for being able to respond quickly with a high-

quality program. Previously established contacts have proven to be the most effective channel to initiate and expand a Jewish HIV/AIDS education effort. AET staff have often been able to go on to more reluctant host sites based on the positive references from groups that had already participated. In 1991/92 alone, the program served over 2,400 individuals.

The AET curriculum was designed to accommodate the need for flexible presentation formats, with a basic core of information on the following four topics: (1) awareness of the extent of the epidemic; (2) transmission; (3) prevention; and (4) HIV antibody testing. There are also expanded presentation outlines for more in-depth sessions on these additional topics: more detailed information about testing; various aspects of risk reduction for groups that request such presentations, including abstinence and safer sexual practices, as well as avoiding the unsafe use of alcohol or drugs; human sexuality and decision making; and overcoming barriers to behavioral change.

Drawing on other training programs for the AIDS information and workshop exercises, the curriculum also includes traditional Jewish source material designed specifically to fit communal settings ranging from relatively secular organizations to religious schools. The topics covered in the Jewish material include the impact of AIDS on the Jewish community and values, such as *pikuah nefesh* — the sacredness of life; the distinction between the obligation to warn others of hazards and the proscription of *lashon harah* — slander or malicious gossip; the obligation to safeguard health; *bikkur holim* as a requirement to attend to the physical and emotional needs of the sick; and a discussion of various sources on the question of whether illness should be viewed as punishment.

Most sessions are one-time workshops of 90 minutes in length, although several agencies have received intensive training comprised of a series of as many as four 90-minute sessions. Typically, the one-time format is used with community groups and agency support staff, whereas the more intensive format is implemented with groups of professional staff or with teens in training to become AIDS prevention peer educators. The type of training, both session length and format and the topics to be covered, is agreed to through consultation between the AIDS educators and the particular program staff at the host agency. For example, sessions for older teens and young adults might focus more deeply on technical aspects of risk reduction, whereas sessions for community adults might cover more general AIDS information. AET staff, including the UJA-Federation AIDS Project Coordinator, are also available to provide referral information for HIV/AIDS testing and services for participants at any presentation, either at the end of sessions or on a consulting basis.

Early experience with the program demonstrated the need for a separate curriculum and training models for members of organizations' boards of directors and executive staffs who deal with legal, liability, health insurance, and program issues. It was decided that the UJA-Federation AIDS Project would undertake this effort centrally through publication of specialized materials, training programs, and consultation. Parallel to the AET curriculum for agency program and clinical staff and community groups, the board and executive staff training drew on general HIV/AIDS materials, particularly those focused on guidelines for complying with New York and federal law, and integrated them with traditional material of specific concern to the Jewish community. The executive and board training focused primarily on nondiscrimination, reasonable accommodation, confidentiality, and implementation of universal precaution procedures. In addition to extensive written material, the UJA-Federation AIDS Project sponsored two conferences on AIDS legal issues and a more intensive HIV/AIDS Training Institute that consisted of four half-day sessions for personnel and senior

program staff. Finally, both through referral to pro bono legal advice and through informal consultation with counsel, agencies were able to have their institutional policies reviewed and receive assistance in resolving legal questions. This effort has yielded a broad readiness throughout the Jewish community in the region to acknowledge the need for HIV/AIDS programs and to implement appropriate organizational policies.

The HIV/AIDS educators in each of the sponsoring agencies have experience in the family life education programs in their respective areas, have received training from one of the HIV/AIDS education training programs approved by the Red Cross or local department of health, and, in one case, has a Ph.D. in health psychology. They also participate in a variety of professional associations of HIV/AIDS educators and service organizations. In addition, the HIV/AIDS educators and supervisory staff from the participating agencies meet quarterly with the UJA-Federation AIDS Project Coordinator to discuss curriculum issues, common outreach problems and strategies, research findings, and the impact of changing information and media coverage of the epidemic. The consultants involved in research have attended workgroup sessions as needed to discuss modifications of the evaluation instrument and to report findings. Data collection was centralized and maintained by the UJA-Federation AIDS Project secretary. Thus, by co-sponsoring the project with beneficiary agencies, UJA-Federation has been able to provide shared technical resources and professional consultation among staff in separate geographic areas. This has ensured a coherent approach without duplication of resources and at the same time enriched the overall program quality.

## IN-DEPTH RESEARCH EVALUATION

In-depth research evaluation has been an integral component of the AET program from its inception. Although somewhat unusual, particularly in a period of financial austerity, the research has been very beneficial in demonstrating specific areas of unmet need, testing the effectiveness of curriculum design and implementation, and refining curricular approaches. A description of the methodology, the results, and the subsequent recommendations illustrates how AET's experience can be used in the design of future programs.

Each participant, whether staff or client, is asked to respond just before and immediately after each training session to a questionnaire that assesses knowledge, attitudes about vulnerability, and self-reported behaviors relating to responsibility in preventing the spread of HIV/AIDS (see Appendix A). Basic demographic information about trainees and descriptive information about the group have also been collected. Participant confidentiality has been strictly maintained by using the last four digits of either Social Security or telephone numbers rather than surnames to compare pre- and post-test data.

There have been three rounds of data collection, of which two have been analyzed — from the winter/spring of 1989/90 and from the same period in 1990/91. A computerized data base was developed to integrate individual responses and demographic data with information about the trainer, the training session, and the type of group trained. The number of individuals from whom data were collected was an adequate sample (433 in 1989/90 and 538 in 1990/91). In the second year, 60% of the individuals responded to both pre- and post-tests in comparison to 25% of the year before. The individuals trained in the second year tended to be younger, more were single, and more resided at home with their parents. This reflects a shift in training priorities to a focus or adolescents and young adults. This shift in priorities followed the increased public recognition that adolescents are increasingly at risk for HIV infection, which has resulted in a clear increase in the number of requests for presentations for these groups and for the professional

staff who work with them. Data analysis compared mean scores, percentage correct, and the amount of change from pre- to post-test. Analyses were also performed on subgroups of the total population to assess whether certain types of individuals responded differently, e.g. males, adolescents, staff, etc. It is noteworthy that the results from Year Two were substantially the same as those from Year One. However, this discussion focuses on the 1990/91 data since over twice as many individuals responded in that period to both a pre- and post-test, enabling more in-depth subgroup analysis.

The questionnaire was modified somewhat in the second year to reflect more accurately the actual material covered during training session. In particular, trainers found it necessary to modify the curriculum to address trainees' discomfort and lack of knowledge about human sexuality. In fact, HIV/AIDS education has often provided an opportunity for adolescents and young adults — and the professional staff who work with them — to raise questions about alcohol and drug use. HIV/AIDS thus provides a window into an entire arena of social problem solving in which the Jewish community needs to be more proactive.

One of the most interesting and consistent findings of the evaluation was that trainees, regardless of demographics, had significantly less detailed than general knowledge about HIV/AIDS, particularly in the more technical areas of HIV antibody testing and prevention. Some improvement in technical knowledge was apparent, but the percentage correct on those questions at post-test was still less than 80%. These results were particularly striking given that many of the trainees had previously attended HIV/AIDS education sessions from other providers, but did no better at pretest than those who did not attend prior sessions. Those who had received previous education may have forgotten what they had learned. However, AET trainers who have been in contact with other programs report that some HIV/AIDS education efforts may not focus on as much concrete technical information about testing and prevention as the AET curriculum does.

Another consistent finding was that most individuals had positive attitudes about people with HIV/AIDS and about the need for education before attending AET sessions, and they did not change their attitudes afterward. Of those who did change, more improved in attitude than worsened. Similarly, trainers rated each group's reaction before and just after training. Most groups were rated as either starting with a positive/receptive manner that was then maintained or starting with a negative/neutral reaction that became positive after the training.

There was a curious result on the attitudinal question that reflects concern about contracting HIV/AIDS from people at work or in public settings (question 9). Although most respondents did not change their attitudes and did not believe casual contact to be of concern, the number who worsened after training equalled or was greater than those who improved in attitude. This was true across demographic subgroups. In discussion with the trainers, it became obvious that this was the only question that asks for an affective response. For a small percentage of those trained, participation in sessions may increase their anxiety about HIV/AIDS by reducing their denial of the reality of the problem. However, this seems to have no impact on their overall attitude toward HIV/AIDS or their sense of being able to help stop the spread of infection. There is no evidence that sessions created pessimism or hostile attitudes toward those infected. This is an important finding, since some other HIV/AIDS education efforts in the workplace were reported to have a negative impact on trainees' attitudes ("AIDS Talks," 1991). AET demonstrated that the majority of individuals report feeling positive about their ability to reduce the spread of HIV/AIDS.

There were several interesting trends that, although not statistically significant,

are important for future program direction. First, although there were no significant differences across various subgroups — males, those previously educated, or adolescents — the most positive gain in technical, concrete knowledge was the "alone" group, i.e. primarily adult, not married, or in a significant relationship, residing alone. More outreach and subsequent evaluation need to be done for this population, which may be at the highest risk for infection. Second, staff did no better than nonstaff on HIV technical knowledge questions, but they had somewhat more positive attitudes. This result was anticipated, given the heightened sense of responsibility that staff have as advocates for healthier lifestyles. Third, another result of this study was the change in attitude and behaviors of the trainers about the evaluation process. Initially, the evaluation was perceived as an annoyance, as invasive to the training process. After the first round of data analysis and dissemination of the results, the evaluation became much more accepted as a mechanism for feedback and program growth, rather than as a means for testing trainers' performance. Trainers became interested in using the results to modify their focus and approach to subsequent training sessions and administered more pre- and post-tests in the second year of research.

The research provided the program with a greatly enhanced degree of coordination since it tested implementation and design of the shared curriculum. This feedback also ensured tremendous confidence in the effectiveness of the program on the part of the UJA-Federation AIDS Project Coordinator and, more significantly, on the part of allocations committee members. Thus, the research was of tremendous value both programmatically and administratively with very modest additional cost — approximately 7% of the total AET budget.

Although the AET program continues to gather data and analyze its training approaches and materials, some conclusions and recommendations are already evident. Training can have an impact on knowledge gained, although it is unclear from the study how long the information is retained by the participants. This evaluation only measured immediate recall and impact. Follow-up studies would be necessary to assess whether the information initially acquired is retained and for how long. It would also be of interest to ask trainees what they have done, directly or indirectly, since the training to reduce their own risk of exposure to HIV/AIDS or the risk of family, friends, or co-workers.

Beyond the in-depth statistical evaluation of the impact of this program, its true value may best be captured in anecdotes about its impact. Three incidents highlight the range of responses:

1. The youth director of one area synagogue somewhat reluctantly agreed to host an AET session, feeling that it was unlikely that adolescents in his group were sexually active or in need of any AIDS prevention information. During questions that followed the session, it became clear that several youths were not only sexually active, but were engaged in risk behaviors. This underscored both the denial that the program addresses and the benefits of this program for participants.
2. AET sessions at one affiliated Jewish Community Center were so effective in reaching the adolescent participants that, in cooperation with its teen staff, the Center went on to form a teen HIV/AIDS peer education program that has been widely utilized by high school groups in the area and has received attention in both the Jewish and general media.
3. A Long Island resident whose son died from AIDS participated in an early AET sessions at the New York Board of Rabbis, went on to participate in several subsequent AET sessions with community groups, and founded the first Jewish support group for parents of people with HIV/AIDS on Long Island.

UJA-Federation's long-term commitment to this program has demonstrated its leadership in discussing HIV/AIDS in the Jewish community. Many Jewish organizations in the New York metropolitan area have moved beyond the notion of "doing" AIDS with a one-time presentation to an understanding that HIV/AIDS awareness and education must be an ongoing part of their institutional life. Staff turnover, turnover in clients or students, and new issues about testing and treatment necessitate periodic updates and regular new cycles of AET presentations at most if not all of the original host sites. The increased visibility and track record of the program are also encouraging new agencies to request AET programs. Copies of the AET Trainers' Manual and other HIV/AIDS informational materials have been distributed widely not only in the Jewish and general communities in the New York metropolitan area but also to federations and Jewish family agencies in over 20 cities in North America and Israel.

## CONCLUSION

AET has resulted in increased awareness of HIV/AIDS in the community, has paved the way for staffs of agencies to respond appropriately to employees' and clients' concerns, and has fostered implementation of appropriate organizational policies. Most importantly, it has made it possible for many more Jews whose lives have been tragically affected by this illness to feel that they can turn to Jewish community institutions for information, understanding, and support.

Finally, the effort to initiate and continue this project demonstrates a determination not to sacrifice or lose faith in the ability to prevent HIV/AIDS. Although it will always remain difficult to demonstrate the effectiveness of prevention efforts in modifying behavior, to neglect the responsibility to warn of hazards is to abrogate central values in our tradition. It would also represent an unacceptably cynical experiment in allowing the spread of HIV/AIDS to go unchallenged by our best efforts.

## REFERENCES

"AIDS talks in study hurt more than help." *New York Times*, May 28, 1991.

*Morbidity and Mortality Weekly*, July 3, 1992.

*Newsweek*, August 8, 1992.

**APPENDIX A.**

**UJA-FEDERATION COORDINATED AIDS EDUCATION PROJECT**
**WORKSHOP EVALUATION FORM**

**PRE TEST[1]**

All answers will be confidential. Please do not put your name on this.

LAST 4 DIGITS OF YOUR SOCIAL SECURITY #: _____

SEX: Male _____ Female_____

AGE: _____

MARITAL STATUS (CHECK ONLY ONE): Single _____ Married _____
In a Relationship_____ Separated _____ Divorced _____ Widowed _____

CURRENTLY LIVING WITH (CHECK AS MANY AS APPLY): Alone _____
Spouse_____ Partner _____ Children _____ Parent(s)_____
Other Relative_____ Friend/Non-Relative_____

HAVE YOU BEEN TO ANY OTHER PRESENTATIONS ON AIDS? Yes____ No____
If yes, where/with whom?

**TO ANSWER QUESTIONS 1 THROUGH 7, MAKE AN X ON THE LINE TO THE RIGHT OF THE ANSWER YOU CHOOSE.**

1. The virus that causes AIDS has been found to be transmitted by mosquitoes.
   TRUE _____ FALSE _____ DON'T KNOW_____
2. Nonoxynol-9 an ingredient in some spermicides, kills the virus that causes AIDS.
   TRUE _____ FALSE _____ DON'T KNOW_____
3. Most people show symptoms of AIDS within 1 - 3 years of being infected with HIV.
   TRUE _____ FALSE _____ DON'T KNOW_____
4. Children can catch HIV/AIDS from another child or teacher through normal school activities.
   TRUE _____ FALSE _____ DON'T KNOW_____
5. HIV antibody testing is most reliable if done immediate after possible exposure.
   TRUE _____ FALSE _____ DON'T KNOW_____
6. People haven't been found to get AIDS by sharing eating utensils.
   TRUE _____ FALSE _____ DON'T KNOW_____
7. What you do, not who you are, puts you at risk for getting AIDS.
   TRUE _____ FALSE _____ DON'T KNOW_____

**ANSWER QUESTIONS 8 THROUGH 14 BY CIRCLING THE NUMBER CLOSEST TO THE DESCRIPTION OF HOW YOU FEEL.**

8. I can help stop the spread of HIV/AIDS.

| Agree Strongly | | Agree Somewhat | | Disagree Somewhat | | Disagree Strongly |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

9. Getting HIV/AIDS from people I work with or see in public settings is something I am.

| very worried about | | a little worried about | | not very worried about | | not at all worried about |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

10. I probably know at least one person who is at risk of getting HIV/AIDS.

| Agree Strongly | | Agree Somewhat | | Disagree Somewhat | | Disagree Strongly |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

11. I plan to use what I learn here to talk with my family and friends about HIV/AIDS.

| Won't at all | | Possibly will | | Probably will | | Certainly will |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

12. The organization sponsoring this session should have policies and procedures regarding HIV/AIDS, such as first aid precautions, confidentiality, non-discrimination.

| Agree Strongly | | Agree Somewhat | | Disagree Somewhat | | Disagree Strongly |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

13. I am glad that I am attending this workshop on AIDS.

| Agree Strongly | | Agree Somewhat | | Disagree Somewhat | | Disagree Strongly |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

[1]The initial questionnaire was developed by independent consultants, Epstein and Fass Associates.