

The Effectiveness of Comprehensive Sexual Education for Lowering rates of HIV/AIDS

The Effectiveness of Comprehensive Sexual Education for Lowering Rates of HIV /AIDS

Samantha Tanen

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Professor Gary Dick, Ph. D

School of Social Work

College of Allied Health and Sciences

University of Cincinnati

Abstract

In the United States, rates of HIV/AIDS diagnosis have increased and have affected a plethora of communities and individuals. In 2018, 37,968 people have received an HIV diagnosis (CDC.gov, 2020). While HIV diagnosis have decreased by 7 % from 2014 to 2018, annual diagnosis have increased among certain groups (CDC.gov). Of the 37,968 new diagnosis reported in 2018, 69% were among gay and bisexual men, specifically Black and African American men who have sex with men, or MSM (CDC.gov). In addition to this, 2018 had been the highest among people of the ages 25-34, as 13,491 newly reported cases had been made (CDC.gov). In the United States, there is a lack of inclusive, medically based sexual education that is needed to prevent rates of HIV/AIDS for all people. Sexual Education programming varies widely across the United States (Planned Parenthood). fewer young people report receiving any form of sex education at all (Planned Parenthood). Comprehensive sexual education includes an intersectional mindset that allows individuals to make safe and healthy decisions for their sexual lives and beyond. This teaching provides medically accurate guidelines that cover human sexuality, reproduction, anatomy, family life, sexual orientation and gender identity, contraception, sexual abuse, HIV/AIDS prevention, and many more necessary tools to practice safe sexual activities (National Guidelines Task Force). These tools may lower rates of HIV/AIDS among all individuals.

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Chapter 1: Introduction

Statement of the Problem

The number of people living with HIV/AIDS has increased over the years and is at an all-time high in Ohio. According to a report conducted by the Bureau of Infectious Diseases Ohio Department of Health titled “HIV Surveillance Annual Report, there were 973 newly reported diagnoses of HIV infection in Ohio in 2019. (Ohio Department of Health). 80% of the newly reported diagnoses were among males and over half of the newly reported cases were among people aged 20 to 34 years old (Ohio Department of Health). 48% of the new diagnoses reported in 2019 were among Black and African American people while 42% for their white counterparts (Ohio Department of Health). Over half of the newly reported diagnoses were among people residing in Cuyahoga, Franklin, and Hamilton Counties (Ohio Department of Health). With this, Black and African American people are disproportionately faced by these recent diagnoses. One of the most common ways people get HIV/AIDS is through anal or vaginal sex, sharing needles, syringes, or other drug injection equipment (CDC.gov). This transmission occurs due to someone with HIV not using protection like condoms, medicine, or clean injection equipment.

Scope of the Problem

According to the Ohio Department of Health, in 2019, Black and African American people accounted for 48% of all newly reported diagnoses of HIV in Ohio. This was followed by 42% of white people, 6% of Hispanic and Latinx people (Ohio Department of Health). The source states that Ohio’s Black and African American population continues to be disproportionately impacted by HIV compared to other racial and ethnicity groups in the State (Ohio Department of Health). At a more macro look, according to statistics provided by the Center for Disease Control and Prevention, there is an estimated 1.2 million people in the United States that had been diagnosed with HIV at the end of 2018 (CDC). Of those people, 14% did not know they had HIV (CDC). For HIV/AIDS rates to decrease in the Hamilton County area, comprehensive sexual education that is inclusive and positive needs to take place: in schools, workplaces, nonprofit programs, etc. (My focus will be on Caracole Inc.). This matters because noncomprehensive sexual education is discriminatory- it is ableist, anti-LGBTQIA+, and does not recognize discrimination faced against drug use and people affected by mental health disparities.

People Affected by the Problem

Everyone is affected by HIV/AIDS whether they are aware of the infection or not. At the beginning of the AIDS epidemic until now, we have lost a generation of people that experienced hardships, trauma, discrimination, and lack of help from their government. There are many groups affected by HIV and I will be talking about MSM, Black/African Americans, Latino/Latinx and Hispanics, and transgender individuals. To this day, there are some populations that are more affected by others even though everyone bares the brunt of this infection. Gay and bisexual men of all races and ethnicities remain the most affected group of the epidemic as MSM “represent approximately 2 percent of the U.S. population, but accounted for 61 percent of all new HIV infections in 2009” (“Populations at Greatest Risk,” cdc.gov). In addition to this, African Americans are the most affected racial/ethnic population in the United States by HIV/AIDS as they are fourteen percent of our population but accounted for forty-four percent of all new infections in 2009 (cdc.gov). To further display who is affected by the problem, Latino/Latinx and Hispanic folks represent about sixteen percent of our population but represent about 20 percent of all new HIV infections. In 2009, “the HIV infection rate among Latinos was three times as high as that of whites” (cdc.gov). Lastly, according to the CDC, among 3 million HIV testing events that occurred in 2017, “the percentage of transgender people who received a new HIV diagnosis was 3 times the national average” (cdc.gov). As we know, there are around 1.1 million people residing in the United States with HIV. While some groups are more affected by others due to health inequities, everyone bares the brunt to this problem because we are all living in a white supremacist nation that enforces systemic and institutionalized racist and western structures. These structures create disparities in medicine, economic, social, and environmental issues.

Justification of the Study

This study is important for social work because it encompasses our work around empowerment, advocacy, self-determination, and public health. People of color are disproportionately affected by HIV/AIDS, specifically Black and African American people. As social work emphasizes, everyone needs their basic needs met and comprehensive sexual education is exactly this. The implications of practice may provide ample information as to why comprehensive sexual education is essential and needed for all clients. This form of sexual education is medically based and constantly updated and revised to be as inclusive and accurate as possible.

What are the implications for practice?

The implications of practice may provide ample information as to why comprehensive sexual education is essential and needed for all clients. This form of sexual education is medically based and constantly updated and revised to be as inclusive and accurate as possible. At a micro level, the implementation of comprehensive sexual education may provide necessary resources for a client or a client's family to make immediate safe decisions regarding safe sex practice. These tools may empower to a client to make a safe decision for themselves and those around them. At a Mezzo level, this may provide a resource for community outreach programs that target people living with HIV/AIDS. Caracole Inc. is a great example of this- they provide outreach programs such as prevention and sexuality education to keep the local community safe and knowledgeable about their health and well-being. At a macro level, implementing comprehensive sexuality education may change legislation and policies that prevent the teaching of medically accurate, HIV focused education. This could have long lasting positive affected on the United States at large.

Background of the Problem

The rates of HIV/AIDS have steadily increased over the years, according to a source titled, *HIV and AIDS In the United States of America (Avert, 2019)*. The source states that since 2018, 1.1 million people have been diagnosed with HIV while 1 in 7 individuals are unaware they have it (2019). HIV/AIDS diagnosis have increased on a global level that affects individuals living in the Hamilton County area. According to an informational response published by the CDC, HIV, or Human Immunodeficiency Virus is a virus that attacks the body's white blood cells and immune system (CDC). The article states that if HIV is not treated properly, this can lead to the development of AIDS, or Acquired Immunodeficiency Syndrome (CDC). When people do not receive treatment for HIV, they typically progress through three stages. The three stages are titled, "Acute HIV Infection, Chronic HIV Infection, and Acquired Immunodeficiency Syndrome, or AIDS (CDC). Fortunately, HIV medicine and medications called Antiretroviral therapy, or ART can reduce the amount of HIV in the blood cell. This is familiarized as the viral load. HIV medication can make the viral load so low that a test cannot detect it, called undetectable. This leads to a person living with HIV obtaining U=U, undetectable equals untransmittable, meaning if a person has an

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undetectable viral load, they have effectively no risk of transmitting HIV to an HIV negative partner through sexual activity (CDC). This is also effective for people who inject drugs or share needles, and mother-to-child pregnancy, birth, and breastfeeding (CDC). Most people can obtain viral suppression control within six months of treatment (CDC). People who take HIV medicine as prescribed may never reach stage 3 of progression.

What evidence did you find in the research indicating this is a problem?

Evidence shows that sex and HIV/STI education programs are a promising form of interventions to reduce sexual risk behavior. According to a source titled, *School Based Sex Education and HIV Prevention in Low and Middle- Income Countries: A Systematic Review and Meta-Analysis*, random effects meta-analysis suggests that students who were exposed to a sexual education intervention were more knowledgeable of HIV and related topics than youth who did not experience an intervention (Virginia A Fonner et al., 2014). Results from meta-analyzed demonstrated that school-based sexual education is an effective strategy for reducing HIV-related risk. This evidence shows that the implementation of comprehensive sexual education may be a great tool for reducing levels of diagnoses in Ohio and globally. Groups that are disproportionately affected like Black and African American People may benefit from this comprehensive tool.

Who is affected by the problem?

People of color are disproportionately affected by HIV/AIDS, specifically Black and African American people. According to a source titled, *HIV and AIDS in the United States of America*, the rate of HIV among Black/ African American MSM has increased by 65% from 2010 to 2016. The rate of HIV among Hispanic/Latinx MSM has increased 68% from 2010 to 2016 (“HIV and AIDS in the United States of America”). In addition to this, according to a source titled, *Understanding Racial HIV/STI Disparities in Black and White Men Who Have Sex with Men: A Multilevel Approach*, “since the beginning of the HIV epidemic, men who have sex with men (MSM) have been the predominantly affected risk group in the United States...More recently, increases in incidence have been concentrated among young MSM of color. Black MSM have over twice the prevalence of HIV than white men, and data from HPTN 061 suggest that Black MSM have HIV incidence rates over five times those of white MSM” (Sullivan et al., 2014). According to the AIDS-VU, local data on Hamilton County shows that 433 of every 100,000 people are living with HIV(AIDS-VU). There are 817,473 currently living in Hamilton County, so this means that there have been 3,540 new diagnoses. To all, this should be an alarming rise of

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new diagnoses and should be deemed as a public health crisis. This study is justified because everyone deserves the right to a safe, knowledgeable, accessible, and supportive sexual lifestyle, whether they choose to engage in these behaviors or not.

Significance of the study

The significance of the study is to provide evidence as to why comprehensive sexual education should be an implemented prevention program for everyone to have access to. This study will work to prove why it is essential to adopt changing and evidence-based theoretical frameworks that consist of intersectional and inclusive solutions.

Underlying Assumptions

My underlying assumptions are that comprehensive inclusive sexual education will be an effective tool in lowering the rates of HIV in the area. I assume that comprehensive sexual education will provide a positive tool for people of all backgrounds regardless of age, race, gender, socioeconomic status and more. This teaching will provide the tools for someone to make safe decisions regarding their sexual health, drug injection use and will allow people to feel empowered and confident about their health and well-being. I may also assume that the teaching of comprehensive sexual education will lower the disproportionate affects that Black and African American people face along with additional communities of color.

What are your assumptions, beliefs about the problem?

My assumptions and beliefs about the problem are formed by the urgency and pressing need for sustainable treatment methods of reducing HIV/AIDS diagnosis on a micro, mezzo, and macro problem. This is a public health crisis that needs to be treated as an emergency. My beliefs about the problem are that everyone is affected by this, even if they are not a person living with HIV/AIDS.

Purpose of the research

The Purpose of the research is to find an effective tool for lowering rates of HIV/AIDS for people in the area and globally. With consistent research arguing that comprehensive sexual education does not increase sexual behavior and leaves a more positive effect on those who received the education, it is important to advocate for this curriculum for our clients and all.

Purpose of the study

The purpose of the study is to provide thorough information of the effectiveness in prevention and comprehensive sexual education for Caracole and additional organizations in the Hamilton County area to follow to reduce HIV/AIDS rates.

Aim of the Study

I propose to study the relationship of medically correct, comprehensive sexual education and rate of HIV/AIDS detection. I will be observing data and stats collected at Caracole on sexual health program sessions.

Identify Qualitative or Quantitative

Qualitative. The research conducted will produce quantitative numbers that will provide evidence of the effectiveness in qualitative outcomes of comprehensive sexual education.

Definition of Terms

AIDS- Acquired Immune Deficiency: AIDS is the most severe phase of HIV Infection. People with AIDS have a very damaged immune system that can lead to developing an increasing number of illnesses, known as opportunistic infections (CDC.gov)

CARE Act- Comprehensive AIDS resources emergency act

CDC- center for disease control

PWID- People who inject drugs

LGBTQIA+- Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Assexual, + - “denotation of everything on the gender and sexuality spectrum that letters and words can’t yet describe”

Comprehensive sexual education- “CSE covers a broad range of issues relating to the physical, biological, emotional and social aspects of sexuality. This approach recognizes and accepts all people as sexual beings and is concerned with more than just the prevention of disease or pregnancy”

MSM- men who have sex with men

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WSW- women who have sex with women

PLWHA- person living with HIV/AIDS

STI- sexually transmitted infection

STD- sexually transmitted disease

Literature Review

The theory I have chosen for my research project is *Systems Theory*. According to a source titled, *web.ausburg.edu*, systems theory is a concept that “emphasize[s] reciprocal relationships between the elements that constitute a whole. These concepts also emphasize the relationships among individuals, groups, organizations, or communities and mutually influencing factors in the environment. Systems theories focus on the interrelationships of elements in nature, encompassing physics, chemistry, biology, and social relationships” (2020). Systems theory applies to my research because it reflects the exact teachings of comprehensive sexual education. Comprehensive sexual education encompasses all learning that is intersectional and multilayered. For example, sexual education relies on research advances in biology, social relationships, social programs, and human behavior. Sexual education that is comprehensive is based on medical and correct biological anatomy that relates to sexual behavior. It is intersectional because along with biological factors, it studies human relationships that are at the micro, mezzo, and macro. Like systems theory, it observes relationships made in one’s environment, community, and relation to structured systems of where someone lives. In relation to HIV/AIDS rates and comprehensive sexual education, systems theory is critical for understanding one’s relationship with their environment and other influences that affect their sexual behaviors, whether they are safe or risky when it comes to contracting the virus.

Sexual Education Outcomes

The scholarly source titled, *The Case for Addressing Gender and Power in Sexuality and HIV Education: A Comprehensive Review of Evaluation Studies* discusses the relationship between addressing gender and power in sexuality education curriculum and whether that is linked to better sexual health outcomes. According to the source, “evidence links traditional gender norms, unequal power in sexual relationships and intimate partner violence with negative sexual and reproductive health outcomes” (Haberland, 2015).

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This source is directly related to my study because it analyzes the importance of teaching gender and power structures to debunk misogynist, violent, suppressive thinking when it comes to traditional gender roles and norms. A second source titled, *Abstinence, Sex, and STD/HIV Education Programs for Teens: Their Impact on Sexual Behavior, Pregnancy, and Sexually Transmitted Disease* notes that there are high rates of teen pregnancy and sexually transmitted disease in the United States. It explores newly developed curriculum education programs to reduce these rates. “All five groups of programs had at least one study demonstrating some positive impact on behavior, indicating that multiple approaches can be effective at changing behavior. Sex and STD/HIV education programs that focused only on abstinence consistently failed to have any significant effect on sexual behavior” (Kirby, 2012). In addition to this, “a very intensive, comprehensive, and long-term program had the most dramatic results and reduced the teen pregnancy rate reported by female teens by about half for 3 years” (2012).

MSM

The source titled, *The Role of Provider Interactions on Comprehensive Sexual Healthcare Among Young Men Who Have Sex With Men* discusses the importance of testing for both HIV and STI's and how that is an essential component of comprehensive sexual healthcare, specifically among men who have sex with men, MSM. The source finds that “among YMSM who visited a doctor, [the] multinomial regression exhibited that those whose provider discussed HIV/STI prevention were most likely to have tested for both HIV and STIs, as compared to the HIV Only and Never Tester categories. Patient-provider communication regarding HIV/STI prevention is critical to motivate comprehensive sexual healthcare among YMSM” (Meanley, et al. 2015). A second source titled, *Male Sex Workers: Practices, Contexts, and Vulnerabilities for HIV Acquisition and Transmission* notes that male sex workers who sell or exchange sex for money or goods encompass an incredibly diverse population across the country and worldwide. The source states, “criminalization and intersectional stigmas of same-sex practices, commercial sex, and HIV all augment risk for HIV and sexually transmitted infections among male sex workers and reduce the likelihood of these people accessing essential services” (Geibel et al., 2014). It is

important to recognize the benefit of comprehensive sexual education as a global issue to benefit and empower people in the United States and throughout the world.

Black and African American cis and trans men

According to the source titled, *Understanding Racial HIV/STI Disparities in Black and White Men Who Have Sex with Men: A Multilevel Approach*, “since the beginning of the HIV epidemic, men who have sex with men (MSM) have been the predominantly affected risk group in the United States...More recently, increases in incidence have been concentrated among young MSM of color. Black MSM have over twice the prevalence of HIV than white men, and data from HPTN 061 suggest that Black MSM have HIV incidence rates over five times those of white MSM” (Sullivan et al., 2014). In the case of HIV/AIDS rates in the Hamilton County area, numbers have remained at high, stagnant percentages from data collected in 2015 to 2019 for Black and African American MSM. According to *Hamilton County HIV Surveillance Data Tables*, the rate of HIV/AIDS in 2015 to 2019 has averaged out to 41% among Black and African American MSM (2019). Although this focuses on a specific population, young Black MSM, it is incredibly important to note in my research because they are disproportionately affected by HIV/AIDS rates due to “higher rates of poverty and unemployment, and lower median income” (2014). As mentioned previously, both systems theory and comprehensive sexual education note the importance of social structures and systems that an individual experiences along with noting intersectional reasonings that relate to race and gender inequities. A second source titled, *Reframing the Context of Preventive Health Care Services and Prevention of HIV and Other Sexually Transmitted Infections for Young Men: New Opportunities to Reduce Racial/Ethnic Sexual Health Disparities* notes the stark differences and the disproportionate HIV/AIDS rates among Black men, specifically MSM. This source notes the need to “strengthen HIV and STI prevention opportunities during routine, preventive health care visits and at other, nontraditional venues accessed by young men of color, with inclusive, nonjudgmental approaches” (Lanier, 2013).

People who use and inject drugs

The first source is titled, *Women Inmates' Risky Sex and Drug Behaviors: Are They Related?* This source discusses the relationship, or lack thereof of sexual behaviors, HIV rates, and drug use. According to the article, “inconsistent condom use with multiple sex partners, a history of a diagnosed sexually transmitted disease (STD), a drug-injecting sex partner, or exchanging sex for money or drugs prior to incarceration were reported by 55% of the women” (Cotton-Oldenburg et al., 2009). Although this source is specifically referenced to woman inmates, it reflects the larger problem of discrimination based on drug use and HIV/AIDS rates with needed support of comprehensive sexual education. The second source, *Estimating the Prevalence of Syringe-Borne and Sexually Transmitted Diseases Among Injection Drug Users in St Petersburg, Russia* focuses on Injection drug users (IDUs) and the HIV epidemic in Russia. According to the study, the median age was 23 years old. “Only two-thirds of subjects recognized condoms to prevent sexually transmitted infections and half knew that oil-based lubricants are not appropriate for condoms. The IDU population studied was young and requires additional interventions to encourage safer sexual behaviors” (Abdala, 2003). Although this source focuses on studies conducted in Russia, it reflects on the United States' epidemic of injection drug use and high rates of HIV/AIDS. Comprehensive sexual programs like the clean needle exchange is an example of inclusive programs and systems theory because of social services and environmental behaviors.

METHODOLOGY

Rationale of Research Design

The reasoning behind this study is to explore new ideas, theories, and ideologies of teaching sexuality and sexual behaviors that seek to improve the overall well-being of individuals. It is essential to analyze the use of comprehensive sexual education with the addition of intersectional perspectives. The purpose of this study is to show the effectiveness of comprehensive sexual education as a tool for combating HIV/AIDS. The rates of HIV/AIDS have steadily increased over the years, according to a source titled, *HIV and AIDS In the United States of America (USA)*. The source states that since 2018, 1.1 million people have been diagnosed with HIV while 1 in 7 individuals are unaware they have it (2019). In the case of HIV/AIDS rates in the Hamilton County area, numbers have remained at high, stagnant percentages from data collected in 2015 to 2019 for Black and African American MSM.. Black and African American men who have sex with men (MSM) and Hispanic/Latinx men who have sex with men (MSM) are disproportionately affected by the virus in referenced by data collected for the United States. *HIV and AIDS in the United States of America* states that the rate of HIV among Black/ African American MSM has increased by 65% from 2010 to 2016. The rate of HIV among Hispanic/Latinx MSM has increased 68% from 2010 to 2016 (2019). As this should be deemed as a state of emergency, it is essential for continued analysis of this health crisis must factor in discrimination and stigmatization as justification as the HIV/AIDS epidemic can be tied to racism, homophobia, transphobia, and Westernized ideologies. The purpose of this study is to debunk the structured ideologies that consist within the Westernized Binary of understanding sexuality and to advocate for comprehensive and intersectional teaching of sexuality to work towards a sustainable and healthy lifestyle for all people. According to a source titled, “How Does Stigma Affect People Living with HIV?” The Mediating Roles of Internalized and Anticipated HIV Stigma in the Effects of Perceived Community Stigma on Health and Psychological Outcomes, “stigma has negative effects on health outcomes, including non-optimal medication adherence, lower visit adherence, higher depression, and overall lower quality of life (Bulent Turan et al., 2017). As

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mentioned previously, Black and African American men are disproportionately affected by HIV/AIDS diagnoses, and harmful stigmatization. According to a source titled, “HIV Stigma and Social Support among African Americans,” stigma can take two forms. These are called the perceived or enacted (Frank H. Galvan et al., 2008) Perceived stigma is felt, meaning it occurs when “there is a real or imagined fear of societal attitudes” (2008). This can result in acts of discrimination directed towards Black and African American PLWHA (2008). “Enacted stigma refers to experiences of discrimination directed to individuals because of specific attributes or conditions that characterize them” (2008). These harmful stigmas can harm the lives of PLWHA. For example, the article reports that this can include a loss in self-esteem as well as deteriorated social interactions with others (2008). In addition to this, HIV-positive African American women “have been found to report a fear of societal stigma related to HIV from a variety of sources” (2008). These sources include family members, fellow church members, health professionals and the broader community (2008).

Type of Study: exploratory, descriptive, explanatory, and evaluative

This is a descriptive study that seeks to determine the effectiveness of comprehensive sexual education to lowering rates of HIV/AIDS in Hamilton County. The study will be produced in survey format given to the Medical Case Managers at Caracole Inc.

Research Questions

- 1) What is your case load from September 2020 to March 2021?
- 2) What are the demographics of your caseload? i.e., Age, gender, sexual orientation, race, PWID, etc.
- 3) Have your clients had sexual education prior to being diagnosed with HIV/AIDS?
- 4) Have your clients received ongoing sexual education after being diagnosed?
- 5) Do your clients practice safe sex? If not, why?
- 6) Have your clients discussed why they use harm reduction tactics regarding safe sex practices?
- 7) How many of your clients are taking HIV medications?
- 8) What is a case that has impacted you, or has stood out to you for any reason?

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Hypothesis

The rates of HIV/AIDS in the Hamilton County area will decrease with the implementation of comprehensive sexual education. Comprehensive sexual education which includes the tools of prevention will provide people with accurate knowledge and safe behaviors to prevent the transmission and diagnoses of HIV.

Variables of Interest

Surveys will be given to the Medical Case Managers at Caracole. This study will use secondary research methods to support data and claims made about the effectiveness of comprehensive sexual education among those living with HIV/AIDS. There are many extraneous variables that can affect the study.

Operational definitions of variables and units of analysis

The Prevention Team's perceptions will be a unit of analysis based on their expertise and work. In addition to this, the research will include secondary research methods to further analyze data published on HIV/AIDS rate diagnosis in Hamilton County.

The Setting

The study will take place in Caracole Inc., located in Northside, Cincinnati, and the questionnaire will be given to the Medical Case Managers. Given the direct order of quarantine and remote work because of COVID-19, the questionnaire will be processed through a form of interview. I will be interviewing six case managers individually using Microsoft Teams as a meeting platform.

Sampling Method

The method that will be used is purposive sampling. This sampling has an element that is selected because of the specific category and position. The study will focus on the entire population of this specific group, people living with HIV/AIDS, PLWHA. Purposive sampling is used to study the effectiveness of this intervention with this population.

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The Sample

The subjects in my study include the Medical Case Managers at Caracole. The Medical Case Managers provide comprehensive care while addressing medical, mental, housing, and sexual health referrals and services. Case managers complete annual and semi-annual psychosocial assessments to determine the need and level of acuity clients at Caracole have.

Protection of Human Subjects

The survey will solely be given out to the Medical Case Managers at Caracole; however, their identities will be anonymous for ethical and protective values. PLWHA will be the topic of the study, however the survey will be given out to the professional staff working with this population. The only person that will have access to the results, information, and identities will be myself.

Human Diversity Issues

The research will be specifically conducted based on past data produced on populations including people living with HIV/AIDS (PLWHA), men who have sex with men (MSM), African American and Black men, and Hispanic and Latinx people, and members of the LGTBQIA+ community.

Data Collection Procedures

The survey will be created by myself and will be given to the Prevention Team at Caracole during field placement hours.

Data Collection Schedule

The survey will be given to the Prevention Team during Spring Semester 2020.

Data analysis plan

The research questions will be answered through a survey created by myself for the purpose of the study. The data will be reviewed and summarized by observing if comprehensive sexual education and prevention is an effective tool for combating HIV/AIDS. The results will be compared to secondary research methods related to the topic.

Limitations of the Study

The limitations of this study include solely interviewing Staff and not clients served at Caracole. The study will not have a first-hand perspective from the clients at Caracole that help confirm the effectiveness of using comprehensive sexual education as a tool for lowering rates of HIV/AIDS. This is due to recent COVID-19 restrictions placed in the United States. Caracole has progressed to remote work since the beginning of the pandemic so there has been a stark limitation to client contact and communication. There are many extraneous variables that can affect or impact the study that are not accounted for.

Chapter 4

Findings

The data I collected was based off the responses of six Medical Case Managers stationed at Caracole Inc. Every Medical Case Manager (MCM) I interviewed was cis-female and white. I will address every research question I had proposed in my interview.

1. What is your case load from September 2020 to March 2021?

Case Manager #1: 70 clients

Case Manager #2: Varies, around 60 clients but it goes up and down.

Case Manager #3: 53 clients

Case Manager #4: Their case load has fluctuated, there was a higher load in September but has gotten more clients recently. CM stated they have about 60-70 clients currently on their case load.

Case Manager #5: Around 80 clients

Case Manager #6: Around 60 clients

2. What are the demographics of your caseload?

Case Manager #1: around 2% substance use, majority of clients between the ages 23 and 45. The rest of their client load are older than 45. CM stated that around 75% of their clientele is gay and bisexual and 25% are heterosexual. CM stated they have one transgender client.

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Case Manager #2: CM stated they have male, female, minors up to seniors. CM stated they have no older or elder clients, the oldest are in their 60s. There are clients that work, some that are disabled, have mental health issues, varying degrees of treatment. There are clients with substance abuse issues. Clients that are over income, under income, and undocumented.

Case Manager #3: 10% of clients are immigrants; of the 10% there is a combination of both documented and undocumented people. Three of those clients are English speaking but they may use translation services for different things due to language barriers. CM stated that there are two clients that are currently sober that have had a history of various drug injection and non-drug injection. CM stated that race was unclear- there is a majority of Black/African American males. CM stated that about half of their case load is gay and half is heterosexual, and two clients are transgender. CM stated they have single and married clients.

Case Manager #4: CM stated at around 1/3 of their case load is Black/African American. 15 clients are over 60 years old. Most of their clients are between the ages of 30 to their 40's. Around 6 or 7 Hispanic/Latinx clients. There are a couple clients that are from Africa and that some clients are not English speaking. About 75% of caseload is gay, and 25% is heterosexual. Around 25% of caseload is women, and 75% are male.

Case Manager #5: Gender split is probably 80% men and 20% women. Clients are about half white, half Black. Most of clients are gay, all women on caseload are straight. Caseload of client age is early 20's to middle aged. A lot of clients are in retirement.

Case Manager #6: Client list is split between Black and white individuals. One client who is Hispanic. The ages range from 17-70 years old. Mostly half and half of straight and gay clients, the majority MSM. Case manager has women clients that identify as heterosexual.

3. Have your clients received sexual education prior to being diagnosed with HIV/AIDS?

Case Manager #1: Unclear, most of their caseload was inherited. CM stated that their new clients seem to be well informed through intake assessments. CM stated that most of their clients have had sexual education.

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Case Manager #2: CM stated this is not something they talk about with clients. For example, the case manager has a teenage client that had been diagnosed with HIV through prenatal transmission. This client gets sexual education from Children's Hospital.

Case Manager #3: CM stated that about half have touched on the topic in the past but that most clients had not received these services.

Case Manager #4: This is not something that their clients had mentioned. Some clients are in monogamous relationships.

Case Manager #5: This is unclear, not anything that clients have mentioned.

Case Manager #6: Very few knew anything about HIV, but within certain age ranges they may have had sexual education. Almost everyone knows how to use a condom, but have they had formal sex ed? I don't know.

4. Have your clients received ongoing sexual education after being diagnosed?

Case Manager #1: Yes, through annual and semi-annual Psychosocial Assessments We make sure we have that conversation every six months. Sometimes it depends on the age, some clients report abstinence and there has been an increase of this due to the Covid-19 Pandemic.

Case Manager #2: Yes, almost every client receives sexual education at the six-month, semi-annual assessment. Some clients are older and are at the point in their lives where sexual activity is no longer interesting and are choosing to remain abstinent.

Case Manager #3: Yes, all of them. Even if it is a client that has been with the CM for a while. Some clients still need in-depth sexual education more than others.

Case Manager #4: Yes, the CM makes it a priority to discuss sexual education. As previously stated, some clients are in monogamous relationships and understand the need for ongoing education.

Case Manager #5: Yes, through the psychosocial assessments.

Case Manager #6: Yes, the psychosocial assessment is a big help.

5. Do your clients practice safe sex? If not, why?

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Case Manager #1: Most of the client's report practicing safe sex. CM's perspective is that out of the majority, 15-20% were actually practicing safe sex.

Case Manager #2: CM stated that their clients have different ideas of what safe sex is- there are some clients who do not due to mental health or substance use issues that can affect impulse decisions. CM stated that there are clients that make plans regarding safe sex practices, but their substance use can provide a barrier to these actions. CM stated that some clients do not view this as a priority and that age may be a factor in this.

Case Manager #3: CM stated that there are some female clients that choose not to engage in safe sex practices- issues surrounding lack of preference for condoms or other protective barriers. These clients state that they are in relationships and do not feel the need for these protections. There are clients that the CM usually must consider cultural differences and often communicates with translators over what is appropriate to ask and what would be violating cultural competencies. Some clients state that they do not need to practice safe sex because they already have HIV.

Case Manager #4: Most if not all clients practice safe sex. The change comes with U=U and the push for PrEP with partners. Some do not do any additional low risk behaviors. Some clients address the purpose for preventing the transmission of additional STI's.

Case Manager #5: Majority of clients practice safe sex. The folks who do not are citing the CDC and their viral load being undetectable. Some clients talk about how their partners have HIV and are not concerned about it.

Case Manager #6: Half of my caseload does not practice safe sex. In monogamous relationships, some clients are undetectable, so they do not feel the need. Some clients do not like how condoms or other tools feel and have the attitude of not feeling at risk because they are undetectable, I would say 30-40%. Clients never report using clients during oral sex. A good chunk report they are not having sex, about 20%. Of the 20%, half are using condoms.

6. Have your clients discussed why they use harm reduction tactics regarding safe sex practices?

Case Manager #1: No

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Case Manager #2: CM stated that there are some young clients that are motivated to use harm reduction tactics to prevent pregnancy. Clients state that it is important to prevent transmission and there is fear of the Felonious Assault Law that has led them to become abstinent. Clients state that they use harm reduction tactics to prevent the transmission of other STI's.

Case Manager #3: One client that participates in the Syringe Service Program, SSP but due to COVID-19, has not mentioned this. Some clients mention that they already have HIV and are not interested in learning about how to prevent it. Some clients participate in safe sex practices due to fear of pregnancy.

Case Manager #4: Not recently. More people have become abstinent during the COVID-19 pandemic.

Case Manager #5: Folks who are adamant about transmission, folks that will not have sex and remain abstinent. They say, no time to date, not part of my life. Older women who no longer find it interesting.

Case Manager #6: Some clients express they do not want to give HIV to anyone. In addition to this, clients report that they do not want to get other STI's and find it necessary to protect themselves and those around them.

7. How many of your clients are taking HIV medications?

Case Manager #1: All my clients, 100%

Case Manager #2: All my clients are prescribed HIV medications. There is question if all of CM clients are taking their medication every day as six are not undetectable.

Case Manager #3: 100% are taking medications. There are some clients that struggle with adherence and sometimes miss daily doses. One client had stated that medication prices and insurance has been a huge barrier to their medication adherence.

Case Manager #4: All of them. There is question as to whether clients are taking their medications every day, but most clients are very good about adherence.

Case Manager #5: To the best of my knowledge, 100% are prescribed. No one is refusing to take medication.

Case Manager #6: Almost everyone is prescribed. 95% are taking them right now.

8. What is a case that has impacted you or has stood out to you for any reason?

Case Manager #1: CM has spent most of their time with this client. CM stated that the client has a lot of cognitive issues due to trauma at an early age surrounding generational alcohol abuse. The client had been sheltered for most of their life and then thrown into independency. The client had become homeless and had troubles with substance abuse and injection problems. The client had made the decision to stop this cycle after multiple overdoses. CM stated that their client has remained sober the past two years and that being able to see their growth and self-determination has been extremely impactful. The CM stated that their client has been going through these systems even though rarely provide actual help and sustainability. The CM stated they are happy that this client has been able to push through.

Case Manager #2: CM that has a client that has struggled with accepting their HIV diagnosis. The client had been in the hospital where they had received an AIDS diagnosis because their HIV status had progressed. The client had not started on medication and had developed an opportunistic infection. The client had continued to tell themselves that they do not have HIV and that their health was getting better, pretending not to be aware of HIV diagnosis. CM stated that this client does not have legal status in the United States and that the client had stopped engaging with Caracole services. The CM stated that even though they refused to engage in services, they refused to disenroll the client. CL had called the CM stating that they felt sick again, and they later found out they had developed an opportunistic infection, Cancer. CM stated that the client has now accepted their diagnosis and that it has been nice to see the CL take their medications and become more involved with their health and mental health.

Case Manager #3: CM has an immigrant client that had been married for less than five years due to abusive tendencies implemented by partner. The client had moved to Ohio to escape from the husband and went to in-laws to receive support for themselves and their children. The client had stated that their husband made it so they could not get dual citizenship. CM stated that the client had eventually opened up to them about this process and it had taken a lot of trust and communication between the two in order for this to happen.

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Case Manager #4: The CM is a strong advocate for clients experiencing homelessness, mental health issues, substance use, lack of resources pertaining to food, shelter, and overall stresses for basic needs to be met. CM had a client from Africa that had been here with their two children. The client had contracted HIV, lost their job, and had Child Protective Services called on them. This case took a lot of work and stabilizing. The client had been in and out of the hospital and worked with the CM for many months to gain some support and stability.

Case Manager #5: A client who was in his own category, he is no longer with us. The client had had mobility issues, transportation assistance, he had an oncologist cardiac issue, substance abuse, mental health issues, housing issues, constantly in and out of the hospital, and problems with the retirement home. He had a difficult life and things have been hard, but he was a character.

Case Manager #6: There was a client that was 21 or 22 when he died. He came to Caracole in a very sick state, and he must have had the infection for a while then. This was always a shock to me.

Chapter 5

Discussion

My personal values impacted my selection of research topics and methods in many ways that are important to myself. I believe it to be a human right for everyone to have ongoing sexual education that emphasizes medically accurate, anti-patriarchal, intersectional, pleasure-based knowledge. It is necessary for our society to understand consent, to destigmatize HIV/AIDS, to promote inclusivity and to debunk heteronormative values in the United States. HIV/AIDS is stigmatized to this day- only after working at Caracole did I find the knowledge that I have now. Without working at Caracole, I would have had no education on HIV/AIDS and intersectional issues with it. Our society needs to be cognizant of the fact that HIV/AIDS is a marginalized issue, and that Black and Brown communities are predominantly affected by the stigmatization, discrimination, and lack of care that their white counter parts have. HIV is a stigmatized sexual infection, and members of our society are affected more than others- and that should be a problem. I think the structure of my organization did not affect my topic in a negative way that provided difficulty in exploring my results and data. I found it interesting to study academic sources provided in the Literature Review that spoke about these topics on a macro scale-through studies and research-based practice. Interviewing the Case Managers was also a very interesting structure to my proposal to get the perspective within Caracole, and to look at these issues on a micro scale. After being enrolled at Caracole, from the six-case manager's information, all clients are receiving ongoing sexual education and are prescribed HIV medications. It was unclear if clients had received proper sexual education prior to services, as all Case Managers stated that very few had brought up the topic. From reading the literature to looking at the results from my research method, it can show that comprehensive sexual education and harm reduction tools such as safe injection needles, condoms supplied for all genders, and other resources provide people with the knowledge and access to safe behaviors. Although clients have enrolled at Caracole because they have HIV, they are provided with the tools to live safe and healthy lives- a status that all people living with HIV/AIDS can obtain. My findings may affect my

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practice with this population in many ways. I will continue to learn about progressive and radical movements such as harm reduction and prevention, two sustainable tools used at Caracole. I will continue to learn and advocate for this because of the results of success created at Caracole and analyzed in articles included in the Literature Review. In my social work career, these findings will provide me with the knowledge of disproportionate affects on Black and Brown communities surrounding HIV. These findings will allow me to provide accurate knowledge on the issue at hand to fully advocate and provide the proper tools for this population. Suggestions I have for future research include the continuity of intersectional, anti-racist studies, reports, and findings. This research needs to analyze the systemic and institutionalized lack of care our government and society has provided for people living with HIV/AIDS. Some strengths of the study included being able to have in-depth conversations with Caracole Case Managers to get an inside perspective of the successes and hardships that clients face while living with HIV/AIDS. I think the biggest limitations coincide with the sample population not being representative of the population. The case managers serve the population, but they do not share the same experiences as their clients, as their clients do not share the same experiences of their case managers. This study was important for furthering my understanding of the topic because it provided me with the insight for the ways in which comprehensive sexual education is necessary for the prevention of HIV/AIDS. I think it is important to note that it was unclear as to whether clients had received ongoing education prior to being diagnosed and that these tools can provide people the opportunity to make decisions that will be in benefit of themselves and others around them.

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Appendices

- 1) What is your case load from September 2020 to March 2021?
- 2) What are the demographics of your caseload? i.e., Age, gender, sexual orientation, race, PWID, etc.
- 3) Have your clients had sexual education prior to being diagnosed with HIV/AIDS?
- 4) Have your clients received ongoing sexual education after being diagnosed?
- 5) Do your clients practice safe sex? If not, why?
- 6) Have your clients discussed why they use harm reduction tactics regarding safe sex practices?
- 7) How many of your clients are taking HIV medications?
- 8) What is a case that has impacted you, or has stood out to you for any reason?

