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Sexually Transmitted Disease Rates and Sexual Education Programs in the Georgia School System

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SEXUALLY TRANSMITTED DISEASE RATES AND SEXUAL EDUCATION PROGRAMS IN THE GEORGIA SCHOOL SYSTEM

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ABSRTACT

The prevention of sexually transmitted infections (STIs) continues to be a significant challenge to public health in the United States. While educational institutions, health professionals, and community outreach programs have helped the rates of transmission on local, national, and global scales, we are still seeing a rise in contraction and spreading of these infections. Half of these STI cases are from individuals ages 15 -24 years of age. For that reason, we must explore why this age group has the highest cases of STI rates (Centers for Disease Control and Prevention [CDC], Sexually Transmitted Disease Transmission 2015). The focus of this project is to explore the relationship between sex education programs in Georgia public schools and their contribution to rise in STIs in this state. Here I argue that the curriculum of these programs affect students in numerous ways through teaching concepts, curriculum choices, romanticized ideology of sex, scare and shame tactics, and inaccurate information. With the consideration of these factors and student testimony, the sex education programs' contribution to the high rates of STIs in Georgia are assessed.

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INTRODUCTION:

Within the United States, sex education in school systems has become more widely accepted since its first introduction in the 1960s. The utilization of this program in public schools throughout the country has been mainly centered on abstinence-based policies with morally-based curriculums. While numerous studies and institutional health agencies like that Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) have found that abstinence-based policies do not improve sexual health outcomes of the youth it is being taught to. It is clear that programs around the country need to reconsider the way information is being transmitted to their students.

With a specific focus on the state of Georgia, I conducted an analysis of its state procedures, curriculum, and student interpretation of the sex education program, which produced a much more complicated picture than anticipated. While the study was originally focused on the effectiveness of these programs to supply knowledge on STI prevention methods and education in the Georgia public school system, it soon became a much larger concern that not only that STI prevention education was not being taught in a manner that was effective for these students but rather a mixture of various ineffective teaching methods were promoting the opposite of safe sexual practice that is encouraged by public health officials. Sex education programs in Georgia were found to not only promote limiting information that left students unprepared for their future sexual experiences but also incorporated an overarching theme of shame and fear in having sexual experience and being sexually reproductive, reproductively healthy, or unhealthy. The

program was also discriminatory in the sense that all information related was based on heterosexual models, leaving students who felt that they did not fall within those guidelines uninformed about STI and HIV/AIDS transmissions. These are but a few of the themes found in these programs that I will be discussing. Considering that individuals ages 15-24 contribute to half of all cases of STIs, where Georgia ranks 5th in HIV, 2nd in primary and secondary syphilis, 6th in chlamydia, and 7th in gonorrheal infections, it was important to consider the ways in which this age group gathers the majority of their knowledge of STI preventions and other sex and sexually based information (Centers for Disease Control and Prevention [CDC], Georgia 2015 State Health Profile, 2015).

METHODS AND LIMITATION:

My research included the utilization of bibliographic sources (peer reviewed scholarly articles and studies as well as Georgia Public Health and Department of Health and Human Services archival recourses) to gain a better understanding of human sexuality, reproductive function, and STI biology, transmission, and infection. Secondly, the CDC archives allowed me to access reports on STI rates in the state of Georgia. In order to conduct this qualitative research, I received approval from the Institutional Review Board (IRB) of Georgia State University. I conducted structured and semi-structured interviews with individuals who had participated in the Georgia sexual education program either in middle or high school levels or both within different counties both rural and urban. Other criteria included having known an individual or they themselves have/had an STI, or have been sexually active, but was not limited to. Individuals were recruited from Georgia State University through handouts and asked to be 18 to 25 years of age. I conducted interviews with 6 individuals between the ages of 20-25, with a mean age of 21. For data analysis, I used NVivo software in order to find trending words and

phrases in source data that correlated with that of the interview. In order to compare similar trends in words in phrases, interviews were audio recorded and went through the process of coding in order to pinpoint specific reoccurring trends.

I encountered several limitations within this study. While the total number of individuals (6) interviewed leaves room for generalization of data, the repetition of trends found in the data could represent the majority. There was also the consideration that this study is mainly based on sources that looked at the United States as whole or by region (I.e: Southern United States (including Georgia)) rather than a singular state. No sources could be collected on Georgia's sex education program other than public health and education records that further explained the required curriculum for the program. Another issue encountered was based on the memory of those who I had interviewed. Many of the questions regarded the student's encounters with the sex education program and what was taught. Recollection of the information aimed at these students had been proven to be difficult to remember due to the amount of time they had last taken the course (4-7 years later) which may or may not have contributed to skewed data or missing data for questions that could not be answered. Lastly, due to state legislation, sex education programs are set by individual county school systems. Due to this, not every county in Georgia was included in this research or was noted through interview question.

LITERATURE REVIEW:

In order to become fully knowledgeable about the topic of sex education in the United States and to understand the impact that language can have on the perception of sex and sexuality, an analysis of several academic sources were conducted in order to become informed on the data concerning this thesis. Drawing on Deborah Cameron's and Don Kulick's (2003) *Language and Sexuality* helped me to clarify why the specific language was being used and the

impact it had on these students. Cameron and Kulick's chapter on the linguistic and discursive construction of sexuality highlighted the interconnection of sex, gender, subjectivity, and agency. Agency, for the purpose of this thesis, was an important factor into understanding why the individual aims to both function independently of the sex education program yet is also being affected by it, thus affecting individual agency. The heteronormativity of society within the United States was also highlighted by Cameron and Kulick, playing an important role in explaining the constraining nature that heterosexual normative models can have on LGBTQIA+ community. While this source drew on a number of examples outside of the nature of the sex education program, it proved to be relevant to understand why and how language about sex and sexuality is ever changing and contingent on a number of factors.

In order to further assess the effectiveness of the sex education program in Georgia, the belief that understanding the system as a whole on the national level was also important. By doing so, a reaffirmation that abstinence-based programs (the most prominent program used in the United States (Weaver et al. 2005, 176) had neglected important information and affected student health was concluded. Through a cross-cultural comparative lens into interpreting the sex education ideology, Heather Weaver, Gary Smith, and Susan Kippax compared and contrasted the Netherlands, France, Australia, and the United States, in order to investigate the relationships between school-based sex education programs and sexual health related statistics of young people in the four respective countries (Weaver et al. 2005, 171). Findings concluded that there was a correlation in sex education policies affecting birth, pregnancy, and abortion rates, age at first intercourse, contraception, and condom use, STI, and HIV infection rates among 15-19-year-olds. While the study's main focus was sex education, they also took into account other factors that may have affected the sexual health percentages such as socio-economic

disadvantages, limited access to health care, and limited access to social services (Weaver et al. 2005, 183).

Lastly, in order to fully understand the construction of stigma and its effects, I found it important to consider stigma theory and moral experience. For the reason that the sex education is based on an exclusive morally ambiguous set of ideologies, it is my assumption that stigma and morality are relevant and necessary to recognize as factors that formulate the sex education program. Drawing from Lawrence Hsin Yang and his colleagues (Arthur Kleinman, Bruce G. Link, Jo C. Phelanc, Sing Leed, Byron Goode) who studied those who stigmatize and those who are stigmatized, I understood how stigmatization could affect people as well as its relation to morality. Lawrence et al. provide several different definitions of stigma as well as the components that make up stigma. For example, they say that stigma is marked by making individuals seem different while devaluating them and that stigma depends on relationship and context, both of which can be socially and culturally constructed (Lawrence et al. 2007: 1525). Here it was essential to identify the many components that then made up the sex education program (those that stigmatizes) and its relationship to its students (those who are stigmatized) and then to assess how this stigma devaluated or morally affected students.

RESULTS:

I asked a total of 27 questions in order to gather information of overall thoughts on and experiences with the sex education course, what was learned, how they conceptualized the information, and more specific questions regarding STI education including their own encounters with STIs. With this information, I have been able to draw several conclusions that revealed trends in language use, curriculum, student opinions, and themes used by the sex education systems that these 6 students had encountered. It must be noted that all students interviewed took

part in the sex education course in the state of Georgia and the analysis of their interviews are based on the program in Georgia public schools and no other state. The analysis is based on student opinion and conceptualization of the program and is meant to serve as a beginning point to understanding the state of Georgia's high rates of STIs, teen pregnancy, and HIV/AIDs.

The following information is focused on several themes that all or more than half of the participants had mentioned separately in their interviews. These reoccurring trends in data reveal not only the overlapping uses in language and suggestive curriculum, but also explains how the sex education program in Georgia fails to educate its students on safe sex practices, STI education and prevention, empowerment of students as sexual beings, and lacks to take into account information that is seen as valuable to these students. By doing so, it is possible that Georgia's sex education curriculum harms its students more than it does well.

Federal, State, and Body Politics:

At this time there are no federal laws that require sex education in schools including set curriculum standards for what is taught and how, this is left up to the individual states (Weaver et al. 2005, 176). Georgia's state policy on sex education programs require sexuality, STI, and HIV prevention education, but mandates education boards of each county to teach the minimum guidelines that the state requires (Chosewood 2014: 1). These instructions include to "emphasize abstinence from sexual activity until marriage as important personal goals", to include discussion of peer pressure and promote high self-esteem, community values, and abstinence as an effective method of pregnancy, STI, and AIDS prevention (Chosewood 2014: 1). Not only are these guidelines broadly defined but they leave room for individual school systems to interpret these standards in a manner to their liking, resulting in inconsistent teaching methods throughout the state (Gates et al. 2015: 192). One has to question how they are teaching discussions of peer

pressure and how it is that they are promoting high self-esteem (what are the contexts that this is being taught in?).

An "Opt out" policy is also included as a requirement of sex education in Georgia, where parents/guardians must be informed that their child will be taught sex education and have the option to remove their child from being taught sex education if the parent/guardian chooses to do so. Although the federal government does not require sex education to be taught, as an incentive for states who do teach abstinence-only programs, federal funding is offered. In order to receive this funding state programs must abide by provisions that encourage teaching that abstaining from sex is the only form of birth control and that any sexual activity before or outside of marriage is likely to lead to adverse psychological and physical effects (Starkman et al. 2002, 314,316). Georgia is one of many states who has profited off of federal funding for their sex education programs. Allocation of this money to school or local programs is difficult to track. Federal contributions to the abstinence-based sex education programs in Georgia may contribute to the difficulty in changing the proposed curriculum as well as the more conservative nature of the state.

Scare Tactic: a Message of Shame and Stigma:

A common theme established in the sex education courses in Georgia was found to involve the message that sexual activity was something to be feared and would likely lead to negative health outcomes. The sex education program achieved in several ways via educating about abstinence, birth control options, and acquiring STI's.

In relation to abstinence, all individuals interviewed stated that this was either the only option given to them or the most stressed option with extremely limited information about birth

control. This limited information on birth control was mentioned in two different settings. (1) Abstinence was either the only form of birth control and no other information was given or (2) Abstinence was the only and best option to avoid negative health effects of sexual activity but that there were other forms of birth control but none were 100% effective like that of abstinence. In the following quote, Eric recalls the importance that percentages had in a conversation regarding abstinence and how they were used to enforce the dangers of engaging the sexual behavior while utilizing other methods of birth control.

"It [the sex education program] covered like success rates or I guess like sex "ratings" or effectiveness…abstinence 100%, so that was literally their first line and then they compared it to the dangers of using anything other than abstinence. So condoms 99%, you got one percent down right there. So yeah, uummm just kind of always revolving around the abstinence program."

- *Eric (Man, 23)*

The stress of the dangers of using any other form of contraception other than abstinence was a common theme. Forms of birth control other than abstinence were compared with rhetoric that signified "dangers" or "not as effective". The comparison between abstinence and other forms of birth control in relation to a percentage of effectiveness was also a common theme used to discourage students from engaging in sexual behavior. This contributed to negative or fearful views of birth control methods and also limited the student's ability to know how these birth control medications and barrier methods functioned, worked with the body, and their role in reproduction. Also, the knowledge that oral or inter-uterine contraception methods were not only used as a literal birth control but could also help women with menstrual cycle regulation, dysmenorrhea, polycystic ovarian syndrome, and other conditions was omitted from the curriculum. This is the same for other birth control methods that were just "grazed over" briefly and were never talked about in depth. For example, conversations about condoms followed two paths: (1) were mentioned as a form of birth control yet were never properly demonstrated or

function was never fully explained or (2) were never mentioned. This left many students with uneducated, misinterpreted assumptions, and limited knowledge about the vast amount of options students had to protect themselves against STI as well as to avoid unwanted pregnancy. One student expressed that because of the lack of information regarding contraception she feared to really look into oral birth control methods expressing it as a "fear of the unknown" and that she did not fully learn to appropriately use a condom until she was in college, years after she had already been sexually active.

Likewise, education on STI contraction and transmission was limited. While students understood that STIs were sexually transmitted they could name none or only a few of these infections, knew very basic information, such as "wear a condom" to protect themselves and were not aware of the different treatments offered or which STIs were treatable and those that were not. The very limited knowledge of STIs for these students and many like them may very well be linked to that of that sex education program. All interviews stated that STIs were talked about briefly but only to the extent that they existed and were acquired by sexual behavior.

The utilization of images was most commonly mentioned during the conversation on STI during sex education programs. Those who were interviewed all recalled viewing images of inflamed and extreme cases of the STIs during the sex education course. Many of the students felt that these pictures were used as a fear tactic to encourage abstaining from sex. The pictures were accompanied by language that was used as a warning that discouraged having sex. Maria, a woman apart of the interview process, recalled her perception of what the rhetoric around these pictures from instructors would be like.

"It was like they would show these pictures of people with STDs and tell you that this is what you WILL get if you have sex ever"

- *Maria (Woman, 24)*

For Maria, the phrase “you WILL get” left no room for options to protect herself with other than abstinence. The act of misleading Maria's perception of sexual intercourse and its relation to STIs led her, and possibly many others, to believe for some time that even with protection the chances of STI contraction was much higher than what public health suggests. The images also served as warnings for those who chose to engage in sexual behavior before or outside of marriage and lacked information on biological and medical explanation regarding STIs impacts on their bodies. Instead, a brief warning was given that excluded information about the biological aspects and facts surrounding commonality, treatments, transmission, and contraction of STIs. This led students to only associate these infections with sexual activity, promiscuous behavior and led to the belief that individuals with STIs should be ashamed.

How might this contribute to the current high rates of STIs in Georgia? This type of rhetoric and imagery surrounding STIs led students to be fearful and chastise STIs creating stigma around the epidemic, including self and perceived stigma. Many studies have been shown to suggest that perceived and self-stigma may strengthen delays in seeking STI-related screenings and care as well as the unwillingness to be tested (Cunningham et al. 2009, 225) (Lichtenstien 2003, 2435-2436). Encouraging this stigma, as the sex education program does, portrays STIs not as common and preventable medical conditions but as rare and unknown. This type of discourse contributes to the shame factor that often follows people’s inability to speak freely about their sexual experiences and most importantly, their sexual health. Likewise, adolescents who are taught STIs through a stigmatizing lens were actually less likely to go through regular screenings (Cunningham et al. 2009, 228). It also causes emotional distress, embarrassment, social isolation, and denial of diagnoses (Litchenstien 2003, 2435). A learning

environment based on this sexual shame ultimately reduces sexual responsibility (Weaver et al.2005,184). What results is a group of ill-informed youth that results in unprotected or risky sexual behavior that contributes further to the STI epidemic, uninformed youth leads to uninformed adults (Weaver et al. 2005, 184).

Exclusion of Homosexuality/ LGBTQIA+:

Many of the interviews mentioned the concern of the discriminatory nature of the sex education program by considering sex, gender, sexuality, as all based on heterosexual models, thus limiting the information needed by a special population who were left in the dark. Heterosexuality is institutionalized in the culture of the Georgia school programs and can be constraining for students who do not fall in that spectrum (Cameron et al. 2003, 72). One concern raised was the concept of sexual intercourse talked about in the sex education program. Jordan, an openly bisexual and asexual woman, was one of 4 of my interviews who brought up the concern she had for her and her fellow students who did not fall within the purely heterosexual standards of sex education. She expressed many times that there was a lack of consideration for LGBTQIA+ youth within the program [Lesbian, Gay, Transgender, Queer, Intersex, Asexual, Plus (all others not included in the acronym)]. Like many, she expressed that the lack of information regarding the type of sex LGBTQIA+ youth were having was excluded from the conversation.

"…It was very much geared towards heterosexual sex, there is no mention of any type of homosexual anything. We pretty much didn't mention oral sex or anal sex."

- *Jordan (Woman , 21)*

Advocating sexual abstinence based on the western model of heterosexual marriage is troubling for several reasons. On reason is that in this model not only is sex assumed to be considered vaginal intercourse and 'penetrative' but that it also involves a biological female and

male. Based on this information, students who have identified as a part of the LGBTQIA+ community are left even more vulnerable than their counterparts. Why is that? If sexual intercourse is defined by not only occurring in marriage but also between one man and one woman, then STIs and HIV/AIDS contraction and transmission is thus assumed to be only contracted through vaginal sex by definition of this program.

The focus on vaginal sex exclusively and to ignore other sexual activity such as oral sex and anal sex leads students to turn to define other sexual activities as "non-sex" activities, that while may not be vaginal sex (as it pertains defined by the sex education program) contribute to risk of STIs (Remez 2002,298). Youth caught between these messages about AIDS and abstinence combat with their natural reaction to being reproductive individuals. Therefore oral sex and anal sex are seen as good alternatives because under sex education definitions, these activities do not qualify as sex. What these students do not know because the program refuses to go into these details, and because of strict moral guidelines, is that STIs have been known to be transmitted via anal sex and oral sex (both fellatio and cunnilingus) (Remez 2002, 299).

Specifically concerning oral sex, STIs that can be transmitted include human papillomavirus, herpes simplex virus, hepatitis B, gonorrhea, syphilis, and chlamydia, while HIV is extremely rare to happen under these circumstances (Remez 2002, 299)(CDC, HIV Transmission, 2017). Interesting enough, there has been an increase in oral cases of STIs. Since the sex education program in Georgia advises against in-depth conversations about contraception methods and will not explicitly name oral sex, protection against oral strains of STIs through dental dams are virtually unknown to these students and later as they become adults, will still

have no idea. The following conversation is with Jordan (age 21), who prior to her interview with me was not aware that there was a specific barrier method used for oral sex.

Jordan: "…and then do you need to use condoms for oral sex? I'm assuming so, but even then that's weird."
Valerie Masutier (interviewer): "Do you know where to get dental dams?"
Jordan: "What is that?"
VM: "It's a barrier methods for oral sex"
Jordan: "Is it just a sheet of plastic? Is it a condom for your tongue? I had no idea that ever existed!"

Anal sex is also another sexual act completely ignored by the sex education program and is in fact considered the more risky sex for transmitting HIV according to the CDC (CDC, HIV Transmission, 2017). This leaves especially students who are males who have sex with males (MSM) or classify themselves as gay (but not limited to) ever more vulnerable to HIV/AIDS. While HIV/AIDs education is required in the Georgia sex education program what information is given regarding it is variable. The extent that this information is diving into during these courses in questionable considering that those at most risk for HIV/AIDS is the gay community. Yet the heterosexual model does not account for those who do not or cannot stick to the strict guidelines of vaginal sex that the program enforces.

Romance in Sex Education:

With the common theme of fear and shame tactics, the sex education program in Georgia public schools also contributes to a romanticized discourse surrounding sex. For many of those interviewed, the sex education program contributed to impacting their future selves and what they would later want out of relationships. Shared characteristics consisted of perceived notions surrounding sex such as that vaginal sex was something done with someone you had known for a prolonged period of time and was an act meant for marriage. Many of those who were

interviewed also shared their opinions that the sex education system and forced abstinence till marriage rhetoric was an unrealistic standard, a standard that was impossible to achieve based on how their own daily lives may have affected the way they perceived sex. Factors influencing this romanticized version of sexual activity with a single partner beginning at the point of marriage included socio-economic factors, culture, and social relationships. The sex education program never included any of those environmental factors as aspects that could contribute to the impediment or desired representation of a student's own sexual preference and desires. Rather, all of those interviewed said that often sex education courses were taught with an overarching theme of involving ambiguous scenarios that represented "decision making" skills and how their choices would affect their lives for the long term. One student (Sherry) gave the following example of such a scenario(s):

"I remember like, doing this project were they wanted to see, like, to show teen pregnancy. It was kind of like, plan your life out to were you're not [taking] risks type of class portion. So we did this time line about what you should be doing at every age of your life. At 15 -16 you're like in high school, then you go to college. They also tied it into drinking, so if you get into a car accident you die like at 16, then you miss out on all these things or if you get a teen pregnancy, you miss out on a lot of things as well."

"…[in regards to instructional videos used for decision making] It was unrealistic, it portrayed like high school kids literally partying every day, having orgies, and like passing out. That was literally the movie. It doesn't apply to everybody and in a way the main character did get pressured, but just the whole way it was spread out, it was unrealistic. Like, who has a party every day, and has sex every day at that age?"

- *Sherry (Woman, 21)*

Similar to the unrealistic nature of the abstinence program that many of these students felt had served them unrealistic standards of sex, relationships, and sexual experiences, the accompanied instructional videos, and assignments that involved planning their lives in accordance to what the school/state wanted equally gave then unrealistic standards to live by in accordance to what others willed of them. Sherry expressed that she thought these videos and

presentations were not only a waste of time but did not account for that she and others were "not the type[s] to [engage in such behavior]". Without the consideration of cultural background or a student's unique environmental experiences, the sexual education program further discriminates its students assuming they all follow normative religious and "moral" or "immoral" ideologies. The sex education intervenes on such environmental and cultural factors based on those standards. Unfortunately, this complicates education from a racial and cultural standpoint.

While the issue of cultural differences in language and sexuality may not be a problem faced by only the state of Georgia, it is an issue that should be discussed. Compared to our European counterparts, the idea that sexuality and sex is a choice rather than a forced ideology, student are most likely to view sex in their own terms based on their environment rather than based on one ideological viewpoint, such as a strict emphasis on abstinence education. What the sex education in Georgia lacks is cultural competency and the ability to focus on students who are more at risk for STIs, HIV/AIDS, and teen pregnancy. Preaching abstinence education and strict but vague religious moral guidelines such as waiting for marriage to initiate sexual behavior leave those who either are aware of these standards or daily lives leave this standard nearly impossible to follow, to ignore the curriculum and think the course is a waste of time. Essentially what happens, in this case, is that students who believe that the sex education program does not pertain to their lifestyle simply ignore the information given to them. Yet, this information is still pertinent married or not married. Sex education needs to be more inclusive.

What the Youth Want:

The Georgia sex education courses and their policies often have several purposes. Most notably sex education has often aimed to prevent teens currently and in their later years from engaging in "risky" sexual behavior in the hopes to decrease the amount of STIs, teen/unwanted

pregnancy, and HIV/AIDs of which are currently on a rise. Another purpose of sex education program is to inform youth about the basics of reproduction such as anatomical parts of the male and female reproductive system, including instilling an awareness of STIs and basic prevention methods. Yet for many students who engage in the sex education course, the basic information meant to work as preventative measures both become crowded in conflicting rhetoric and never really fulfill their questions about sex, identity, and their bodies.

Through the course of the interviews, students voiced what they would ultimately have wished to have encountered in the sex education program and how the lack of certain information impacted them as sexual beings. Two questions truly highlighted the responses that opened the underlying desire to see a change in the curriculum. (1) Was there any information that was not relayed that you thought may be more useful or insightful to you? and (2) Was there any information you thought was irrelevant? Responses to both these questions all accompanied the same answers and are elements missing from the sex education courses that in Georgia have either claimed to cover or lack of covering in depth to benefit these students. Advocates for abstinence-based sex education often voice that comprehensive version would promote sexual activity and curiosity in sexual behavior including prompting inappropriate questions for a teen's age, although what is considered "inappropriate" is relative to the family and culture. Yet, through this data students at the time of taking the sex education course desired to learn quite the opposite. Rather, questions ranging from biology to gender and sexuality shows that students desire to take the initiative in wanting to know how to prevent negatives reproductive health outcomes, promote sex-positive dialogue, as well as change the discourse surrounding sexual shame.

The biology of sex and a student's body was voiced as concern for those interviewed. While sex education programs often include basic anatomy of the reproductive organs, this information was considered not good enough. The desire to learn more about the biological functions of their own reproduction processes included how babies were made and how the functions of a healthy vagina or penis should look and act like. They also desired to learn more about other reproductive problems, disease, and illnesses that could occur other than STIs.

Those who classified themselves as women were curious about learning about the pap smear as well as what took place during a routine gynecological visit. Even more interesting was the collective response concerning rape culture in relation to the sex education course. Many of the women expressed the desire to teach a new set of ideology regarding rape including a focus on consent.

"They teach how to not get raped, but not to not rape"

- *Jordan (Woman, 21)*

"I remember some guys asking if it was still okay to keep touching a girl if she says no as long as it's over the clothes"

- *Maria (Woman, 21)*

Following Maria's recollection of (the above quote) what the boys had said in her sex education course, I asked if the boys had been given an answer to their questions. To which she has told me that, no, there was no response but rather laughing from male students in the class. Comments such as these (and lack of educating) show that women are singled out in the sex education system. While it may not be explicitly said, the sex education courses in Georgia often embody the rhetoric that teaches students that they are not supposed to activity peruse their sexual desires and are often held responsible for provoking these situations, a responsibility that the rhetoric assumes it will fall on the woman(Cameron et al. 2003, 34). Particularly concerning

the responsibility of women, the "just say no" approach to rape culture encourages scripts and strategies for women and girls to fend off these "advances" of unwanted sexual behavior from boys/men, but leaves them curious about their own desires and ability to make sexual choices (Oliver et al. 2013, 145). Sex education programs, in a sense, join the conversation of obstructing sexual confidence of its students, particularly young girls, of which encouraging the curiosity in one's body is dependent on (Thompson 1990, 358). All woman interviewed also stated that the desire for access to a sexual counselor would have been helpful to ask questions, talk to about rape, or to just to talk to about sex and sexuality in general. This was accompanied by a discussion about instructors who taught sex education.

According to the data from the Georgia Public Health Association, sex education instructors were either health education teachers or sports education teachers (physical education/sports coaches for school teams). Students felt that their instructors at the time were ill prepared, uninterested, or unable to accurately present the information. Students are not the only ones who see the issue of unprepared instructors. In fact, the concern involving expertise and teaching standards for sex education are shared by both students and the instructor (Gates et al. 2015, 193). According to a study done by the Georgia Public Health Association, Georgia instructors had indicated the need for further education in STI/HIV prevention as well as human sexuality (Gates et al. 2015, 193). Educators who are uncomfortable or ill-informed about this type of information may contribute to the fact that students also felt that the ability to ask questions during sex education was difficult and awkward. Without an open forum where the ability to discuss their bodies and sexuality, students and educators are both unprepared for these types of conversations because (1) the environment for discussion is stigma based leaving

students afraid or unwilling to ask questions and (2) educators are ill-informed and therefore or either unwilling to answer questions or no prepared for the types of questions.

Concepts of comfort and relationships and their dynamics was also a topic of conversation. Many were interested in the idea of engaging in a discussion about what healthy relationships should be like and how one would communicate with a sexual partner or significant other about sex, desire, consent, comfort, and sexual exploration. Consideration for the manner in which the sex education course is formulated advises against this conversation. Rather many sex education courses involved discourse about making "good choices" and avoiding sexual experiences altogether. Rhetoric with the singular option of abstinence discouraged the initiation about sex and communication with potential or long term partners limiting the capacity for students to become self-regulating in their sexual health. By omitting information about the dynamics of a healthy sexual relationship, student directly associated this with their inability to vocalize what they wanted sexually with their partners after the course had been taken. This comprised the desire to ask a partner to wear a condom and to get tested for STIs. This is the adverse intention of the sex education course.

Other desired outcomes of the sex education course also included learning about gender and body empowerment including sexual orientation, homophobia, and the stress of more in-depth conversations about contraception. Many of these concerns parallel what is already discussed in European countries, such as the Netherlands or France, and have effectively and noticeably reduced the numbers of unwanted and teen pregnancy, abortion, and STIs (Weaver et al.2005, 179- 181). Taking into account that teens do have questions, concerns, and desire to learn about sex and sexuality not for the purpose to engage in sex but to make sense of themselves as sexual beings can allow for a more open and preventative sex education system.

Alienation and anxiety about sex increase when it is pathologized and silenced as a discussion (McCarthy et al. 2011,228). As a result, youth who learn this from an early age discern that sexual feelings and experiences should be hidden from parents, adult, and doctors (McCarthy et al. 2011, 228). By limiting their access to this information and actively contributing the oppression and suppression of [their] body empowerment the opposite of a public health prevention program is formed.

DISCUSSION:

Through the data collected it can be concluded that the Georgia public school system sex education program, their curriculum, policy, and the way students perceive the information, is ineffective at preventing STIs and promoting safe sex practices. This has been seen via interviews I had conducted with 6 students that inquired about their thoughts, experience, and reflections on the sex education program. The interview process ended with questions that then assessed if they had or had not engaged is what public health agencies such as the Centers for Disease Control and Prevention and the World Health Organization, would consider risky sexual behavior thus increasing the chance of teen/unwanted pregnancy, STIs, and HIV/AIDs. The questions to assess this inquired about the number of sexual partners they had if they had ever engaged in unprotected sex, if they or a partner had been tested for STIs, and if they themselves or anyone close to them had ever had an STI. The results I gathered from coding interviews and correlations with language usage between and within interviews, revealed trends found to display obvious relationships between sex education information that was taught and the way students were affected by the information presented. Students were negatively affected by their respective sex education programs primarily through the lack of information and forced ideology.

With consideration of the previous results, one may ask why any of this matters? From a public health standpoint, it is simple. Public school sex education courses are often the only and common form of sex education a teen may receive, this means that it is relied on as the main source of information about STI prevention, safe sex methods, and teen pregnancy prevention. These are considered major public health concerns in relation to human sexuality. When the main source of prevention and education fails its students it fails society as a whole. By this, I mean that sexually uninformed youth lead to sexually uninformed adults thus leading to a rise in STIs, no use or inconsistent use of condoms, and rises in unwanted or teen pregnancies. Public health services aim to further educate the public on sex-related health problems and prevention methods are commendable and necessary because the facts have been thoroughly studied and have been proven to be preventative. Never the less, public health cannot force people to partake in safe sex and they cannot force the public school system to follow the recommended information that sex education courses should be incorporating into their curriculum. Public health's role in improving sex education courses in minimal.

From an anthropological perspective, the need to intervene is imminent. Sex education in Georgia is damaging to its students in several different ways to the point where it has made a type of sexual culture between youth and their future selves. The rhetoric surrounding sex that embodies shame and fear tactics may seem harmless and effective as a prevention method, but long term it does major damage. It has been made clear that via fear, shame, and instilling stigma about sex that adults who engaged in the sex education course in Georgia were likely to not only have engaged is risky behavior but purely out of shame refused to ask partners to wear condoms, refused to ask partners to be tested for STIs, feared for themselves to be tested for STIs because of possible results, were unaware of treatments or causes (meaning ways in which STIs are

contracted beside the vague "sexually") of STIs, and could only name few methods of contraception (condoms was mentioned in every interview while "birth control" was the second common).

The rhetoric also provides a sex-negative environment, it lacks body empowerment important for youth to take charge of their own bodies including wanting to seek family planning services, contraception methods, and engaging in sex-positive behavior like communications and consent when they begin to encounter and understand these situations. Even more so, on a grander scale, this type of rhetoric is not only seen in Georgia but all around the United States and may contribute to the countries constant fascination of sex and its ever more ironic perversion and apprehension to discussing it in an open setting. Shame factors and fear messages from the sex education program contribute to youth being fearful of speaking up about their bodies, the issues, and the surprises that can come from engaging in sexual behavior. The truth of this matter is that sex education is not just another class student's sit through, rather they are actively listening and using the information or lack thereof. There is also the consideration that for students who already abstain from sex out of choice or are LGBTQIA+, may be ignoring the information that is presented because it does not pertain to them.

I became aware that while the sex education course attempts to constrain natural sexual impulses the reality is that sexuality and sexual behavior are an expression of the individual and cannot be constrained by rules, categories, or definitions that contribute to abstaining from sexual behavior (Cameron et al. 2003, 43). Likewise, the discourse surrounding sex and sexuality (rules, categories, definition) evolve over time and sex education in Georgia needs to account for the changes in sexual discourse that is out of date and that do not apply to the present and future students (Cameron et al. 2003, 43). Yet, sexuality and sex are nonetheless political and in the

case of sex education the state use federal funding as an initiative to support instilling abstinent based sex education courses. Both the constraining nature of the sex education program and its underlying money based initiative have contributions to Georgia's placement in the top 10 rankings of HIV, syphilis, chlamydia, and gonorrhea.

I am not suggesting that the structure and content (and lack of content) in sex education are the only contributors to the STI epidemic in Georgia but they definitively contribute to the problem for those who have been through the program and others outside of Georgia whose states also enact the same rhetoric. If this is the case, where do we go from here? Can we intervene and if we can, how? It is apparent that we need to consider engaging in a more comprehensive version of sex education. It may be imperative that we begin to distinguish between the forced ideology of the state (and the money it follows) and the actual practice in the sexual behaviors of real youth in real sexual situations (Cameron at al. 2003: 135). The truth is that teens are having sex and to enforce that their bodies' natural and biological responses are shameful sensations is teaching them to suppress any issues they may have later or currently with their reproductive systems. As a consequence of avoiding this type of open conversation, we teach them to be ashamed thus giving them the tools to harm themselves and others. Intervening may prove to be difficult. For one reason, there is the money involved, in 2014 the state of Georgia received $1,839,018 from participating in Title V State Abstinence Education Program, the federal funding program that outlines abstinence only until marriage (Chosewood 2014, 1). Secondly, it is challenging to adjust a more conservative state into one that can reconsider a more comprehensive sex education course. School systems must also consider parent backlash if any to a changing curriculum that takes a more liberal stance.

CONCLUSION:

The initial purpose of this study was to research strictly the effects that the sex education course in the Georgia public school systems may or may not have had on Georgia's STI rates. While it had been considered that not everyone from Georgia who has had an STI lived in Georgia their entire life, taken the sex education program, or had even contracted an STI within the state, it was valuable to assess a program that's influence is utilized worldwide (meaning that the United States is not the only country with a type of sex education at the secondary school level and that millions of students go through the program). During the interview process, the purpose of this research began to change. I came to the realization of how flawed the entire United States sex education program is compared to those in other countries, which are enacting sex education curriculum similar to what the people I interviewed had desired to see, and whose sexual health statistics are drastically better than the United States.

As a former student of the Georgia public school system, I myself have taken part in the sexuality education program in Georgia. Reflecting back on the program through the course of this study I found that many of my experiences paralleled those of who partook in the interview process. I remember quite clearly seeing photos of STIs, being told nothing of contraception, and being given mindless definitions with no real explanations behind them. I remember taking the pledge to become abstinent until marriage and receiving little rubber bracelets with the words "NO until I DO" engraved in them. My program, like many others, was quick and precise. It took two days to complete and left me with nothing to remember or learn and utilize from. During my time in the sex education program my number of sexual partners had been high, I did not use contraception consistently, and I never knew that getting tested for STIs was available or that I should ask partners to get tested, I was one of those who would be considered at risk of STIs, HIV/AIDs, and (at the time) teen pregnancy. Now, I am considered one of the lucky ones. I

have had no STIs, I have had no unwanted or teen pregnancies, and I have also never had HIV. Yet it was clear that during that time, the sex education course failed me individually along with my fellow student body. It was not until college that I had realized had options, that I could empower myself to be reproductively responsible and to make choices regarding my own body. College is too late for many of us that fall under the high-risk category or are in the age range to be at high risk (15-25 as a reminder) to make these realizations. Sex education must pick up the slack and begin considering that its value is much greater that a few abstinence pledges and scary STI pictures. It may be time to reconsider what we are teaching in the sexual education program and rather it is time to understand how it is influencing sex and sexuality.

Appendix: Questions Asked During Interview Process

Age:
Sex:

1. In which portion of the sex education program did you participate? (Elementary, middle, high school, all , or some)
2. Can you describe what this program was like in your school?
3. What are your thoughts on the sexual education program in Georgia?
4. What was the overall message that the sexual education program aimed to give its students?
5. Was the sex education program you participated in helpful and/or insightful?
6. Could you utilize the information the sex education program relayed to you in your daily life?
7. Was there any information that was not relayed that you thought may be more useful or insightful to you?
8. Was there any information you thought was irrelevant?
9. Did you understand everything the program taught?
10. Did you feel comfortable asking questions about anything sex-related?
11. Where the causes and treatments of STDs/STIs communicated effectively for you to understand?
12. Did the program cover the uses on contraceptive methods (in detail? to what extent?)
13. Are you sexually active?
14. Do you practice safe sex (what is safe sex to you)?
15. What type of contraception/ birth control, if any, do you use (and in what instances)?
16. What are your thoughts on unprotected sex (Have you ever had unprotected sex)?
17. What is "sex" to you (What constitutes as sex)?
18. Have your parents/legal guardian/older sibling/ trusted adult given you "the talk"? Was it a one-time talk or more of an ongoing conversation or dialogue over the years?
19. Were your family members open to talking about sex?
20. If so, what was more informative (sex education or "the talk")?
21. What made either more successful (sex education or "the talk")?
22. What do you consider are good and bad sexual behaviors?
23. How many partners have you had?
24. Have you been tested or asked to be tested for STIs?
25. Have you asked a partner to be tested?
26. Have you or anyone you know had/has an STI?
27. How did they/you deal with the news of having an STI?

Bibliography

Cameron, Deborah, and Don Kulick.
2003. *Language and sexuality*. Cambridge: Cambridge University Press

Centers for Disease Control and Prevention.
2015. "Georgia State Health Profile". Division of STD Prevention. Department of Health and Human Services, Atlanta, GA.

Centers for Disease Control and Prevention.
2015. "Sexually Transmitted Disease Surveillance 2015. Division of STD Prevention". *Department of Health and Human Services*, Atlanta, GA.

Centers for Disease Control and Prevention.
2017. "HIV Transmission". *Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, Sexual Transmitted Diseases and Tuberculosis Prevention, Centers for Disease Control and Prevention*, Atlanta, GA.

Chosewood, Debra C.
2015. "SIECUS State Profile: Georgia". *Georgia Division for Family and Children Services*.

Cunningham, Shayna D., Deanna L. Kerrigan, Jacky M. Jennings, and Jonathan M. Ellen .
2009. "Relationships Between Perceived STD-Related Stigma, STD-Related Shame and STD Screening Among a Household Sample of Adolescents." *Perspectives on Sexual and Reproductive Health* 41, no. 4 : 225-30. http://www.jstor.org/stable/20697074.

Irvine, Janice M.
2004. *Talk about sex: The battles over sex education in the United States*. Univ of California Press.

Lichtenstein, Bronwen.
2003. "Stigma as a barrier to treatment of sexually transmitted infection in the American deep south: issues of race, gender and poverty." *Social science & medicine 57*, no. 12:2435-2445.

McCarthy, B., & Grodsky, E.
2011. "Sex and School: Adolescent Sexual Intercourse and Education". *Social Problems*, 58(2), 213-234. doi:10.1525/sp.2011.58.2.213

Remez, Lisa.
2000. "Oral Sex among Adolescents: Is It Sex or Is It Abstinence?" *Family Planning Perspectives* 32, no. 6: 298-304. doi:10.2307/2648199

Starkman, Naomi , and Nicole Rajani.

2002. “The Case for Comprehensive Sex Education”. *AIDS Patient care and STDs* 16(7): 313–318.

Thompson, S.
1990. “Putting a Big Thing into a Little Hole: Teenage Girls' Accounts of Sexual Initiation”. *The Journal of Sex Research,* 27(3), 341-361. Retrieved from http://www.jstor.org/stable/3812805

Vanessa Oliver, Emily van der Meulen, June Larkin, Sarah Flicker, & Toronto Teen Survey Research Team.
2013. “If You Teach Them, They Will Come: Providers' Reactions to Incorporating Pleasure Into Youth Sexual Education”. *Canadian Journal of Public Health / Revue Canadienne De Santé Publique,* 104(2), E142-E147. Retrieved from http://www.jstor.org/stable/canajpublheal.104.2.e142

Weaver, Heather, Gary Smith, and Susan Kippax
2005. “School-Based Sex Education Policies and Indicators of Sexual Health Among Young People: A Comparison of the Netherlands, France, Australia and the United States”. *Sex Education* 5(2): 170–188

Yang, Lawrence Hsin, Arthur Kleinman, Bruce G. Link, Jo C. Phelan, Sing Lee, and Byron Good.
2007. "Culture and stigma: adding moral experience to stigma theory." *Social science & medicine* 64, no. 7: 1524-1535.