United States General Accounting Office

Report to the Chairman, Committee on Governmental Affairs, U.S. Senate

AIDS EDUCATION

Staffing and Funding Problems Impair Progress

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-230539

July 28, 1989

The Honorable John Glenn
Chairman, Committee on
Governmental Affairs
United States Senate

Dear Mr. Chairman:

This letter responds in part to questions raised in your September 26, 1988, request concerning oversight of programs managed by the Centers for Disease Control (CDC) to prevent the spread of the human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS). As part of our ongoing review of HIV education and prevention efforts,[1] you asked us to obtain information on CDC's management of prevention funding to state and local health departments.

In 1989, CDC planned to provide about $144 million in funding support to state and local health departments to operate HIV prevention programs. The health departments target health education and risk reduction messages to persons at increased risk of infection, such as homosexual men, intravenous drug users, and minorities.

Without a vaccine or cure on the horizon, AIDS prevention programs are critical because they are the only public health tool available to reduce the potential medical and social costs of the HIV epidemic. While education programs have been expanding over the past few years, information about their implementation and effectiveness is still limited.

Background

The HIV epidemic is a national public health threat of potentially catastrophic proportions. Through April 1989, CDC reported over 94,000 cases of AIDS, of which over 54,000 persons were known to have died. The Public Health Service predicts that as many as 1.5 million Americans may already be infected with HIV, and epidemiological research suggests that more than 50 percent of those infected will develop AIDS.

[1] At your request, we addressed education efforts to reach high-risk persons through counseling and testing programs (AIDS Education: Issues Affecting Counseling and Testing Programs, GAO/HRD-89-39, Feb. 3, 1989). In this report, we examine staffing and funding of health education and risk reduction programs. Our ongoing work focuses on education aimed at school and college-aged youth and intravenous drug users. We also reported on CDC's general education program (AIDS Education: Activities Aimed at the General Public Implemented Slowly, GAO/HRD-89-21, Dec. 16, 1988).

CDC, the lead federal agency for AIDS prevention programs, assigned responsibility for reaching persons at increased risk of infection to its Center for Prevention Services (CPS). CPS funds these AIDS prevention programs principally through cooperative agreements with state and local health departments. Between 1985 and 1989, funding for programs targeted to persons at increased risk grew from $13.5 million to $184 million,[2] almost doubling annually.

State and local health departments are responsible for managing and operating the cooperative agreements, which fund a wide variety of prevention activities, including health education and risk reduction programs. These activities include

- HIV counseling and testing for clients at sexually transmitted disease and drug abuse clinics;
- telephone hotlines;
- media campaigns, such as radio and television public service announcements; and
- diverse efforts by community-based organizations, such as teaching women who are intravenous drug users how to clean needles, educating persons at soup kitchens, and sponsoring HIV awareness days for low-income blacks and Hispanics.

Objectives, Scope, and Methodology

In response to your request, we focused this review on

- CPS actual and targeted staffing levels for managing HIV cooperative agreements,
- oversight of federally funded HIV prevention activities, and
- problems in the funding cycles of AIDS prevention cooperative agreements.

We conducted our work at CDC headquarters in Atlanta, where we interviewed program officials responsible for managing AIDS activities. We also reviewed financial, staffing, monitoring, and other CDC records associated with these activities. Although we did not conduct detailed reviews of AIDS prevention programs in state and local health departments, we obtained the views of state officials by interviewing directors

[2]About $144 million is budgeted for state and local health departments, and the remainder includes funds for national organizations, such as the U.S. Conference of Mayors and the National Hemophilia Foundation.

of state health departments at a meeting of the Association of State and Territorial Health Officials.

Our work was performed primarily between September 1988 and January 1989 in accordance with generally accepted government auditing standards.

Difficulties in Meeting Staffing Targets

The HIV epidemic has resulted in the Center for Prevention Services taking on new and growing responsibilities. CPS's funding for cooperative agreements with state and local health departments for HIV prevention increased from about $25 million in 1986 to about $144 million in 1989.

Under the cooperative agreements for AIDS prevention, CPS is responsible for providing general guidance and technical assistance regarding activities the state and local health departments should carry out. CPS is also responsible for monitoring and evaluating health department activities to help ensure effective use of federal HIV prevention funds.

CPS officials believe that they need to hire additional staff to oversee this rapid expansion in federal funding and to recruit staff with different skills. CPS has traditionally been responsible for funding and coordinating state health department efforts to control sexually transmitted diseases, such as syphilis and gonorrhea. Because these diseases can be cured, programs have emphasized clinical treatment and investigation of cases, with education and efforts to modify sexual behavior playing a minor role.

AIDS, in contrast, is currently incurable and can be controlled only by preventing transmission. Moreover, HIV prevention programs have had to address new and relatively unproven educational approaches, such as how to motivate long-term changes in sexual and drug-using behaviors that spread HIV. As a result, CPS officials said that technical assistance to state health departments for HIV prevention programs would require hiring staff with specialized skills, such as expertise in behavioral sciences and in community health education methods.

CPS was first provided staff for HIV prevention programs in 1985 with an allocation of 13 full-time staff. By February 1988, 40 full-time staff[3] at CPS were allocated to work on HIV prevention programs. Even with this

[3]This does not include 35 field staff assigned to state and local health departments.

expansion, CPS concluded that it did not have enough staff to keep up with its growing responsibilities.

Staffing problems continued through 1988.[4] On four occasions in 1988, the Center for Prevention Services officially requested more staff. CDC was unable to fully meet these repeated requests, however, because of agencywide staffing constraints. For example, in October 1988, CPS requested 67 additional staff, but CDC approved only 24. CPS also encountered difficulties in filling even approved positions because of problems in hiring individuals with the requisite specialized skills. Not until September 1988, for example, had CPS hired staff with behavioral science or health education expertise to provide technical assistance for developing health education and risk reduction programs.

Agency officials reported that in 1989, staffing shortages continue to hamper CPS's ability to accomplish its AIDS oversight and technical assistance responsibilities effectively. In February 1989, CPS requested 65 additional positions, which were all approved by CDC. Because of insufficient funds to pay for these positions, however, CPS will be able to fill only 35 of the 65 positions.

As of May 31, 1989, CPS had 93 full-time staff working on HIV programs as well as approval and budget to hire 33 more by the end of fiscal year 1989. If all these positions are filled at that time, CPS officials believe they will still need about 30 more positions to carry out their AIDS responsibilities.

Staffing Shortages Have Hindered Key Monitoring Activities

CPS is responsible for providing general guidance to and monitoring of health departments to help ensure effective use of federal HIV prevention funds. This responsibility includes

- providing health departments with technical assistance in planning, operating, and evaluating targeted education activities;
- assisting health departments in evaluating the overall effectiveness of program operations; and
- developing and disseminating information on HIV prevention program activities and evaluation methods that are effective.

[4]We testified in June 1988 (Issues Concerning CDC's AIDS Education Programs, GAO/T-HRD-88-18, June 8, 1988) that staff shortages hampered CDC's ability to manage its AIDS activities effectively.

Several state officials told us that they were not receiving the technical assistance they needed from CPS to help them implement their AIDS prevention programs. They particularly needed help in designing programs that motivate individuals to change their sexual and drug-using behaviors.

State officials also reported a need for more federal technical assistance in developing Knowledge, Attitude, Beliefs and Behavior (KABB) baseline data. These data measure the community's knowledge about HIV and the extent to which behaviors that spread HIV are practiced. Health departments can use these data to identify gaps in knowledge, establish priorities for HIV education activities, and set objectives for increasing knowledge and reducing risky behavior. Follow-up KABB surveys can then provide a basis for CDC and the health departments to measure program effect.

Beginning in April 1986, CDC provided funds to 55 state and local health departments nationwide to conduct KABB surveys relating to the general public and high-risk groups. By March 1987, CDC required the health departments to use the survey data to develop measurable program objectives. The departments were specifically asked to evaluate observed changes in knowledge and behavior patterns.

In spite of CDC's requirements, as of September 1988, many health departments had not gathered and used baseline data to manage their HIV education programs. (See table 1.) In particular, CDC records indicated that several states and territories with large numbers of AIDS cases had not completed KABB surveys or used available KABB data to set program objectives.

Table 1: Progress of 55 Health Departments in Completing and Using KABB Data (Sept. 1988[a])

Group	Number of health departments that have	
	Completed KABB surveys	Used KABB data to set objectives
General public	45	30
Homosexual and bisexual men	33	13
Intravenous drug users	18	8

[a]Most recent data tabulated by CDC.

According to CDC and state health department officials, progress in collecting and using KABB data has been impaired in part by staffing problems. Some states tried at first to conduct KABB surveys in house but

later realized that they lacked the expertise to successfully complete the surveys. Staff diversions to other AIDS priorities, such as addressing state AIDS legislation, also contributed to delayed KABB data collection in some states. CPS hired two additional staff in October 1988 specifically to provide technical assistance to state and local health departments to help them develop program objectives linked to KABB data.

CPS officials reported that because of staff shortages, they have not been able to conduct other important program monitoring activities. For example, at the end of 1988, CDC had not evaluated state and local health department HIV prevention programs. This is an essential component of technical assistance, according to CDC program requirements. Staff shortages also precluded assistance in coordinating programs aimed at preventing HIV transmission among intravenous drug users.

Funding Cycles for HIV Prevention Programs

We reported in 1987 that the federal public health education response to the HIV epidemic appeared uncoordinated.[5] Experts we interviewed told us that the patchwork of federal and state funding and the lengthy and cumbersome grant application procedure had prevented quick response to the epidemic in many instances. For example, some public health officials were concerned that public health educators and other professionals were spending inordinate amounts of time responding to requests for proposals instead of providing HIV education.

Table 2 shows the funding cycles for HIV prevention programs. State and local health departments will have received HIV prevention funds on eight occasions in less than 3 years, or an average of every 4 months.

[5]AIDS Prevention: Views on the Administration's Budget Proposals (GAO/HRD-87-126BR, Aug. 12, 1987).

Table 2: Flow of AIDS Funds From CDC to State and Local Health Departments (Apr. 1986 to Jan. 1989)

Dollars in millions

Type of AIDS prevention funds	Date of award	Awards
Health education/risk reduction	Apr. 1986	$9.5
Health education/risk reduction	Aug./Sept. 1986	1.7
Counseling and testing	Aug. 1986	9.9
AIDS prevention[a]	Apr. 1987	24.4
AIDS prevention	Sept. 1987	26.6
AIDS prevention	Apr. 1988	86.3
AIDS prevention	Sept. 1988	8.9
AIDS prevention	Jan. 1989	129.7

[a]In fiscal year 1987, CDC consolidated the health education and risk reduction, and counseling and testing awards into one AIDS prevention award.

Both CDC and state officials told us that, while these funds were needed, the irregular flow of funds has made it difficult to plan and manage effective programs. For example, in 1987, health departments had developed annual program plans based on specific funding awarded in April. In September, they were awarded additional funding that had to be committed within the next 7 months. Also, the same staff are frequently responsible for both developing program applications and implementing programs, which are competing priorities. CPS staff are also diverted from their program implementation responsibilities to award new projects.

The reasons for this disruptive transfer of funds have largely been beyond CDC's control. In fiscal year 1988, for instance, the administration had CDC conduct a national seroprevalence study[6] and a nationwide mailing of an HIV information brochure. As a result, CDC reduced the prevention funds available to state and local health departments. Rather than reduce monthly expenditure levels to the health departments, however, CPS reduced the 1988 funding cycle from 12 to 8 months. Consequently, CPS awarded fiscal year 1989 funds in January 1989 rather than late April 1989.

In part, however, the irregular funding cycles also reflect CDC's response to rapidly changing knowledge about the HIV epidemic. CDC officials stated that disruption of the funding cycles was necessary to address important, unanticipated needs, such as activities targeted to minorities.

[6]A seroprevalence study measures the relative frequency or number of individuals in a given population or community whose blood tests positive for antibodies to an infection, in this case the number of Americans with HIV infection.

Future changes in the course of the epidemic may cause continuing discontinuities in funding cycles to meet new needs as quickly as possible.

Agency Comments

We discussed the contents of this report with responsible CDC program officials, who agreed with the information presented. The Director of CDC acknowledged that limited staff hampered the HIV program at the Center for Prevention Services, even though CDC allocated staff to the HIV program from other public health programs. He told us that additional staff could not be diverted to HIV from other core programs, including immunization and sexually transmitted disease control programs. The Director of CDC also emphasized that CPS staff have made significant positive contributions in the HIV prevention area, even though understaffing has resulted in very heavy workloads.

Unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services, the Director of CDC, and other interested parties and will provide copies to others on request. The major contributors to this report are listed in appendix I.

Sincerely yours,

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