Position Paper

Josh Edwards
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ELP 515: Bitting

THE SUBTEXT OF SEX ED:

[THE REAL MESSAGE OF AMERICAN SEX EDUCATION]

In 1987, western, developed nations launched the world's first massive anti-AIDS campaign – a massive effort, warning citizens to defend themselves against this new illness. Great Britain delivered a national bulletin to every home, titled, "Don't die of ignorance." Australia illustrated the dangers of "the AIDS virus" with a grim bowling match, including Australians of every age and race as the Grim Reaper's bowling pins. In the United States, a deathly image of an adolescent boy, covered in open sores, interrupted television broadcasts, ending with the words, "Don't die of AIDS. DON'T GET IT."

In a time where the American understanding of both HIV and AIDS was limited to the unexplained deaths of gay men across the country, we knew no better than to use scare tactics to warn the world of this illness' dangers and the helplessness of its victims. Until the late 1990s, an HIV-positive diagnosis carried an average life span of less than 10 years, and an almost certain agonizingly painful death.

Today, however, the story of living with HIV is much different. Individuals all over the world are living longer, healthy lives of 70 years or more (similar to that of uninfected individuals), thanks to the availability of medications that support the human immune system as it weakens. (Bhaskaran 2008) Even so, sex education in the United States has not caught up to these medical advances.

Until March of this year, the national policy on sex education mandated that American schools teach "abstinence only." Since the beginning of this policy, the US has seen as many as 10 million new sexually transmitted infections (STIs) among adolescents, ages 15 to 24, each year. (Guttmacher 2009) The most closely observed among these STIs has been HIV. Since 2002, the rate of HIV incidence (the rate of occurrence of *new* HIV infections) has remained predominantly steady across the broad

population. Persons living with HIV and AIDS are living to normal life expectancies, and the number of HIV infections progressing into AIDS has decreased tremendously. (CDC 2007) These statistics reveal that, as a nation, the US is doing well in the fight against HIV/AIDS here at home. But holistic statistics keep a horrifying secret. When these rather optimistic statistics are broken down into subgroups, such as race identity groups, age, or the source of viral transmission, the numbers tell a *very different story.*

HIV/AIDS infection rate statistics among North Carolina's adolescents and young adults.

Rate (per 100,000 people) of persons living with HIV				
	Adolescents (13 – 25) living with HIV	Children (<13) living with HIV	Adolescents (13 – 25) living with AIDS	Children (<13) living with AIDS
USA, National average	154.2	6.0	185.1	1.7
NC, Statewide	175	4.2	122.2	0.8
By the end of 2007, there were more than 22,000 persons *under the age of 25* living with HIV or AIDS in NC. Southern states have the highest regional rate of incidence of HIV and AIDS in the US.				
Charlotte–Gastonia–Concord MSA	221.7*	5.5*	210.6*	1.3*
Raleigh–Cary MSA	226.6*	5.5*	215.3*	1.3*
Austin, TX, Portland, OR, and San Jose, CA are MSAs with similar HIV/AIDS demographics.				

Average number of new HIV or AIDS diagnoses for 2007-2009			
County	Adolescents (13 – 25) diagnosed with HIV	Adolescents (13 – 25) diagnosed with AIDS	These data have not been adjusted for differences in regional population size. These data reflect the average of the raw number of new diagnoses in the area named. These should be considered within the context of the various regions they describe.
Wake	244.3	137	
Durham	124	54.3	
Johnston	33.7	24.3	
Guildford	169.3	69.3	
Mecklenburg	413.3	172.3	

All data is representative of information available from 2007 - 2009.
*Data calculated/extrapolated based on regional data reported by CDC
MSA Metropolitan statistical area

Data from CDC HIV/AIDS Surveillance Report (2007) and North Carolina HIV/STD Quarterly Surveillance Report (Feb. 2010)

A note about MSAs with similar HIV/AIDS demographics: Austin and Raleigh

It might also be interesting to note that **Austin, Texas** is considered a "model city" by the City of Raleigh Department of City Planning. This is because growth population and commercial growth patterns are very similar between these two cities. Also, demographics, political trends, local public administration priorities, and economic resources are very similar in both Austin and Raleigh. Industries and major economic players are similar, including research and development, internet technology development, pharmaceuticals, and medical technologies research. Both populations are highly physically active with a growing population of young adult singles, and rely heavily on highway systems for local commuting and transportation. Both regions are anchored by strong, nationally-recognized institutions of higher education and boast large local school systems achieving national recognition for excellence.

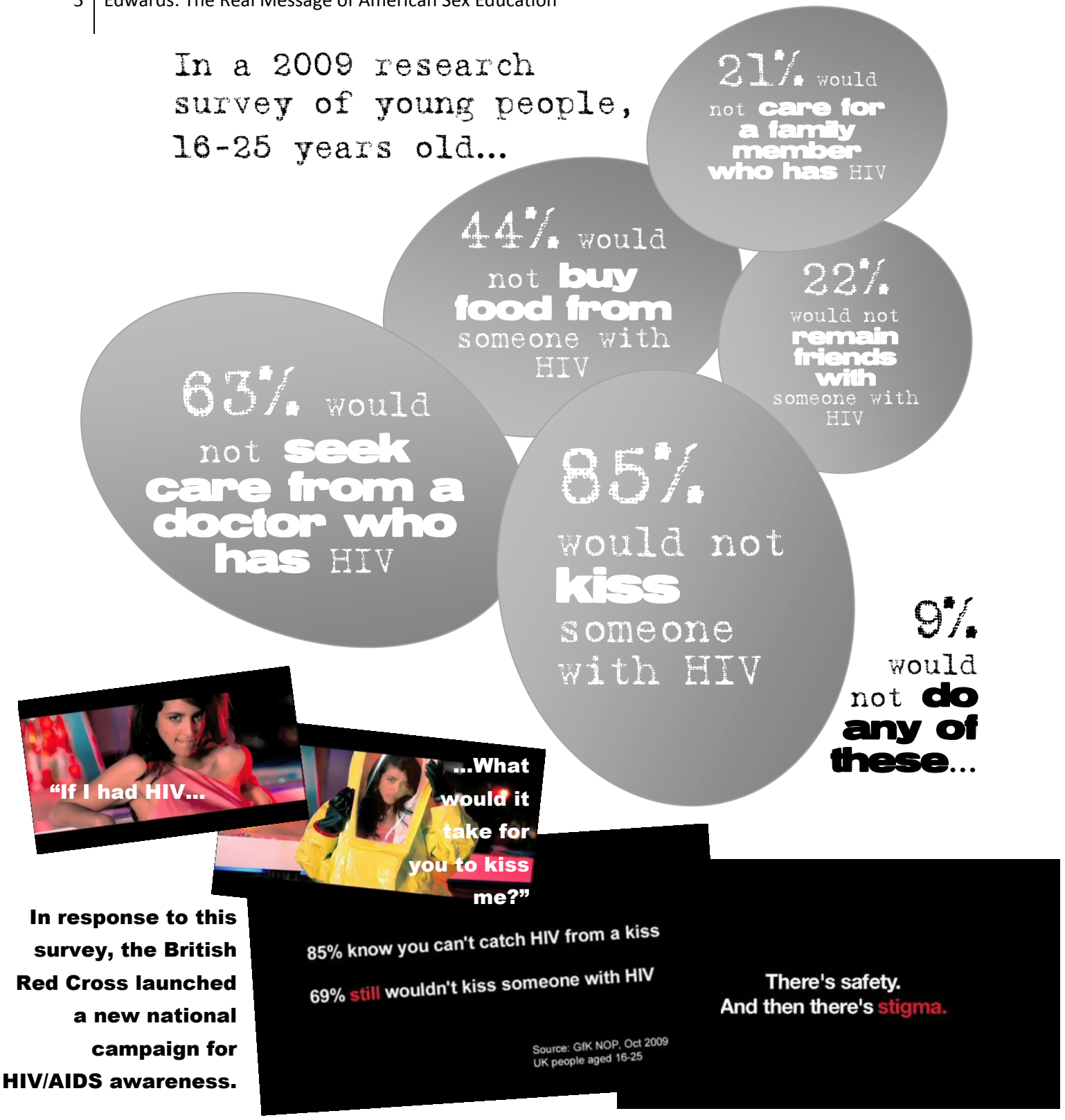
We have successfully provided the possibility of a healthy life for persons living with HIV/AIDS; we are preventing the expansion of HIV/AIDS' impact on the broader western society. We have failed in

stemming the tide of the AIDS epidemic among American *youth*. **The only subgroup wherein Americans find an increasing rate of HIV incidence is among adolescents, age 13 to 25.**

With new federal funding for evidence-based sex education and the development of comprehensive curricula (as of December 2009 and March 2010), education leaders will have to face difficult issues, including the astronomical rates of STIs among middle and high school-aged students and the increased incidence of HIV infection among adolescents. These infections are directly linked to a shift in adolescent sexual behaviors. Young people, ages 13 to 25, are becoming sexually active at younger ages. They are more consistently sexually active with multiple partners. They engage in more dangerous (risky) sexual behaviors, and are *less likely* to utilize safe practices, such as the use of condoms. **What are the underlying causes of these behaviors? What are the local, social roots of these statistics? What must our response be, in order to protect the next generation of Americans?**

> **"About a third of new diagnoses [of HIV or AIDS] are occurring among young people… We are losing the battle… in getting an AIDS-free generation."**
>
> **Kevin Fenton**
> Director, National Center for HIV/AIDS,
> Viral Hepatitis, and TB Prevention
> CDC

In October of 2009, a research study of 261 young people, ages 16 to 25, was conducted. Researchers approached young people in many casual environments, across 11 regions, and asked them a series of questions regarding their scientific understanding of HIV, their opinions about it, and their views of individuals living with HIV. Of those that were willing to respond, 85% correctly understood that HIV cannot be transmitted through kissing. However, 69% of respondents still stated that they would *not* kiss a person they knew to be HIV-positive.



In response to this survey, the British Red Cross launched a new national campaign for HIV/AIDS awareness.

(British Red Cross 2009)

The underlying goal of American sex education has been to prevent adolescents from engaging in sexual activity. This goal, based on traditional morality, has led us to tell our children just enough

about sex to *scare* them into abstinence. This morality has also prevented us from comfortably talking about sex, especially across generational lines. American social values discount the realities of human sexuality, especially that of our children. In response, adolescent curiosity has been forced underground; our children have no one to talk to about the emotional, social, or psychological impacts of sexual development. As long as we provide no resources and no support for young people to explore these questions, we are putting them at risk.

Culturally, American sex education has yielded a wealth of controversy, misconceptions, and irrational fears among adolescents. These irrational perceptions of STIs, most specifically of HIV and AIDS, have manifested themselves in a societal marginalization of individuals living with (or perceived to be living with) HIV or AIDS. As the 2009 Red Cross survey demonstrates, even the idea of coming into contact with a person who is HIV-positive is enough to scare the average young person away. **That should be good, *right*?** We should be glad that adolescents are terrified of HIV; even the *idea* of HIV should have them running away from sex. **No sex, no HIV. *Right?*** This has been the message of American sex education. Sex is bad, HIV is bad. Don't have sex; don't get HIV. **This message has *failed*.**

Fear of HIV does not prevent adolescents from having sex. Fear of HIV prevents adolescents from *talking* about sex. Today, adolescents are less likely to talk to their parents about sex than they have ever been in the past. They are also less likely to talk to other meaningful adults in their life, such as mentors, teachers, and coaches. Adolescents today are less likely to have meaningful conversations about sex with their friends, other peers, or their sexual partners. Young people are not talking about the risks of sexual activity, and how to protect themselves. **They are uninformed, unprepared, and unsupported. So, they are figuring it out for *themselves*.**

Adolescents have sex. They have sex with multiple partners. They have sex without using condoms. They *do not* talk to their parents about it.

In the midst of exploring their own sexuality, adolescents are torn between contradictory messages about sex. Culturally, American adolescents are bombarded with sexual media. American entertainment and popular culture are highly sexual. American consumerism, advertising, and marketing are also heavily attached to sex, and these messages are being increasingly targeted to capture the attention of young, impressionable adolescents. American young people have been socialized to believe that they are *expected* to have sex. There is mounting pressure on today's middle and high school students to be sexually active, and to use these sexual encounters to gain social capital. Morally, however, Americans hold conservative views of sexuality, promoting chastity and modesty. Even in a culture fueled by sex appeal, acting upon the sexual desires promoted by American popular culture is associated with promiscuity. To which of these messages are young people taught to ascribe?

In an effort to satisfy the adolescent craving for security, belonging, and comfort, young people are choosing to act on their sexual inclinations as a way of saving face among their peers. Yet, in order to balance these peer pressures with the moral impressions of their parents and mentors, young people are disguising their sexual behaviors by avoiding conversations about sex with the meaningful adult influences in their life. Instead, they are trusting the incredibly limited input they have received during sex education classes and the broadly flawed influence of their peers and the internet. Considering the frequency of misinformation in easy-to-access internet resources, and the increased likelihood of misconceptions being reinforced by abstinence-only sex education curricula, many young people have established inaccurate or incomplete understandings of STIs, contraception and protection, and the risks of sexual activities. The consequence is the broad holding of irrational fears and misconceptions about HIV and AIDS among American adolescents. Combined with the contradicting messages of traditional sexual morality and popular imagery in American media, young people are left with stigmatized attitudes regarding sex, sexuality, and the risks of sexual expression.

In striving to "fit in," adolescents use their sexual experiences as a source of identity and social belonging. They will also use sexual experiences against one another, seeking to define themselves and others according to acceptable norms. One of these norms is that HIV is the result of homosexuality and promiscuity; another is that using a condom is prudish. If a girl asks to use a condom, it *must* be because she has sex with *so* many guys that she has to be worried about having HIV. If a guy asks to use a condom, it *must* be because he's actually *gay*, and got HIV from having sex with another *guy*. Thus, adolescents are scared to talk about HIV… and condoms… and the risks of sexual choices. **If we are not willing to engage young people in meaningful conversations about sex, through which they can come to thoughtful conclusions about their own choices, risks, and options, *where will they turn*?**

The lack of meaningful learning about sex, sexuality, the risks and dangers therein, and the resources and support available, has led to a broad "othering" of those individuals who are struggling to live with HIV. (Campbell 2005) Along with this "othering," adolescents have developed a fear that they might be grouped into these isolated communities, and "othered," simply based on perceptions. So, adolescents do not talk about protection for fear that they will be outcast; adolescents do not talk about their HIV status, nor even seek out testing to find out what their status may be, for fear that they will be ostracized.

When adolescents do not have meaningful sources of support – parents or mentors – in finding safe alternatives to risky sexual behaviors, they are less likely to consider these risks in the midst of social relationships. When adolescents do not consider or talk about the risks of their sexual behaviors with their partners, they are less likely to use protection. Adolescents who do not use protection are more likely to contract HIV, and less likely to know they have it (Close 2008).

Stigma among adolescents is directly linked to their heightened risk for HIV infection. Stigma has become the key indicator in whether or not adolescents will protect themselves, and seek help

when they are in need. **Adolescents who hold stigmatized views of individuals living with HIV/AIDS are more likely to be infected.** Adolescents isolated by stigmatized views of individuals living with HIV/AIDS are less likely to follow life-prolonging treatments that support the immune system, such as medication regiments or the continued care of a physician. **Adolescents isolated by stigmatized views of individuals living with HIV/AIDS are more likely to die from AIDS-related illnesses.** *Stigma*, rather than *sex*, is the common denominator in the American adolescent AIDS epidemic.

> "**Stigma** remains the **single most important barrier** to public action. It is a main reason why too many people are **afraid** to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because **people fear the social disgrace of speaking about it**, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to **devastate** societies around the world."
>
> **Ban Ki-moon**
> Secretary-General
> United Nations

Stigma is not new. Stigma has stood as a barrier to the acceptance of diverse segments of the international community throughout history. Human societies have never easily adapted to the introduction of someone who is "different." Thus, it has become the nature of the human social response to *exclude* those that are not like us. This isolation of specific groups has been particularly

"A process by which individuals with devalued physical, behavioral, or medical attributes experience prejudice, discrimination, stereotyping, and exclusion."
(Dovidio et al, 2000)

what is stigma?

exacerbated by the human fear of mortality. When a "different" population is thought to pose a threat to the well-being of the majority, the instinct is to isolate and segregate that population, even violently, in the name of local security. The true threat, however, is the realization by both parties that the contagion – HIV, leprosy, mental illness, homosexuality, progressivism – may not even be legitimate. A socially manufactured or perceived threat may be just as much reason to outcast a minority. Stigma is almost completely based in *perception* rather than reality. (Mutalemwa 2008, Campbell 2005).

It has been thought since the late 1980s that these perceived views and assumptions of HIV may be the underlying force that has allowed the AIDS epidemic to progress, internationally as well as in our own community. These misperceptions have come to be known as *stigma*. The struggle among researchers since that time has been to define exactly what HIV/AIDS-related stigma is and is not, where its roots may be socially, the forms it may take (which will vary based on the local social, political, educational, and historical contexts), and the impacts that stigma will have on both the broad community and the individuals that have become victimized. By now, there is substantial evidence that demonstrates the connectedness of HIV/AIDS-related stigma and the progression of the AIDS epidemic among adolescents, worldwide. (UNAIDS 2009) What must be done in order to start building a genuine

pathway toward reducing stigma? What must we do to counteract stigma in the future, and reconcile the individuals who have been isolated by stigmatizing attitudes? We must analyze the roots of stigma within our own lives and context, work toward universal access to treatment, care, and support networks, and build meaningful relationship-based conversations with our children regarding sex, sexuality, the risks and how to safeguard against those risks, and where they can seek refuge and support in times of need. We must aggressively pursue a critical consciousness in American society that will lead and teach our young people to accept, support, and care for individuals living with HIV and AIDS. (Campbell 2005). **The roots of stigma can be easily identified. The hardest part of the battle that lies ahead will be facing our own selves and the attitudes each of us hold that have allowed the pain and isolation of stigma to exist. We must march forward into a time of awareness and acceptance, consciousness and care.**

"We are dealing with a disease that is entirely preventable. …This crisis does not have to be the reality. Everyone and every action counts… All of us have a role to play in ending this epidemic, whether in reducing risk behaviors, talking about HIV to our family and friends and those who we love, getting HIV tested, knowing our HIV status and encouraging others to know their status, mobilizing our political leaders, our community leaders, and our faith leaders around this epidemic, **tackling stigma and discrimination and the silence which continues to kill so many members of our community every day**. These are strategies that we can all employ and we must employ if we are going to get ahead of this curve.

Kevin Fenton
Director, National Center for HIV/AIDS,
Viral Hepatitis, and TB Prevention
CDC

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other resources

AVERT.org

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educAIDS.org

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